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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BPYY

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 **05/14/2018** (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 **116** (L18)
13.Total Certified Beds **116** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(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):

An increase in the number of certified SNF/NF beds from 101 beds to 116 beds, effective May 1, 2018, in accordance with a change in licensure. Due to fifteen beds being relicensed (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective May 1, 2018, all 116 facility beds are certified SNF/NF. After this change they currently have zero (0) beds on layaway.

17. SURVEYOR SIGNATURE Date:
Susie Haben, Unit Supervisor 06/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/12/2018 (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
04/10/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245295

June 1, 2018

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

Dear Mr. Glad:

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

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

Effective May 4, 2018 the above facility is certified for:

101 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 101 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 1, 2018

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Numbers S5295027, H5295131, H5295132, H5295134

Dear Mr. Glad:

On February 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 8, 2018 that included an investigation of complaint numbers H5295131, H5295132, H5295134. 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 April 17, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective April 22, 2018. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 8, 2018. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 17, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 8, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on February 8, 2018, that included an investigation of complaint numbers H5295131, H5295132, H5295134, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on April 5, 2018. The most serious deficiencies at the time of the revisit were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 14, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on April 5, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our visit, we have determined that your

facility has corrected the deficiencies issued pursuant to our survey completed on February 8, 2018 and a PCR, completed on April 5, 2018, as of May 4, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 4, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of April 17, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 8, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 8, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 8, 2018, is to be rescinded.

In our letter of April 17, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 8, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 4, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BPYY

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 **04/05/2018** (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 **101** (L18)
13.Total Certified Beds **101** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(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 :
Robyn Woolley, HFE NE II 03/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 04/10/2018 (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**

A recertification survey was conducted 2/5/18, through 2/8/18, and complaint investigations were also completed at the time of the standard survey. At the time of the survey, investigation of complaints

H5295131, was substantiated at F686
H5295132, was substantiated at F791
H5295134, was substantiated at F690

Investigation of complaint H5295133 was completed and found to be unsubstantiated.

Electronically delivered

April 17, 2018

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Numbers S5295027, H5295131, H5295132, H5295134

Dear Mr. Glad:

On February 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 8, 2018 that included an investigation of complaint numbers H5295131, H5295132, H5295134. 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 April 5, 2018, the Minnesota Department of Health and on March 20, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 8, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 20, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our a standard survey, completed on February 8, 2018. The deficiencies not corrected are as follows:

F565 -- S/S: E -- 483.10(f)(5)(i)-(iv)(6)(7) -- Resident/family Group And Response
F578 -- S/S: D -- 483.10(c)(6)(8)(g)(12)(i)-(v) -- Request/refuse/dscntnue Trmnt;formlte Adv Dir
F585 -- S/S: D -- 483.10(j)(1)-(4) -- Grievances
F641 -- S/S: D -- 483.20(g) -- Accuracy Of Assessments
F657 -- S/S: D -- 483.21(b)(2)(i)-(iii) -- Care Plan Timing And Revision
F812 -- S/S: E -- 483.60(i)(1)(2) -- Food Procurement,store/prepare/serve-Sanitary

In addition, at the time of this revisit, we identified the following deficiency:

F0867 -- S/S: E -- 483.75(g)(2)(ii) -- Qapi/qaa Improvement Activities

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective April 22, 2018. (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 8, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective May 8, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 8, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bethel Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 8, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division

Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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,

- Include electronic acknowledgement signature of provider and date.

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 remedy be imposed:

- 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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 August 8, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	R-C 04/05/2018

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
{E 000}	Initial Comments There were no deficiencies identified for Appendix Z during the recertification survey 2/8/18.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on April 3 through April 5, 2018. The provider was found NOT to have corrected all citations issued during the survey exited February 8, 2018. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		
{F 565} SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	{F 565}		5/4/18

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

Electronically Signed | 05/10/2018

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 _____	R-C 04/05/2018

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 565}	Continued From page 1 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow up on resident council concerns regarding grievances identified during resident council meetings with 5 of 5 residents (R1, R4, R5, R13, R400) reviewed. Findings include: A resident council meeting was held during the post certification revisit on 4/3/18, at 10:45 a.m. with five residents (R1, R4, R5, R13, R400) in attendance. These five alert and oriented residents, agreed the facility had not discussed the results of the survey from the 2/8/18 recertification survey. When interviewed on 4/3/18, at 11:30 a.m,. the administrator verified there had been no direct follow up to the concerns identified for individuals addressed in the recertification survey exited 2/8/18. The administrator verified there was no	{F 565}	F565E Resident/Family Group and response: Immediate corrective action: 1. A special resident council meeting was held on 4/17/2018. Residents #1, 4, 13 and 400 were among those in attendance. Resident #5 refused the invitation, but the Activity Director will review the minutes with him. The agenda followed at the meeting included a review of the recent annual survey and those areas remaining outstanding at Revisit as well as the Grievance process and any new or outstanding grievances the group may have. Action as it applies to others: 1. The Grievance/Concern Policy remains current. 2. The Administrator, DON and Activity Director were re-educated on 4/11/2018 by the Corporate Quality Director on the	

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{F 565}	Continued From page 2 documentation of any audits, nor investigation of the concerns expressed in the recertification survey pertaining to resident council specific concerns. The administrator stated he should have addressed each deficiency with the staff so they would have had clear direction on who was responsible for which issues identified during the February recertification survey. The facility policy Resident Council Meetings and Resident Concerns dated 8/14, indicated the concerns brought up at resident council would be followed up, resolved in a prompt manner and reported back to the resident council or appropriate resident.	{F 565}	Grievance/Concern Policy, the regulations regarding group grievances and suggestions given for resident council minutes and agenda format. 3. All staff re-education on the Grievance/Concern Policy began on 4/12/2018 and will be completed by 4/25/2018. 4. A log of all council grievances will be maintained by the Activity Director to assure timely follow-up and resolution. 5. All grievances will be brought to the Quality Conference each day, discussed, resolution assigned and written response given timely to the satisfaction of the council/council representative. 6. The regularly scheduled resident council meeting will take place on 4/25/2018 with the Ombudsman in attendance. The agenda will include a discussion of progress seen by the council in addressing their grievances timely. Date of completion: 5/4/2018 Recurrence will be prevented by: 1. Audits of weekly grievances will be conducted each week x90 days to assure timely resolution and response. These audits will be maintained and reviewed by the QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Administrator/Activity Director	
{F 578} SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or	{F 578}		5/4/18

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{F 578}	Continued From page 3 discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	{F 578}		

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{F 578}	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan and Physician Ordered Life sustaining Treatment (POLST) reflected the current wishes for 1 of 3 residents (R30) reviewed whose care plan and physician orders did not match the resident's health care directive and physician orders. Findings include: On 4/3/18, at 12:55 p.m. R30 stated she had completed a new advance directive/POLST form in the last week or two. R30 stated the form completed reflected her desire to have no resuscitation, no tube feeding, and no intubation, but did identify her wish to have intravenous (IV) and/or oral antibiotics. A review of R30's record revealed a POLST form signed by the physician on 3/22/18, indicating R30 did not want resuscitation, but did want selective treatment, including IV fluids and antibiotics. R30's advance directive information under the "Profile" tab of the electronic health record (eHR) indicated R30 was a full code (CPR/resuscitation). The information had not been updated to reflect R30's 3/22/18 revised code status. R30's care plan last revised 2/8/18, indicated R30 was "Full Code" and included, "I make my own healthcare decisions with assist from my husband as needed. I make my own health care decisions and I do have a formal health care directive, which is located in my chart. My husband is my	{F 578}	F578-D Request/Refuse/Discontinue Treatment; Formulate Advanced Directive Immediate corrective action: 1. The Care Plan for resident #30 was revised to indicate the updated POLST wishes and MD order for DNR with selective treatment as soon as the discrepancy was identified. Action as it applies to others: 1. The Policy and Procedure for Advanced Directives remains current. 2. The IDT was re-educated on the Advanced Directive Policy on 4/10 and 4/11/2018. 3. All staff re-education on the Advanced Directive Policy began on 4/12/2018 and will be completed by 4/25/2018. 4. All resident charts will be reviewed to assure the information on the POLST document is reflected in PCC and on the Care Plan. Date of completion: 5/4/2018 Recurrence will be prevented by: Five random weekly audits to include all new admissions will be completed x90 days to assure the POLST document matches PCC and the Care Plan. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Designee	

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{F 578}	Continued From page 5 primary HCA [Health Care Advocate] and my daughter, [Name] is my alternate HCA." The care plan had not been updated to reflect R30's 3/22/18 revised code status. On 4/3/18, at 1:45 p.m. registered nurse (RN)-A stated R30 was full code, but that R30 had just signed a new POLST form, which RN-A had reviewed for accuracy. At 2:30 p.m. 4/3/18, RN-A stated she'd made a mistake regarding R30's code status. RN-A stated R30's code status should be do not resuscitate, with limited treatments. RN-A verified R30's care plan had not been revised correctly to reflect R30's do not resuscitate and limited treatment requests.	{F 578}		
{F 585} SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	{F 585}		5/4/18

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{F 585}	Continued From page 6 §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident	{F 585}		

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{F 585}	Continued From page 7 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promptly respond to grievances for 1 of 1 residents (R5) who expressed concern about the filling of the portable liquid oxygen tank and call light wait times.	{F 585}	F585-D Grievances Immediate corrective action: 1. On 4/4/2018 resident #5 was revisited pertaining to his concern of running out of oxygen and call light answering times. His plan of care was updated to include	

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{F 585}	Continued From page 8 Findings include: The facility policy for Grievance/Concern dated 2013, under procedure indicated Grievances/Concerns would be submitted in writing, using the Grievance/Concern Report form and signed by the person filing the report. Completed Grievance/Concern form would be given to the facility Administrator or Social Services Director. The policy included: "All grievances/concerns will be logged and assigned to appropriate designated person for investigation. A written report of investigation and recommended actions will be completed and returned to Administrator/Social Service Director within 72 hours. Administrator will review investigation findings and determine corrective actions to be taken. A meeting with the resident/representative will occur to review the findings and actions taken and/or those that will be taken. If they are not satisfied with the results, other actions will be developed as needed." When interviewed on 4/3/18, at 10:30 a.m. R5 stated the facility does not fill the portable liquid oxygen tanks and R5 "worries terribly" that the oxygen will run out because he never knows when the staff will fill the tanks. R5 verified no staff have addressed this concern even though it had been brought to the staffs' attention at the time of the recertification survey exited 2/8/18. R5 also expressed concerns about long call light times on various shifts. When interviewed on 4/3/18, at 12:50 p.m. licensed practical nurse (LPN)-A who works full time, was not aware R5 had expressed concerns about the filling of the portable liquid oxygen tank,	{F 585}	staff checking at beginning of shift and q4 hours as well as adding a second portable tank to his wheelchair for peace of mind there would always be one full tank immediately available. The resident stated timely answering of his call light was improving. The Grievance Form was updated and resident was satisfied with the plan and informed audits of his O2 tank filling times as well as call light timeliness would be initiated to assure staff compliance. Action as it applies to others: 2. The Grievance/Concern Policy remains current. 3. The Administrator and DON were re-educated on 4/11/2018 by the Corporate Quality Director on the Grievance/Concern Policy, 4. All staff re-education on the Grievance/Concern Policy began on 4/12/2018 and will be completed by 4/25/2018. 5. A log of all grievances will be maintained by the Administrator/Social Services to assure timely follow-up and resolution. 6. All grievances will be brought to the Quality Conference each day, discussed, resolution assigned and written response given timely to the resident/resident representative. Date of completion: 5/4/2018 Recurrence will be prevented by: 7. Audits of weekly grievances will be conducted each week x90 days to assure timely resolution and response. These audits will include call light timeliness and O2 filling times for resident #5 as part of	

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{F 585}	Continued From page 9 and long call light wait times at the time of the original recertification survey exited 2/8/18, and that R5 continued to have these concerns. When interviewed on 4/4/18, at 12:00 p.m. full time registered nurse (RN)-A was not aware R5 had been addressed at the time of the recertification survey 2/8/18, as having concerns about the filling of the portable liquid oxygen tank. Furthermore, RN-A verified no audits of the oxygen tank filling, or call light audits had been completed and stated there had been no meeting with R5 regarding these concerns. RN-A stated she would address the concerns immediately. When interviewed on 4/4/18 at 1:15 p.m. the administrator verified there had not been a specific planning meeting to determine who would take care of each deficiency and each resident listed in the deficiency. The administrator verified he should have addressed each deficiency with the staff so they would have had clear direction on who was responsible for which issues identified at the time of the recertification survey in February.	{F 585}	his Grievance resolution to be completed 2x weekly x 30 days. The results will be maintained and reviewed by the QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Administrator/Social Services	
{F 641} SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure transfer and bed mobility status was coded accurately on the minimum data set (MDS) assessment for 1 of 5 (R32) residents reviewed for accurate	{F 641}	F641-D Accuracy of Assessments Immediate corrective action: 1. Resident #32 MDS was modified to reflect his independence with bed mobility,	5/4/18

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{F 641}	Continued From page 10 assessment. Findings include: During observation on 4/5/18 at 9:08 a.m., R32 was observed to independently transfer himself out of bed, and walked out to the dining room. R32 was directed to sit at a dining room table by a staff, and was given a beverage and a snack. At 9:21 a.m., R32 was observed to stand up independently from a chair in the dining room. Staff guided R32 back to the correct room, but R32 was able to stabilize himself and walk without the use of any assistive devices. Review of a transfer assessment dated 3/14/18, revealed R32 had been assessed by a registered nurse as "independent with bed mobility, transfer, and ambulation." The care plan for mobility/fall prevention, last revised 3/14/18, described R32 as "independent with bed mobility, transfers, and ambulation." Although identified for the provider as inaccurate 2/8/18, the quarterly MDS dated 1/22/18, continued to be coded to indicate R32 required extensive assistance with bed mobility and transfers. During interview on 4/4/18 at 3:36 p.m., registered nurse (RN)-D was asked about the MDS previously identified 2/8/18 as inaccurate. RN-D explained being unaware that R32's MDS required modification, and confirmed staff had not modified R32's MDS. RN-D briefly reviewed the data staff had entered for R32's transfer and bed mobility status during the MDS lookback, and verified R32 should not have been coded as needing extensive assist. RN-D confirmed that	{F 641}	transfers and ambulation. Action as it applies to others: 1. The Policy and Procedure on MDS assessments remains current. 2. Education was provided to the IDT involved with the MDS, assessments and care planning on 4/17/2018. 3. All staff training on accuracy of assessments was started on 4/12/2018 and will be completed by 4/25/2018. 4. Audits have been completed weekly for all MDS completed since Exit and corrections made if indicated. Date of completion: 5/4/2018 Recurrence will be prevented by: 1. Weekly audits of MDS accuracy will be conducted x90 days and corrections made as indicated for any errors. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/MDS Coordinator	

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{F 641}	Continued From page 11 payment was affected by the way staff coded residents for levels of assistance needed for activities of daily living, such as bed mobility and transfers.	{F 641}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure care conferences were	{F 657}	F657-D Care Plan Timing and Revision Immediate corrective action:	5/4/18

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{F 657}	Continued From page 12 conducted every quarter for 2 of 2 residents (R79, R403) reviewed. Findings include: R79 was admitted to the facility on 12/14/17, and a care plan was initiated on this date. However, there was no documentation found indicating the interdisciplinary team (IDT) had met to develop the care plan through a care conference or that R79 had attended a care conference. There was no documentation found indicating R79 had ever attended a care conference or that a care conference had ever been scheduled/held. A review of the medical record revealed R79 had a quarterly MDS completed, with an assessment reference date (ARD) of 3/23/18. On 4/4/18, at 11:30 a.m. Registered nurse (RN)-D stated a care conference should have been held no later than the last date of the MDS, 3/23/18. RN-D stated the social worker was expected to schedule a care conference anywhere between seven (7) days prior to the ARD, and the date of the ARD. Licensed social worker (LSW)-A and RN-D confirmed R79 should have had a quarterly care conference in the month of March, 2018. LSW-A and RN-D also stated they hadn't been employed at the facility in December 2017. LSW-A stated the "Assessment" section of the eHR (electronic health record) was where care conference attendees were supposed to be documented. R403 had a quarterly MDS conducted with an ARD of 3/30/18. However, no care conference had been conducted. On 4/3/16 at 10:58 a.m., a copy of the care conference list provided by LSW-A was reviewed.	{F 657}	1. Care Conference was held for Resident #79 on 4/5/2018 and Resident #403 on 4/16/2018. Action as it applies to others: 1. The Policy and Procedure for Care Planning and Care Conferences remains current. 2. The IDT received education on 4/17/2018 on Care Planning, MDS and Care Conferences. 3. All staff education on Care Planning and Care Conferences began 4/12/2018 and will be completed by 4/25/2018. 4. The facility fell behind in holding care conferences. The plan for correcting others affected is care conferences that were missed in March will be held in April as well as those scheduled in April. The facility will then be caught up for May's schedule and forward. Date of completion: 5/4/2018 Recurrence will be prevented by: 1. 5 weekly audits will be conducted of scheduled care conferences will be completed x90 days to assure timeliness. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: DON/Social Services	

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 _____	R-C 04/05/2018

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

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{F 657}	Continued From page 13 There was no record of R403's quarterly care conference having been completed. RN-D and LSW-A confirmed the care plan 7 day look back period was 3/30/18 and indicated 3/31/18 was when the care conference should have been held. The Care Planning policy last revised November 2017, required that "Resident care conferences are held within the first 21 days of admission, and at least quarterly thereafter... Resident/Resident Representative will be invited to the care conference."	{F 657}		
{F 812} SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 812}	F812-E	5/4/18

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 _____	R-C 04/05/2018

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

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{F 812}	Continued From page 14 review, the facility failed to ensure eating items were air dried and not stored wet. This had the potential to affect 79 of 89 residents currently residing at the facility. Findings include: On 4/3/18, at 9:45 a.m. a tour of the kitchen revealed the following: 1) Plastic pitcher lids were stored wet in a large plastic bin. Water droplets were noted on the top and inside of the plastic pitcher lids, and there was a two-handled cup which had been placed in the bin and the inside of the cup was wet. 2) In the dishwasher area, plate lids were stacked and stored wet on a solid shelving unit near the dish machine. Dietary aide (DA)-A stated she had been trained to air dry dishes before storing them. DA-A stated after wiping down the stainless steel area below the solid shelving unit, she was going to stack the lids on the area to dry. 3) Two floor carts, ready for the noon meal, were noted to contain plastic trays on individual shelves. Each of the trays had been set up with silverware, cups and plastic glasses for the noon meal. Approximately 26 coffee cups and approximately 26 large and small clear plastic glasses had been stacked together and placed directly on the trays. The wet coffee cups and plastic glasses were noted to have water droplets inside leaving a wet round ring on the plastic tray. At 9:55 a.m. on 4/3/18, the dietary manager (DM) confirmed during the tour, that the plastic glasses were stacked together wet and the coffee cups were stored wet on trays set up for the noon	{F 812}	Immediate corrective action: 1. The wet lids, two handled cup, coffee cups and lids were removed and rewashed and air dried when the discrepancy was identified. Action as it applies to others: 1. The Policy for Warewashing remains current. 2. All dietary staff and the Dietary Manager were re-educated on the Policy for Warewashing which includes air drying all dishware. 3. Extra dishware has been ordered as well as extra drying racks to allow a more conducive area for air drying dishware. 4. Audits are being conducted 5x weekly on the air drying of dishware to assure nothing is stored until completely dry. Date of completion: 5/4/2018 Recurrence will be prevented by: 1. 5x weekly audits will be held x90 days to assure dishware is properly air dried before stored. The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease or discontinue the audits. The correction will be monitored by: Dietary Manager/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 _____	R-C 04/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 812}	Continued From page 15 meal. The dietary manager (DM) stated the facility had focused their attention on the wet plates identified during the February 2018 survey, and not the glasses and coffee cups. During a follow up interview with the DM on 4/4/18 at 2:15 p.m., she stated she regularly reviewed the importance of ensuring dishes and utensils were dry before storing. The DM also stated the normal routine was for staff to wipe off the stainless steel area of the dish machine and put the plate lids on that area to air dry. On 4/5/18, at 9:00 a.m. cook-A and DA-A confirmed they had received training about the importance of air drying dishes and utensils. DA-A stated it had been a fluke that the coffee cups and plastic glasses had been put away wet. On 4/5/18, at 9:05 a.m. the DM stated the facility's policy regarding air drying dishes and utensils had not changed and all items were to be air dried.	{F 812}		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility's Quality Assessment and Assurance (QAA) committee did not develop a plan of action to address the deficient practices in the areas of	F 867	F867 QAPI Immediate corrective action: 1. A QAPI Committee meeting to include the ID Team will be held on 4/25/2018	5/4/18

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 _____	R-C 04/05/2018

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

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F 867	Continued From page 16 resident council, advance directives, grievances, care conference timing and revision, Minimum Data Set (MDS) assessment accuracy, and kitchen sanitation as identified in the recertification survey exited 2/8/18. The failure to develop a plan of correction had the potential to affect any residents currently residing in the facility. Findings include: The facility's QAA committee did not develop a system of monitoring quality problems from the past survey deficiencies and failed to develop, implement and monitor plans of action to address the past survey deficiencies. During an interview on 4/4/18 at 1:15 p.m., and 4/5/18 at 11:40 a.m., the administrator verified there had not been a specific planning meeting to determine who would take care of each deficiency and each resident listed in the deficiency. The administrator verified he should have addressed each deficiency with the staff so they would have had clear direction on who was responsible for which issues identified at the time of the recertification survey in February.	F 867	facilitated by the Corporate Quality Director to review Action Plan for monitoring and assignments of deficient practices identified in the Annual Survey and the subsequent survey Revisit. Action as it applies to others: 1. The Facility QAPI Plan and the Policy and Procedure for QAPI remain current. 2. Education on the QAPI process will be provided to the IDT at the QAPI meeting on 4/25/2018. 3. A review of each deficiency, assignments for ongoing compliance and future review of audits with action plans will be completed at the QAPI meeting on 4/25/2018. Date of completion: 5/4/2018 Recurrence will be prevented by: Audits and input will be completed by participation in monthly QAPI Committee either via phone or in person x 90 days by corporate regional staff. The results of these audits will determine if the participation will continue monthly or be reduced to random participation by corporate staff. The correction will be monitored by: Administrator/Designee	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BPYY

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 **02/08/2018** (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 **101** (L18)
13.Total Certified Beds **101** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	101			
(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 :
Robyn Woolley, HFE NE II 03/20/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 04/10/2018 (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**

A recertification survey was conducted 2/5/18, through 2/8/18, and complaint investigations were also completed at the time of the standard survey. At the time of the survey, investigation of complaints

H5295131, was substantiated at F686
H5295132, was substantiated at F791
H5295134, was substantiated at F690

Investigation of complaint H5295133 was completed and found to be unsubstantiated.

Electronically delivered
February 28, 2018

Mr. Cory Glad, Administrator
Bethel Care Center
420 Marshall Avenue
Saint Paul, MN 55102

RE: Project Numbers S5295027, H5295131, H5295132, H5295134, H5295133

Dear Mr. Glad:

On February 8, 2018, 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. In addition, at the time of the February 8, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5295131, H5295132, H5295134.

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 electronically delivered CMS-2567, whereby corrections are required. In addition, at the time of the February 8, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5295133 that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at

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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

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 March 20, 2018, 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 March 20, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 8, 2018 (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 August 8, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	02/08/2018

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 A recertification survey was conducted 2/5/18, through 2/8/18, and complaint investigations were also completed at the time of the standard survey. At the time of the survey, investigation of complaints H5295131, was substantiated at F686 H5295132, was substantiated at F791 H5295134, was substantiated at F690 Investigation of complaint H5295133 was completed and found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend	F 565		3/20/18

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

Electronically Signed | 03/10/2018

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 _____	02/08/2018

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

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F 565	Continued From page 1 resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to follow up on resident council concerns regarding grievances expressed during a resident council meeting which had the potential to impact 6 of 6 residents (R1, R5, R13, R62, R69, R78) reviewed in attendance. Findings include: Document review of the resident council minutes revealed a grievance/concern was expressed in	F 565	F565 Resident/Family Group and Response Immediate Corrective Action: 1. All outstanding grievances have been addressed. Action as it applies to others: 2. A Resident Council meeting will be	

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F 565	Continued From page 2 the 9/17 resident council meeting. Review of the facility tracking log identified: 1. Slow call light response. Follow up Administrator and Director of Nursing to provide updates to system and process to improve resident satisfaction. 2. Not enough staff on fourth floor night shift. Follow up, Administrator and Director of Nursing to collaborate on updated staffing plans to meet resident needs. 3. Staff are sometimes rude to residents. Follow up, monitor for future grievances. Provide on the spot reeducation of staff when rude behavior observed. 4. Medications are not administered timely. Follow up, monitor for future grievances. Provide resident education as appropriate. Document review of the actual Grievance/Concern Report Form dated 9/27/17 from the resident council meeting to co-inside with the tracking log read, *Slow call light response, sometimes up to an hour. * Inadequate Staffing on 4th floor, especially 3rd shift. *Staff are sometimes rude to residents, yelling at them or showing impatience at requests- 3rd shift is often rude. *Nurses don't administer medications in a timely manner. The action taken on the Grievance/Concern report dated 9/27/17 read, "Discussed the above concerns with new DON (director of nursing) The complaints have been shared by residents for an extended period of time. Working with new bodies to build an accountable work culture." Document review of the 10/17 Resident Council Meeting Minutes failed to include a follow up to the concerns expressed in the 9/17 meeting. Six residents attended the resident council	F 565	held no later than March 16, 2018 to review grievances/concerns and to see if any other issues remain unresolved. The Grievance/Concern Policy remains current. The Administrator/DON were education on the Grievance/Concern Policy and follow up. The ADM/DON/Designee educated the Interdisciplinary Team (IDT) to assure team members understand the Grievance/Concern Policy requirements for timely and satisfactory resolutions. Date of Completion: 3/20/18 Recurrence will be prevented by: 3. The Administrator/designee will audit grievances/concerns each week to ensure response is timely and the resolution is to the resident's satisfaction. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The Correction will be monitored by: Administrator/Designee	

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F 565	Continued From page 3	F 565		

meeting with state surveyors and the ombudsman on 2/6/18, at 2:30 pm.
Document review of R1's cognitive assessment dated 10/26/17, revealed cognitively intact.
Document review of R5's cognitive assessment dated 10/22/17, revealed cognitively intact.
Document review of R13's cognitive assessment dated 9/15/17, revealed cognitively intact.
Document review of R62's cognitive assessment dated 9/24/17, revealed cognitively intact.
Document review of R69's cognitive assessment dated 8/31/17, revealed moderate impairment.
Document review of R78's cognitive assessment dated 7/23/17, revealed cognitively intact.

When interviewed during the resident council meeting on 2/6/18, at 2:50 p.m. R1, R5, R13, R62, R69 and R78 were asked if the facility responded to concerns. The residents unanimously reported the facility did not respond to their concerns. The residents stated they fill out concern forms and no one from the facility got back to them on the progress of a resolution. R78 said the facility was quick to get back to them if a resident had bad conduct but not about a concern expressed by a resident. R1 stated a belief that the concern forms were thrown away by management. R5 indicated filling out concern forms to let management know about the concern but no one ever got back to them with a solution. R5 expressed a particular issue at the January Resident Council meeting related to running out of oxygen in a tank. R5 believed the facility had not come up with a good system to address the problem of running out of oxygen in the portable tanks.

Continued interview with resident council members R1, R5, R13, R62, R69 and R78

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F 565	Continued From page 4	F 565		

revealed they are not afraid to fill out a concern form because nothing ever happened with filling out a grievance. R78 stated, "But don't say anything negative about the staff because then they will put in your medical record that you are a behavior problem."

R1, R5, R13, R62, R69 and R78 agreed the facility did not post the results of the State inspections and they did not know where they were. The residents did not recall having any discussion at the resident council meetings pertaining to the state inspection results. Furthermore, the residents all expressed they were not allowed to view their medical record and have asked but were told no when asked.

Document review of the facility policy dated 8/14, titled, Resident Council Meetings and Resident Concerns indicated the concerns brought up at resident council would be followed up, resolved in a prompt manner and reported back to the resident council or appropriate resident.

On 2/7/18, at 8:33 a.m. the administrator stated there had not been a good system at the facility to follow through with resident grievances and concerns due to staffing challenges. The administrator expressed being without a social worker for three to four months but in the past month had hired a social worker. The administrator acknowledged there were no follow up investigations to the resident council concerns expressed in September. There were no documents to verify audits or interviews. The administrator stated there should be a documented investigation to the resident concerns and there were no documents available. The administrator verified the residents were to

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F 565	Continued From page 5 have prompt follow up to concerns addressed in resident council. The administrator stated there were two concern forms submitted in January and no concern forms submitted in December.	F 565		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post survey results in a prominent area, or post notice of their availability. This had the potential to affect all 94	F 577	F577 Right to Survey Results/Advocate Agency Info Immediate corrective action:	3/20/18

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F 577	Continued From page 6 residents who lived in the facility. Findings include: During the resident council meeting on 2/6/18, at 2:30 p.m. held with the ombudsman and surveyors, residents (R)-1, R5, R13, R62, R69 & R78 expressed having no idea where the facility's survey results were posted and stated they did not know how to obtain them. Observation of the front entry, the area by the elevators, and the second and third floor elevator areas revealed there were no survey results posted or notice of where to find them. On the first floor, therapy hallway, a note was posted which directed the reader to ask the receptionist if wanting to view the facility survey results. When interviewed on 2/6/18, at 4:00 pm the administrator confirmed the survey results were not posted, rather were locked in the receptionist desk drawer because the residents' would take them. The administrator verified the survey results must be made readily available and stated the system would be changed immediately. In addition, the administrator verified the current area with the posting directive was not utilized by all residents therefore was not a prominent location in which residents and visitors frequented. The administrator stated the facility did not have a policy related to the survey posting requirements but knew it was a regulation therefore would immediately ensure the survey results were correctly posted.	F 577	1. The survey results were posted, corrected at the time of the survey and bolted to an end table in the front lobby. Action as it applies to others: 2. The survey results were posted and the sign was updated to reflect where to find them. Education was provided to the Administrator to ensure understanding on the regulation of having the survey binder available to the public. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The Administrator/designee will visually audit the survey book to ensure it is available and the required documents are inside the binder. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: Administrator/Designee	
F 578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		3/19/18

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F 578 SS=D	Continued From page 7 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578		

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F 578	Continued From page 8 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan and Physician Ordered Life sustaining Treatment (POLST) reflected the current wishes for 1 of 1 resident (R30) reviewed whose care plan and POLST did not match the resident's health care directive and physician orders. Findings include: R30's advance directive information under the "Profile" tab of the electronic medical record (EMR) indicated R30 was a full code (CPR/resuscitation). A Physician Ordered Life Sustaining Treatment (POLST) form dated 10/23/13, located in R30's paper medical record indicated R30 did not want to be resuscitated/intubated (DNR/DNI) however, authorized the administration of antibiotics and intravenous (IV) fluids. In the same paper record, a Health Care Directive dated 10/12/15, indicated R30 wanted CPR if the heart or breathing stopped, as well as other treatments, including antibiotics and IV therapy. R30's care plan dated 10/13/15, indicated "My current POLST is DNR/DNI. I make my own healthcare decisions with assist from my husband as needed. I make my own health care decisions and I do have a formal health care directive, which is located in my chart. My husband is my primary HCA and my daughter, [Name] is my alternate HCA."	F 578	F578 Request/Refuse/Discontinue Treatment; Formulate Dir Immediate corrective action: 1. R30's healthcare directive and care plan were updated to reflect the resident's wishes to now be a Full Code. Action as it applies to others: 2. The facility completed a review of all residents to ensure the profile in PCC and the POLST matched their wishes and care plan. Education was completed with licensed nursing staff and IDT on POLST, updating PCC, and care plan to match the resident's wishes. Date of completion: 3/19/18 Recurrence will be prevented by: 3. The DON/designee will audit random residents weekly to assure the POLST, PCC, and the care plan match the resident's wishes. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings.	

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F 578	Continued From page 9 R30's physician orders dated 2/18, indicated an order for full code status (resuscitation efforts) On 2/8/18, at 8:43 a.m. registered nurse (RN)-A reviewed R30's POLST, health care directive and care plan and verified the care plan and POLST had not been updated and was not an accurate reflection of R30's advance directive information.	F 578	The correction will be monitored by: DON/Designee	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the	F 582		3/20/18

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F 582	Continued From page 10 Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to provide proper and timely notices when residents discharged from a Medicare Part A stay with benefit days still remaining, and became liable to pay for services previously covered under Medicare Part A. This affected 2 of 3 residents (R52, R37) reviewed for beneficiary notification review. Findings include: Review of form CMS-20052, completed by the facility, revealed R52's Medicare Part A services	F 582	F582 Medicaid/Medicare Coverage/Liability Notice Immediate corrective action: 1. Failure to issue the proper notices and timely for R52 and R37 cannot be corrected for these residents. Action as it applies to others: 2. Education was provided to staff members who will provide the letters to	

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F 582	Continued From page 11 started 10/6/17, and the last covered day of Part A service was 1/12/18. The form indicated the "facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted." R52 remained in the facility after 1/12/18. Further record review revealed the facility provided a form titled SNF Determination on Continued Stay, which explained that the services provided would no longer be covered under Medicare beginning 1/13/18. R52 signed and dated the form on 2/7/18, although the coverage had already ended and R52 was liable for payments since 1/13/18. Another form, the Notice of Medicare Non-Coverage, also noted that coverage for services would end 1/12/18. R52 signed and dated this notice on 2/7/18. Request for evidence of notice provided to R52 had been provided to facility staff on 2/6/18. Review of form CMS-20052, completed by the facility, revealed R37's Medicare Part A services started 9/22/17, and the last covered day of Part A service was 1/7/18. The form indicated the "facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted." R37 remained in the facility after 1/7/18. Further record review revealed the facility provided a form titled SNF Determination on Continued Stay, which explained that services provided would no longer be covered under Medicare beginning 1/8/18. R37 signed and dated the form on 2/7/18, although the coverage had already ended and R37 was liable for payments since 1/8/18. The facility did not provide the Notice of Medicare Non-Coverage form to R37. Request for evidence of notice provided to R37 had been provided to facility staff on 2/6/18. On 2/8/18, at 2:50 p.m. the administrator was	F 582	residents when their coverage is ending. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The Administrator/designee will audit random residents whose coverage has ended to ensure they received the appropriate notice and that it is provided timely. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: Administrator/Designee	

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F 582	Continued From page 12 asked about the liability notices identified above, dated 2/7/18. The administrator confirmed that it was his understanding that staff completed and provided the liability notices to R52 and R37 on 2/7/18.	F 582		
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman	F 583		3/20/18

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	245295	A. BUILDING _____ B. WING _____	02/08/2018

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F 583	Continued From page 13 to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal privacy for 9 of 10 residents (R53, R83, R46, R5, R37, R62, R393, R394, R80) reviewed on the transitional care unit. Findings include: On 2/5/18, at 1:30 p.m. R53's bedroom was observed to have a 30 x 36 inch mirror located centrally on the wall at the foot of bed A and Bed B. There was a single privacy track on the ceiling between the beds but there was no privacy curtain hung on the track. Between bed A and bed B was an aluminum framed 3 section privacy screen on wheels, approximately 60 inches wide. It did not cover the length of the 72 inch bed. There was no privacy screen noted at the end of either bed. Observation of the transitional care bedrooms identified all were set up with the 30 x 36 inch mirror with the privacy screen between the beds. There were no privacy curtains hung in any rooms. On 2/5/18, at 1:30 p.m. R53 expressed dissatisfaction with the lack of privacy. R53 was alone in the room because the roommate had been discharged. R53 stated, "I could see everything they did for my roommate and my roommate could watch all of my cares, just by looking in the mirror." R53 indicated the facility had been informed there was no privacy, but no one addressed the problem.	F 583	F583 Personal Privacy/Confidentiality of Records Immediate corrective action: 1. Personal privacy is provided for R53, R83, R46, F5, R37, R62, R393, R394, and R80. Action as it applies to others: 2. All residents rooms were reviewed to ensure personal privacy is provided and proper curtains are in place. Education was provided to the Maintenance Director on proper curtain placement and need for personal privacy for residents. Date of Completion: 3/20/18 Recurrence will be prevented by: 3. The Administrator/designee will audit random resident rooms to ensure curtain placement and personal privacy is maintained. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: Administrator/Designee	

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F 583	Continued From page 14	F 583		

Document review of R53's Face Sheet indicated R53 was admitted on 7/11/17. On 1/17/18, R53 was assessed as cognitively intact according to the Brief Interview for Mental Status (BIMS). The plan of care dated 1/17/18, identified R53 required total assistance with all activities of daily living (ADL's).

On 2/5/18, at 6:47 p.m. R83 complained there was not privacy in the room because cares could be observed by looking in the mirror on the wall. R83 was currently alone in the room because the roommate was discharged. R83 expressed concern about getting a new roommate because there would not be privacy. R83 explained when complaining about the privacy to staff they stated it was a temporary situation due to facility renovation which had begun in 4/17.

Document review of R83's Face Sheet indicated R83 was admitted on 11/29/17. On 12/6/17, R83 was assessed as cognitively intact according to the BIMS. The plan of care dated 12/6/17, indicated indicated R83 required total assistance with all ADL's.

When interviewed on 2/6/18, at 10:00 a.m. R46 expressed concern that the roommate could watch everything that was happening on R46's side of the room. Additionally, the roommate had to come by R46 to get out the door so there was absolutely no privacy. R46 expressed dissatisfaction with the situation but staff said that was how it is until the privacy curtains came in. Staff explained the room was renovated to be a single room but until all the renovation was completed, the facility was placing two residents in the room with the portable divider screen for privacy.

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F 583	Continued From page 15	F 583		

Document review of R46's Face Sheet indicated an admission of 11/11/17. On 11/29/17, R46 was assessed as cognitively intact according to the BIMS. The plan of care dated 12/1/17, indicated R46 required total assistance with all ADL's.

On 2/6/18, at 10:05 a.m. licensed practical nurse (LPN)-A performed a dressing change to a wound on R46's coccyx. R46's roommate (R5) was able to watch the procedure by observing in the 30 x 36 inch mirror on the wall.

On 2/6/18, at 11:58 a.m. R5 verbalized being upset the roommate could watch all cares through the mirror. Additionally, R5 could see R46 receiving personal cares. R5 stated, "There is no privacy and it is a problem with cares. The single screen is not effective for privacy and it is upsetting for no privacy." R5 verified staff was informed there was no privacy and stated, "but no one did anything about it."

Document review of R5's Face Sheet indicated an admission date of 8/25/17. On 9/1/17, R5 was assessed as cognitively intact according to the BIMS. The plan of care dated 11/8/17, indicated R5 required total assistance with all ADL's.

On 2/6/18, at 10:39 a.m. R37 was sitting up in the wheel chair with two privacy screens on wheels in the bedroom. R37 stated it was difficult to maneuver in the small space with the privacy curtains in the room. R37 said if the door was open there was no privacy because there was no curtain between the beds and there was no privacy curtain if the door was opened from the hallway. R37 said the person next door who is alone in the room gave up their privacy screen so

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there would be two screens for R37. The other resident had heard how upset R37 was about the lack of privacy so gave up their screen. R62 was also in the room and verified they could watch each others cares through the mirror up until they got the second screen this week. R37 and R62 indicated staff told them this is how it was because of the renovation project. The rooms were designed for one person, but they were placing two residents in the room until the renovation was complete.

Document review of R37's Face Sheet indicated an admission date of 1/22/18. On 2/1/18, R37 was assessed as cognitively intact according to the BIMS. The plan of care dated 2/4/18, indicated R37 required total assistance with all ADL's.

Document review of R62's Face Sheet indicated an admission date of 9/17/17. On 11/17/17, R62 was assessed as cognitively intact according to the BIMS. The plan of care dated 11/17/17, indicated R62 required total assistance with all ADL's.

On 2/6/18, at 12:15 p.m. R393 and R394 who were roommates, complained at the same time about the lack of privacy in the room. They indicated they have complained to the staff about the portable privacy screen not being effective in providing privacy.

Document review of R393's Face Sheet indicated an admission of 1/23/18. R393 was currently in the assessment process for cognition but the temporary plan of care dated 2/4/18, addressed mentation as alert and oriented to person, place and time. The temporary plan of care also

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F 583	Continued From page 17 identified R393 required total assistance with all ADL's. Document review of R394's Face Sheet indicated an admission of 1/12/18. R394 was currently in the assessment process for cognition but the temporary plan of care dated 2/2/18, addressed mentation as alert and oriented to person, place and time. The temporary plan of care also indicated R394 required total assistance with all ADL's. On 2/6/18, at 2:00 p.m. R80 expressed concern about the lack of a privacy when the bedroom door was open to the hallway. R80 felt the door needed to remain closed because there was no privacy. Although there was a privacy curtain track in the ceiling, there was no privacy curtain hung from the track. R80 stated the facility staff reported the curtains were on order because of the renovation project. Document review of R80's Face Sheet indicated an admission date of 12/20/17. On 1/10/18, R80 was assessed as cognitively intact according to the BIMS. The plan of care dated 1/10/18, indicated R80 required total assistance with all ADL's. When interviewed on 2/7/18, at 3:00 p.m. the administrator verified the privacy screens were not adequate for full visual privacy. The bedrooms were set up with privacy ceiling track to accommodate one resident when the renovation was completed. Meanwhile, two residents sharing the space did not receive adequate privacy with the use of the portable privacy divider.	F 583		
F 585	Grievances	F 585		3/20/18

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F 585 SS=E	Continued From page 18 CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone	F 585		

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number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not

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F 585	Continued From page 20 confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promptly respond to grievances for 5 of 5 residents (R5, R394, R78, R37, R1) who expressed concerns. Findings include: On 2/5/18, at 3:00 p.m. R5 was observed in the bedroom, seated in the wheelchair, taking off the oxygen nasal cannula (NC) which was hooked to a portable liquid oxygen tank on the back of the wheel chair. R5 expressed concerns about running out of oxygen in the portable tank because it had happened before. R5 stated staff seemed to depend on R5 to tell them when the tank was low. R5 further elaborated that staff seemed to resist filling the oxygen tank because they were supposed to take the tank downstairs and it was a long process. R5 stated "They just don't want to do it." R5 said all of the shifts were a problem with making sure the portable oxygen tank was full. R5 stated staff was aware and	F 585	F585 Grievances Immediate Corrective Action: 1. All outstanding grievances have been addressed. Action as it applies to others: 2. A Resident Council meeting will be held no later than March 16, 2018 to review grievances/concerns and to see if any other issues remain unresolved. The Grievance/Concern Policy remains current. The Administrator/DON were education on the Grievance/Concern Policy and follow up. The ADM/DON/Designee educated the Interdisciplinary Team (IDT) to assure team members understand the Grievance/Concern Policy requirements for timely and satisfactory resolutions.	

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F 585	Continued From page 21 thought staff would have completed a concern form. R5 stated the concern had been written down but no one had ever responded to it and R5 continued to worry about the process. R5 expressed wanting a system to ensure staff would automatically check the portable oxygen tanks so R5 would not have to "worry about it all the time." On 2/5/18, at 4:00 p.m. R5 turned on the call light to report the portable oxygen tank was on empty. R5 demonstrated feeling oxygen still coming through the NC. Registered nurse (RN)-F answered the call light and confirmed the tank was almost empty and would take care of it right away. On 2/5/18, at 4:30 p.m. RN-F verified the facility did not have a system to routinely check and fill the portable oxygen tanks. Additionally, there was no documentation process to ensure the portable tanks remained filled. RN-F verified being aware R5 became anxious about having the portable oxygen tank filled but did not think the tank had ever completely run out of oxygen. R5's brief inventory of mental status (BIMS) assessment identified R5 was cognitively intact 11/29/17. Review of resident grievances identified an undated document which read, "Staff no fill {sic} tank. They talk on the phones not working." On 2/7/18, at 9:00 a.m. upon review of the document, R5 verified it was the complaint R5 filed "last month." R5 indicated no one responded to R5 about this concern and again expressed worry about the issues.	F 585	Date of Completion: 3/20/18 Recurrence will be prevented by: 3. The Administrator/designee will audit grievances/concerns each week to ensure response is timely and the resolution is to the resident's satisfaction. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The Correction will be monitored by: Administrator/Designee	

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R5 also completed a grievance related to answering call lights. A Grievance/Concern Report Form dated 9/11/17, read: "Resident reported to writer staff have not been answering [R5's] call light in a timely manner. causing [R5] to go to the bathroom in [R5's] pants." Resident stated, "You can turn that buzzer (call light) on and you're lucky to get someone in an hours time." Resident told writer [R5] has asked for help on multiple occasions and staff have told [R5] they will help, but then they never come back to actually help [R5].

The form was written by the social worker no longer working at the facility. The person assigned as responsible for follow up is no longer at the facility, but wrote: "Call light audit completed (answered in 3 minutes) Will complete random audits as needed." The administrator signed the form on 9-13-17.

On 2/7/18, at 2:30 p.m. the administrator verified R5 should have had follow up with the concern voiced about filling the portable oxygen tank, and a form should have been completed. Additionally, the adminstrator verified there were no documents to indicate an audit of call lights occurred for R5 or any further investigation and resolution of the grievance.

R394 voiced a concern related to the timely administration of pain medication based on physician orders.

R394 was admitted in January 2018, based on the Face Sheet, with a diagnosis of nondisplaced intertrochanteric fracture of the left femur. A progress notes dated 1/12/18, identified R394 was alert and oriented and able to make needs

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known to staff.

A Grievance/Concern Report dated 1/17/18, read: "Resident had a complaint about pain medications not available upon request and not being given exactly in 4 hours as scheduled for prn [whenever necessary] medications. Resident also complained about regularly scheduled medications not given. Upon checking records it was noted that all medications were given and were administered on time. Resident was offered non-pharmacological means of pain relief, such as ice-packs, repositioning and positive reinforcement. Resident stated "What it will do for me? I already put ice pack- it did nothing." Resident was offered to wait until the next dose of prn pain medication can be given." Date of follow up with resident was 1/17/18, indicated R394 was not satisfied with follow up and objected to alternative to pain control. The administrator signed the grievance/concern form on 1/18/18.

On 2/6/18, at 12:15 p.m. R394 reported being upset RN-D did not administer the pain medications timely and the record was not checked. R394 was certain pain medications were not administered every four hours on the date of the complaint.

R394's physician orders indicated Oxycodone HCl (narcotic pain medication) tablet 5 mg. Give 10 mg by mouth every 4 hours as needed for pain rated 8-10. According to the Medication Administration Record (MAR), this medication was given at 12:22 a.m. a pain level rated at "8", 3:29 p.m. a pain level rated at "10", and 7:30 p.m. for a pain level rated at "9" on 1/17/18. There was no documentation after the medications were administered to indicate if R394 received relief

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from the pain medication.

R394's MAR's for 1/17/18, identified physician orders for Oxycodone HCl tablet 5 mg., give 5 mg by mouth every 4 hours as needed for pain rated 5-7. This medication was given at 4:44 a.m. for a pain level rated at "8". There was no documentation after the medication was administered to indicate if R394 received relief from the pain medication.

During an interview on 2/8/17, at 12:30 p.m. RN-D verified remembering R394 was not happy about non-pharmacological interventions. RN-D verified the medication sheets were not checked to determine the accuracy of R394's complaint and verified the follow up could have been better now that the record reveals R394 did not receive the prn medication for pain every 4 hours as ordered by the physician. RN-D verified the facility should have discussed the findings with the resident and validated the resident concerns with a follow up investigation to the concern.

R78 expressed concern adjusting to a new room and roommate. Document review of R78's BIMS assessment dated 1/9/18, indicated R78 was cognitively intact.

On 2/6/18, at 1:30 p.m. R78 stated staff did not get back to R78 in a timely manner and used the example of the grievance/concern from 9/28/17. R78 stated, "I think they throw out the concerns we write because I fill them out and no one gets back to me. Check December and January, you will see, I bet they can't find any from me."

Document review of a form titled Grievance/Concern Report Form dated 9/28/17,

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read: "Resident is very emotionally disturbed due to [R78] feelings that Unit Manager (UM) moved [R78] to another floor. [R78] feels that the new roommate's bed positioning has removed a lot of [R78's] space and now [R78] is cornered and this is triggering [R78] claustrophobia [R78] feels UM is picking on her. Monitored resident demeanor and adjustment to new space while casually checking in for a few days. Nurse Manager (new) was meeting with [R78] frequently to assist [R78] with settling in. I met with [R78] formally 10/4/17 to discuss grievance. New concerns addressed 10/4/17."

On 2/7/18, at 2:30 p.m. the administrator verified there was no documentation to accompany the grievance form from R78. The staff documenting the concerns was no longer at the facility. The administrator signed the form 10/4/17. There was no documentation to verify the facility followed through with R78's grievance. The Resident signature line on the grievance form was blank. The administrator acknowledged there were no grievance concern forms filled out in December and there were two grievance concern forms filled out in 1/18 but none for R78.

R37 voiced a grievance related to the seating arrangement in the dining room. R37's BIMS assessment dated 1/2/18, indicated R37 was cognitively intact.

On 2/8/18, at 10:56 a.m. R37 said a grievance/concern was filed with the administrator because the dining room table arrangement was changed without resident consultation. R37 stated, "The administrator dictated a 60 day trial to a situation that affected the residents and the residents were not

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consulted prior to the changing of the dining room tables. The flow was not a good system and ended up being switched back after much anxiety for the residents." Furthermore, R37 stated, "I think the administrator throws away the grievances and the staff do not listen. I have written multiple grievances and don't know what happens to them."

Document review of a grievance completed for R37 on 10/5/17, read: "Resident spoke with administrator regarding dining room arrangement. Resident states that dining room arrangement is not conducive to the environment with wheelchairs. Administrator stated that the situation would be re-assessed in 60 days, however resident would like for more immediate action to be taken. In 2nd month of reorganizing dining tables. 90 day trial end November 30th. Will take corrective action as needed at that time. 11/30/2017-Ended trial 10/15/2017 and returned tables to previous location." There was no documented follow up with R37. There was no signature from the resident on the form.

On 2/8/18, at 1:00 p.m. the administrator verified there were no documents to accompany the grievance/concern completed by R37. There was no evidence an investigation was completed for the grievance. The administrator did not have any documentation to indicate meeting with R37 regarding the grievance/concern.

R1 was told staff would receive education to remove dirty linen and briefs properly. Document review of R1's BIMS dated 1/26/18, indicated R1 was cognitively intact.

On 1/2/18, R1 completed a Grievance/Concern

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Report Form which read, [nursing assistant (NA)-C] removed my roommate from my room and left the urine soaked clothes and bed sheets. There was a hand towel with a good deal of feces on it. [NA-C] never came back to remove the items. When I talked to [NA-C] about it [NA-C] seemed to think it was funny. Action taken to address the grievance written by registered nurse (RN)-C read, I followed up with NAR (nursing assistant registered) who stated that [NA-C] bundled the dirty sheets and left it on resident roommate bed after [NA-C] got roommate up and proceeded to get other resident's up due to being challenged on the floor. Educated to take bags in the room and remove dirty linen/briefs right away from the room when care was completed.

When interviewed on 2/8/18, at 8:30 a.m. RN-C was not able to produce any documentation to indicate follow up with R1 was completed and that R1 was satisfied with the resolution.

On 2/8/18, at 2:00 p.m. the administrator explained the facility was without social workers for a few months and no one was assigned to be responsible for follow through with the grievances and concerns. The administrator indicated a social worker started at the facility "last month" and would take over the process for grievances. Furthermore, the administrator acknowledged there was not a good process to review the grievances/concerns, quantify the data and ensure resident follow up.

The facility policy for Grievance/Concern, dated 2013, under procedure read, Grievances/Concerns would be submitted in writing, using the Grievance/Concern Report form and signed by the person filing the report.

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F 585	Continued From page 28 Completed Grievance/Concern form would be given to the facility Administrator or Social Services Director. All grievances/concerns will be logged and assigned to appropriate designated person for investigation. A written report of investigation and recommended actions will be completed and returned to Administrator/Social Service Director within 72 hours. Administrator will review investigation findings and determine corrective actions to be taken. A meeting with the resident/representative will occur to review the findings and actions taken and/or those that will be taken. If they are not satisfied with the results, other actions will be developed as needed.	F 585		
F 606 SS=D	Not Employ/Engage Staff w/ Adverse Actions CFR(s): 483.12(a)(3)(4) §483.12(a) The facility must- §483.12(a)(3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. §483.12(a)(4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for	F 606		3/20/18

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F 606	Continued From page 29 service as a nurse aide or other facility staff. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to perform and maintain record of background checks at the time of hire for 1 of 5 new employees (E-N) reviewed. Findings include: The facility Abuse Prevention Plan, dated 10/17, required the facility to "submit a criminal background check on the potential employee" following a conditional job offer. Review of a list of new employees revealed employee (E)-N was hired on 12/27/17. E-N's background check was requested. In an email dated 2/12/18, at 5:31 p.m. the administrator attached a New Associate General Orientation Checklist dated 7/31/14. The checklist required the facility to complete background studies on new employees, including but not limited to a criminal background check. The administrator was unable to provide evidence of criminal background check submission or completion for E-N. In a follow up email dated 2/22/18, at 11:05 a.m., the administrator confirmed being unable to provide additional documentation regarding background studies at the time of hire for E-N.	F 606	F606 Not Employ/Engage Staff with Adverse Actions Immediate corrective action: 1. Staff E-N has had a background check completed and is cleared to work. Action as it applies to others: 2. All employee files were audited to ensure the facility has their criminal background checks. Criminal background checks will be completed prior to employee hire and placed in their individual file. Education was provided to the HR/designee on completing criminal background checks prior to hire and place in the employee file. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The Administrator/designee will audit random employee files for criminal background checks. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: Administrator/Designee	

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F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		3/20/18

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F 623	Continued From page 31 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 32 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to send notice of a facility initiated discharge to the Office of the State Long-Term Care Ombudsman. This affected 1 of 2 residents (R92) reviewed who had discharged from the facility. Findings include: Review of a progress note dated 12/20/17, revealed the facility initiated R92's discharge when the resident was "yelling profanities at the top of [R92's] lungs and physically charging toward the Administrator, kicking smoke barrier doors and carts on wheels along the way. Other residents were very fearful for both staff 's and their own safety." Per a progress note dated 12/21/17, the facility received corporate approval for immediate discharge. The Notice of Discharge revealed the facility	F 623	F623 Notice Requirements Before Transfer/Discharge Immediate corrective action: 1. Notification of R92's discharge to the Ombudsman's was completed. Action as it applies to others: 2. Notice of discharges initiated by the facility will be sent to the Ombudsman's office. The Policy and Procedure of Notifying the Ombudsman of resident transfers is current. Education was provided to the IDT team regarding notification of discharges to the Ombudsman's office. Date of completion: 3/20/18	

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F 623	Continued From page 33 discharged R92 on 12/21/17, for the following reasons: "the resident's health has improved sufficiently so the resident no longer needs services provided by the facility," and "the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident." During interview on 2/8/17, at 1:46 p.m. the administrator confirmed that R92 became violent toward residents and staff, which resulted in a need to discharge the resident. When asked whether staff notified a representative from the Office of the State Long-Term Care Ombudsman when developing the facility discharge, the administrator was unable to find documentation that the Ombudsman was notified. The administrator said he probably had not notified the Ombudsman of the discharge.	F 623	Recurrence will be prevented by: 3. The DON/designee will audit random residents who discharge from the facility to ensure proper notification has been completed. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 2 of 3 residents (R31, R85) with oral issues; 1 of 4 residents (R32) with decline in activities of daily living; and 1 of 1 residents (R39) with a terminal illness. Findings include: A review of R31's most recent MDS dated 10/18/17, was not an accurate reflection of R31's oral status. The annual MDS indicated R31 had	F 641	F641 Accuracy of Assessments Immediate corrective action: 1. Resident R31 and R85's MDS have been modified to address oral issues. R32's MDS has been modified to address bed mobility and transfer status. F39's MDS has been modified to address their level of care change to hospice. Action as it applies to others:	3/20/18

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F 641	Continued From page 34 no dental issues. A previous annual MDS dated 10/28/16, indicated R31 had no natural teeth and or had tooth fragments. On 2/5/18, at 12:51 p.m. R31 was observed to have no teeth or dentures. At this time R31 stated dentures were needed, as R31 did not have any teeth. On 2/8/18, at 8:13 a.m. registered nurse (RN)-C checked R31's oral cavity and verified R31 did not have any teeth or dentures. At 8:46 a.m. RN-C verified the MDS was not accurate and the person who had completed the most recent annual MDS for R31 was no longer working at the facility. R85 On 2/6/18 at 1:54 p.m., R85 was observed to have several missing upper and lower teeth or no partial dentures. At this time, R85 stated partial dentures were needed and wished to be seen by in-house dentist, as R85 did not have many teeth. During review of the resident oral/dental status assessment dated 2/2/18, it was revealed R85 had "Own Teeth None of the above oral mucosa pink and moist no lesions noted and denies pain". R85's admission assessment MDS dated 11/3/17, failed to accurately reflect oral/dental status. R85's admission assessment MDS indicated, "None of the above were present". R85's care plan dated 11/1/17: "Oral cares: I cannot complete my own oral hygiene tasks. I do have my own teeth and have no chronic or	F 641	2. All MDS's submitted this month will be reviewed for accuracy/missed significant change. The MDS Policy is still current. The Director of Reimbursement will educate the IDT team on ensuring correct coding of the MDS and the RAI Manual is followed. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit random resident MDS to ensure they are coded accurately. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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recurrent oral issues. I totally rely on staff to provide all my oral hygiene cares ..."

On 2/7/18 at 11:01 a.m., registered nurse (RN)-E verified after reviewing the medical record that the admission assessment MDS had not been coded accurately to reflect R85's dental status. RN-E stated, had made a mistake because was not aware that resident had missing teeth. RN-E added, "I might mix him up with another resident."

On 2/8/18 at 8:45 a.m., RN-A verified R85 had numerous missing teeth both upper and lower and stated staff reeducate regarding assessing resident oral/dental status accurately. At 8:50 a.m., R85 mentioned to RN-A, he is interested to visit with the in-house dentist and be evaluated for partial denture.

R32

Review of R32's annual MDS dated 10/23/17, revealed staff coded R32 as needing extensive assistance with bed mobility, and supervision during transfers from one surface to the next (e.g. transferring out of bed and into a chair). Review of the most recent quarterly MDS dated 1/22/18, revealed staff coded R32 as needing extensive assistance with both bed mobility and transfers.

R32's transfer assessment dated 1/22/18 described R32 as independent with bed mobility and transfers. The mobility section of R32's care plan, last revised 11/16/17, described R32 as "independent with bed mobility, transfers, and ambulation" and as needing "supervision and

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cues to safely move in bed, transfer, and ambulate."

On 2/05/18, at 6:11 p.m. R32 independently stood up from a chair in the dining room unassisted, and began walking down the hall until staff guided R32 back to the table to wait for food to be served. At 6:21 p.m. R32 stood up from the dining room chair unassisted. Staff requested R32 to remain at the table for dinner, and R32 sat down again. At 6:26 p.m. R32 independently stood again, and began to walk away from the table.

On 2/7/18, at 7:33 a.m. R32 was observed in bed through the open doorway. At 7:39 a.m. R32 independently got out of bed and walked into the hallway. At 7:55 a.m. licensed practical nurse (LPN)-F stated R32 was confused and did not always know where to go, but confirmed R32 could get in and out of bed independently. When asked if R32 ever needed help transferring, LPN-F stated "no."

During further observation on 2/7/18, at 9:17 a.m. R32 stood up from a table in the dining area, walked down the hall, went into a resident room, and independently laid down on the bed.

During an interview on 2/7/18, at 1:24 p.m. registered nurse (RN)-E stated a remote nurse at a different facility had completed some of the MDS coding, and must have gone by what the nursing assistants had charted. RN-G thought there was some confusion about coding, and explained that further staff education regarding MDS coding was part of an improvement plan in discussion. RN-G clarified that coding a resident as needing "extensive assistance" meant staff

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F 641	Continued From page 37	F 641		

assisted a resident with weight bearing, or in other words that the staff used muscle while helping a resident.

On 2/7/18, at 2:00 p.m. nursing assistant (NA)-D described working with R32, and stated R32 was independent with transfers.

R39

Review of R39's significant change MDS, dated 8/28/17, revealed the following question in Section J: "Does the resident have a condition or chronic disease that may result in a life expectancy of less than 6 months?" Facility staff chose the response "No." The most recent quarterly assessment, dated 10/30/17, revealed staff did not answer the question as yes or no, but instead choose the answer "not assessed/no information."

R39's physician's order dated 8/18/17, the provider wrote, "Admit to Health Partners Hospice on 8/18/17 [with] terminal [diagnosis]...."

A progress note, dated 8/22/17, revealed the following: "Was discussed with [interdisciplinary team] that [R39] has signed on to [Health Partners] hospice 8/18/17. Will do a significant change MDS [assessment reference date] 8/28/17"

During interview on 2/8/18 at 11:54 a.m. RN-G explained the process would be to first look for a doctor signed order for hospice with diagnosis less than six months. RN-G stated once staff have that from the doctor, the MDS question in Section J regarding life expectancy of less than

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F 641	Continued From page 38 six months should be answered "yes." On 2/8/17, at 3:04 p.m. when asked about a policy for coding the MDS, the administrator stated staff used the RAI (resident assessment instrument) user manual as policy. Policy and procedure titled MDS (minimum data set) dated 11/22/2016, read, "It is the policy of Welcov Homes to insure the timelines and accuracy of all MDS'. This will be done following the guidelines laid out in the RAI (resident assessment instrument) Manual. 5. The information obtained through the assessment process and the MDS/CAA (care area assessment) process will be used to create and update the care plan." CMS's (Center for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual, page L-2, dated October 2017, read, "Check L0200A, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous/lacks all natural teeth or parts of teeth... Check L0200Z, none of the above: if none of conditions A through F is present."	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 656		3/20/18

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F 656	Continued From page 39 assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan interventions for 1 of 1 resident (R31) reviewed for behavioral/emotional concerns, and vision and hearing needs.	F 656	F656 Develop/Implement Comprehensive Care Plan Immediate corrective action: 1. R31's care plan reviewed/updated and	

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F 656	Continued From page 40 Findings include: R31 was observed on 2/5/18, at 12:51 p.m. and was not observed wearing glasses or hearing aids. R31 stated he needed glasses and hearing aids, but had not gotten new glasses and hearing aids. R31's medical record revealed a form titled, On-Site Hearing, dated 2/7/17, which indicated R31 had hearing loss and was still hoping to receive hearing aids, but due to insurance issues R31 might not be eligible, but the hearing company would check R31's insurance. The care plan had not been updated to indicate R31's desire and need for hearing aids, which were dependent on insurance coverage. R31's medical record also revealed a form titled, Minnesota Vision Outreach, R31 dated 11/15/17, which indicated R31 had impaired vision, the vision prescription had been confirmed and renewed and R31 had requested to order new glasses. Review of R31's care plan, revised 11/16/17, identified R31 had diagnoses of anxiety disorder, insomnia, and chronic hepatitis C. The care plan listed R31 had aggression towards other resident, who he had pushed and listed various interventions which included R31 had been educated to keep his hands to himself, will follow up with ACP (Associated Clinic of Psychology clinic) as ordered by my physician. However, R31's care plan lacked psychologist recommendations from the 5/22/17 evaluation. Further, R31's care plan did not address R31's vision or hearing status, and did not address R31's need for glasses or hearing aids.	F 656	care plan is being followed. Action as it applies to others: 2. Care plans have been reviewed to ensure plans of care are up to date to reflect the need of glasses or hearing aids. The Policy and Procedure for Care Planning remains current. The DON/designee will educate the IDT team on ensuring plans of care are updated as resident changes occur. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit random care plans each week to ensure they are accurate. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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R31's medical record revealed R31 had been seen by an ACP psychologist on 5/22/17, because of a resident to resident altercation, where R31 was pushed by another resident and R31 pushed back.

The psychologist made the following recommendations, which were not addressed in R31's care plan: due to cognitive impairment, R31 may have difficulty with impulse control and self regulation. Recommend keeping this in mind when assigning him a new roommate. Consider having staff check in with R31 in passing throughout the day with phrases like "are you keeping the peace around here today" or "how is it going keeping the peace?" The recommendations also identified R31 responded well to validation, consider validating his feelings around current concerns before attempting to problem solve with him. Further, the recommendations included R31 could benefit from dementia protocols such as approaching from the front, making eye contact, giving 1-2 step instructions, give plenty of time to respond, provide auditory/visual/physical cues to encourage cooperation with cares; and greet from the front in a warm/friendly manner, smile as this may help put R31 at ease, and offer compliments and praise to communicate acceptance. 1-step instructions, give plenty of time to respond, provide auditory, visual and physical cues to encourage cooperation with care.

On 2/8/18, at 8:35 a.m. registered nurse (RN)-C stated R31's care plan had been reviewed on 12/28/17, but RN-C was not aware of the psychologist recommendations.

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F 656	Continued From page 42 RN-C stated on 2/7/18, at 10:03 a.m. that the vision and hearing companies had been contacted on this date. RN-C stated that at the time of the vision and hearing examinations R31 was not eligible for hearing aids, but as of this date was now eligible. RN-C verified the care plan had not been developed to address R31's vision or hearing needs. The facility's policy 11/17, revised policy titled Care Planning, indicates a resident's care plan was to be updated as necessary; between care conferences to reflect the current care needs if the individual resident as changes occur.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.	F 657		3/20/18

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F 657	Continued From page 43 (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care conferences were conducted every quarter for 3 of ?? residents (R30, R84, R31) in the sample. Findings include: On 2/8/18, at 1:40 p.m. R30 stated a care conference had not been conducted in a "very, very, long time." R30 stated all care conferences were held in R30's room, as R30 stayed in bed the majority of time. R30's BIMS score was 15/15. On 2/7/18, at 3:02 p.m. registered nurse (RN)-C stated care conferences had not been held recently because of facility did not have a Minimum Data Set (MDS) nurse or social worker. RN-C stated care plans were reviewed at the time of the quarterly assessments, but care conferences had not been held. A review of R30's care plan revealed the care plan was last revised on 2/7/18, but no care conference was observed being held on this date during the survey. A review of paper and electronic medical record did not indicate when the last care conference was held for R30. On 2/6/18, at 11:41 a.m. R84, who had a BIMS	F 657	F657 Care Plan Timing and Revision Immediate corrective action: 1. Care conferences that were not held for R30, R84, and R31 cannot be corrected. Action as it applies to others: 2. A review of care conferences on all residents this month will be conducted to ensure they are completed. The Policy and Procedure on Care Planning remains current. Education was provided to the IDT team on the process of care conferences. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit random care conferences each week. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings.	

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F 657	Continued From page 44 score of 14/15, stated no recall as ever having attended a care conference. On 2/7/18, at 1:54 p.m. the director of recreation therapy stated the facility social worker was to make a care conference note in the medical record, and since the facility had been without a social worker recently, the nurse managers were taking that role. A review of the progress notes revealed R84 had attended a care conference on 3/29 and 8/28/17. A review of R84's care plan revealed the care plan was revised on 12/6/17. However, there was no documentation to indicate a care conference was held on that date or if R84 had attended. The last dated documentation of a care conference having been conducted for R84 was dated 8/28/17. On 2/7/18, at 2:02 p.m. RN-C stated R84 probably had not had a care conference, because until recently the facility had not had a Minimum Data Set (MDS) nurse or a social worker. A review of R31's record revealed R31 had a court appointed guardian/conservator. The care plan indicated a revision dated of 11/16/17, however there was no documentation indicating R31 had attended the care conference or which other disciplines had been in attendance. On 2/8/18, at 8:46 a.m. RN-C stated R31's care plan was reviewed on 11/16/17, but there was no care conference held as the facility did not have a social worker or a MDS coordinator. An email was sent on 2/8/18, at 10:58 a.m. to R31's guardian/conservator. A reply was received	F 657	The correction will be monitored by: DON/Designee	

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F 657	Continued From page 45 on 2/9/18, at 7:28 a.m. indicating the guardian/conservator had never been invited to a care conference for R31. The Care Planning policy last revised November 2017, required that "Resident care conferences are held within the first 21 days of admission, and at least quarterly thereafter.... Resident/Resident Representative will be invited to the care conference."	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 2 of 2 cognitively impaired residents (R43, R75) in the sample who were reviewed for activities Findings include: R43 was not provided activities per resident/resident's family identified preferences. R43 was observed throughout the survey from 2/5/18 through 2/8/18, to consistently be in her	F 679	F679 Activities Meet Interest/Needs Each Resident Immediate corrective action: 1. R43 and R75 have had a new activity assessment to meet their individual interests. Action as it applies to others: 2. A complete review has been	3/20/18

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F 679	Continued From page 46 room, with her television on. Only nursing staff was noted to go into R43's room. On 2/7/18, at 10:00 a.m., a small church service was held in the fourth floor lounge. R43 was not in attendance. R43's face sheet identified an admission date of 12/11/12, with diagnosis including: chronic respiratory failure with hypoxia, hyperlipidemia (high cholesterol), hypertension (high blood pre pressure), type 2 diabetes, major depressive disorder, anxiety, quadriplegia (paralysis of all 4 extremities), anoxic brain damage, tracheostomy (placement of tube to assist with breathing), and gastrostomy (placement of tube in stomach for feeding and receiving medications). R43's Minimum Data Set (MDS) assessment dated 12/28/17, indicated the Brief Interview for Mental Status (BIMS) assessment identified R43 with moderate cognitive impairment. R43's care plan last reviewed on 12/11/17, indicated R43 could "communicate my wants and needs" and identified "I love church" and watching television including "anything with Eddie Murphy," and "Christian channels". The care plan also identified R43 liked to listen to gospel music, Mary Mary, Commodores, and Kirk Franklyn. The care plan identified R43 would like to continue the previous lifestyle including attending church, watching TV, and visiting with others. Staff was directed to turn on the television and activity staff was to have 1:1 visits to do things such as hand massages, reading and sensory stimulation. Nursing staff was to ensure R43 was up in a chair and out of the room to prevent isolation as much as possible.	F 679	completed to ensure all residents have been assessed to see what activities meet their individual interests. The Role of the Activity Director Policy and Procedure is current. The Activity Director/designee has been educated on assessing residents to meet their individual interests, completing activities, and documenting appropriately. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The Administrator/designee will audit weekly to ensure activities are meeting the resident's individual interests. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: Administrator/Designee	

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F 679	Continued From page 47	F 679		

Interview with the director of recreational therapy (DRT) on 2/8/18, at 1:00 p.m., indicated the activity aide kept a book with calendar for every resident on the fourth floor, and would circle or highlight whenever an activity was attended. Review of calendars indicated R43 participated in two activities in 12/17, and church services 3 times, 1:1 twice in 1/18. On 2/8/18 at 2:48 p.m., the DRT verified the activity attendance for R43. DRT stated the activity aide must not be charting correctly.

R75 was not provided activities of preference. R75 was observed throughout the survey from 2/5/18 through 2/8/18, to always be in her room, in bed. Only nursing staff was noted to go into R43's room.

R75's face sheet identified an admission date of 12/2/12, with diagnosis including acute and chronic respiratory failure with hypoxia, anemia (low hemoglobin), diabetes mellitus, major depressive disorder, generalized anxiety disorder, tracheostomy, and gastrostomy.

R75's annual MDS dated 1/5/18, indicated R75 was not interviewable for mental status and was rarely/never understood.

R75 plan of care last reviewed on 1/9/18, indicated R75 wanted to be invited to programs, and enjoyed watching television. The care plan did not identify what television programs R75 enjoyed. The care plan identified R75 enjoyed exercise group and bingo. The plan of care directed staff to provide 1:1 attention/assistance to plan daily leisure activities. The care plan indicated activity staff would have 1:1's with R75 and provide hand massages, and reading. The

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F 679	Continued From page 48 plan of care indicated "Continuing the activities I did prior to admission is important to me." Those included watching TV, playing with dolls, and listening to music. Interview with DRT on 2/8/18, at 1:00 p.m., identified the activity aide kept a book with a calendar for every resident on the fourth floor, and would circle or highlight whenever an activity was attended. Review of calendars indicated R75 participated in 1:1's four times in 12/17, and 1:1 twice, church services once, and one movie in 1/18. R75 was out of the facility in the hospital for 11 days in 12/17. On 2/8/18, at 2:48 p.m., the DRT verified the activities attended by R75. She indicated the activity aide must not be charting correctly.	F 679		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively	F 686	F686 Treatment/Services to Prevent/Heal Pressure Ulcer	3/20/18

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F 686	Continued From page 49 assess skin condition in order to determine appropriate interventions to prevent the development and promote healing of pressure ulcers for 1 of 1 resident (R62) with 5 current stage 2 pressure ulcers. R62 was not provided repositioning to relieve pressure to the pressure ulcers. Findings include: R62's significant change Minimum Data Set (MDS) dated 11/17/17, listed diagnoses which included morbid(severe) obesity, acute and chronic kidney disease, chronic respiratory failure, had identify intact cognition and required extensive assistance with all activities of daily living (ADLs). Further, the MDS indicated R62 had no open skin areas and skin was intact. R62's Care Area Assessment (CAA) dated 11/20/17, included: Possible complications related to elevated BMI (body mass index) include skin breakdown. Resident needs assist of 2 for dressing, pericare, turning and position changes, and incontinence cares of bowel and bladder. Assist of 1 for personal hygiene cares, and catheter cares. Other skin conditions present: Bilateral posterior thigh excoriation. R62's form titled, Braden Scale (tool for predicting pressure sore risk) dated 1/8/18, revealed R62 had slightly limited sensory perception, often had very moist skin, was chairfast, made occasional slight changes in body or extremity position but unable to make frequent or significant changes independently, and had a problem with friction and shear. The form identified R62 had scored at moderate risk. No further assessments of R62's pressure ulcers	F 686	Immediate corrective action: 1. R62 has had a comprehensive skin assessment. Action as it applies to others: 2. A complete review of all residents to ensure they have interventions in place to reduce or prevent pressure ulcers including complete skin assessments. The Repositioning Policy and Procedure has not changed. The licensed nursing staff have been educated on repositioning and completing comprehensive skin assessments. The CNAs have been educated on repositioning and prevention of pressure ulcers. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit weekly to ensure comprehensive skin assessments are completed and interventions are in place for those residents in need. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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were found in the clinical record nor provided by facility staff.

R62's plan of care, revised 2/5/18, listed SKIN: My last Braden was completed on 12/27/17 and I scored a 19, putting me at risk for skin breakdown. I do have some moisture related wounds on the backs of my bilateral thighs. R62's care plan listed various interventions which included: nurse to check air mattress is intact and functioning every shift, staff assist of 2 to turn and reposition every 2 hours as allowed, and R62 was totally dependent on 2 staff assist for transfers with a [mechanical] lift.

Continuous observations were conducted on 2/5/18, at 1:00 p.m. R62 was seated in a specialty bariatric power wheelchair with pressure to the posterior thighs and buttocks in the dining room. R62 legs were extended in front while seated at a forty-five degree angle, with the back of her thighs and calves resting directly on the platform of the chair. The chair was elevated and did not allow R62 to sit at any table in the dining room. At 2:00 p.m. R62 remained seated in the specialty chair in the dining room and was visiting with other residents. The television was on and residents were gathered. During continuous observations at 3:00 p.m. R62 remained in the dining room seated in the specialty wheel chair in the same position without staff offering to reposition nor was education provided to R62 on the importance of position changes or offloading to relieve the pressure to the buttocks and posterior thighs. At 4:00 p.m. R62 remained seated in the specialty chair in the dining room and was interacting with various residents and staff. There were no offers for a position change and there was no education provided on the

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importance of position changes. At 5:00 p.m. R62 was observed visiting with roommate in the dining room and watching television. There were no offers for a position change and no staff intervention for cares to be provided. At 6:00 p.m. residents gathered for the evening meal. R62 remained in the dining room and was served the evening meal while sitting up in the specialty wheel chair. Staff were not observed to offer a position change, nor education on the importance of position changes to R62. At 7:00 p.m. R62 remained seated in the dining room.

During an interview, on 2/5/18, at 7:00 p.m. R62 expressed was unable to change own position sitting up in the wheel chair. R62 revealed because the wheel chair was motorized, it had the ability to recline the chair, but that did not relieve the pressure to the posterior thighs where open areas were present. When asked whether staff had assisted or offered to change positioning, R62 stated, "Once I get up about noon there is no one to change my position until I get into bed at night. I sit up all day."

During wound care observation on 2/7/18, at 11:00 a.m. registered nurse (RN)-B performed wound care to the five open areas on R62's thighs. RN-B removed the old foam dressings from each site and proceeded to perform wound care. R62 had five open areas, 3 on left posterior thigh and 2 on the right posterior thigh, which all had the top layer of dermis missing and all 5 areas had a small amount serous drainage noted and appeared moist. RN-B verified all five open areas appeared to be stage 2 pressure ulcers (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may

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also present as an intact or open/ruptured blister), but the facility utilized a protocol to identify the wounds as moisture related and not to stage open areas.

Review of the Weekly Wound Documentation Form completed by registered nurse (RN)-B on 2/8/18, identified 5 wounds with no staging completed and addressed as "moisture."
Wound #1. Left upper thigh length 2 centimeter (cm), width 1.5 cm, depth 0.1 cm.
Wound #2. Left Mid thigh length 1.5 cm, width 1 cm, depth 0 cm.
Wound #3. Left lower thigh length 1 cm, width 0.5 cm and depth 0.1 cm.
Wound #4. Right lower thigh length 0.5 cm, width 0.5 cm, depth 0.1 cm.
Wound #5. Right upper thigh length 0.5, width 0.2 cm, depth 0.1 cm.

Review of the Weekly Wound Documentation Form completed by registered nurse (RN)-B on 1/23/18, identified 5 wounds with no staging completed and addressed as "moisture."
Wound #1. Left upper thigh length 2 cm, width 1.5 cm, depth 0.1 cm.
Wound #2. Left Mid thigh length 1.5 cm, width 1 cm, 0 depth.
Wound #3. Left lower thigh length 1 cm, width 0.5 cm and depth 0.1 cm.
Wound #4. Right lower thigh length 2.0 cm, width 1.0 cm, depth 0.1 cm.
Wound #5. Right upper thigh length 4.0 cm, width 5.5 cm, depth 0.2 cm.

Review of R62's nurse practitioner (NP) visit note dated 1/16/18, at 5:36 a.m. read, "Multiple wounds: [R62] has had pressure mapping done for new seating/wheelchair. [R62] has an air

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mattress. [R62] is followed by the facility wound nurse and is receiving daily wound care."

During continuous observations on 2/8/18, at 12:00 p.m. R62 was seated in a specialty bariatric power wheelchair in the bedroom visiting with roommate, R62 legs were extended in front while seated at a forty-five degree angle. The chair was elevated and R62 used an elevated tray table for the meal tray. At 1:15 p.m., R62 independently propelled herself in the power chair to the day room and visited with other residents. There were no offers from staff to change position or to offload the pressure to the buttocks and thighs from sitting up in a 45-degree angle with legs extended. At 2:00 p.m. R62 remained seated in the specialty chair at a 45 degree angle with legs extended out in front of her, with continued pressure to the buttocks and posterior thighs and calves, in the day room and was visiting with other residents. R62 continued to be seated on buttocks and posterior thighs and there were no offers from staff to position change or offload the pressure from sitting at a 45-degree angle with legs extended. At 3:00 p.m. R62 remained seated at a 45-degree angle, continued to have pressure to the posterior thighs and buttocks with legs extended and visited with other residents in the dining room and . At 4:00 p.m. R62 remained seated in the dining room and there were no offers from staff for a position change or to offload the pressure from the buttocks or posterior thighs.

During an interview on 2/8/18, at 3:00 p.m. nursing assistant (NA)-A was asked when R62 would have a position change and stated, "I wait for [R62] to ask." NA-A verified did not offer to assist R62 with a position change and indicated

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she was unaware the last time R62 had been assisted or offered to reposition.
On 2/8/18, at 3:30 p.m., RN-B reported the facility expectation for re-positioning would be for staff to encourage and assist R62 to change position every two hours when sitting up in the chair and validated due to body mass R62 would not be able to change the chair position independently.

When interviewed on 2/8/18, at 4:00 p.m. licensed practical nurse (LPN)-A indicated staff did not need to reposition R62 when up in the chair because it was a power chair and R62 could lay down in the chair. LPN-A stated, "I thought that was a position change."

When interviewed on 2/8/18, at 4:00 p.m. R62 verified no staff offer to change position once up in the wheel chair for the day because it requires 2 staff and the mechanical device. R62 stated, "It takes two staff to move me, and that does not happen very often." R62 verified did not like to tilt back in the wheel chair because due to weight there is no way to offload the pressure unless R62 is in bed. R62 explained she was able to independently roll over to her sides in the bed, but was unable to independently relieve any pressure when seated in the specialty chair.

The facility policy titled, Repositioning, dated 2013, indicated: The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed- or chair-bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. Repositioning the resident in the chair read, 1. Encourage the chair-bound resident who

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F 686	Continued From page 55 is able to move, to change positions or shift weight at least every fifteen (15) minutes, or as often as possible. 2. Check the care plan, assignment sheet or the communication system to determine resident specific positioning needs including special equipment, resident level of participation and the number of staff required to complete the procedure. 3. Ask the resident's permission to reposition or assist in repositioning. Take the resident to a private location, if indicated. 4. Assist the resident to change his or her position in the chair. Monitor the need for toileting or incontinence care when changing position. The facility did not have an offloading policy but the Intervention and Care strategies with the facility repositioning policy directed, "Residents who are in a chair should be on an every hour (q 1 hour) repositioning schedule.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision for 1 of 4 residents (R32) that was reviewed for wandering.	F 689	F689 Free of Accidents/Hazards/Supervision/Devices Immediate corrective action:	3/20/18

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F 689	Continued From page 56 Findings include: R32's undated Face Sheet revealed that R32 had a primary diagnosis of Alzheimer's disease. During the most recent annual Minimum Data Set (MDS) assessment, dated 10/23/17, the brief interview for mental status (BIMS) identified R32 to have severe cognitive impairment. The Care Area Assessment (CAA), dated 11/2/17, indicated R32 wandered daily, that staff were required to monitor and keep track of R32's whereabouts, redirecting as needed. There was no other analysis of R32's wandering including things such as patterns, physical and psychological concerns such as pain, constipation, loss, and unmet needs such as hunger, toileting, boredom. R32's mobility care plan, last revised 11/16/17, confirmed R32 was known to wander, and needed staff supervision and guidance for safety when out of R32's room. The care plan described an altered cognition causing R32's inability to know where or when to lay down. The care plan indicated R32 needed staff supervision when walking in the hallway to ensure R32 did not wander into other residents' rooms. Although the care plan identified the problem of wandering, there were minimal individualized interventions developed due to the lack of a comprehensive assessment of R32's wandering. During interview with R15 on 2/7/18, at 8:58 a.m. R15 was upset with R32's wandering. R15 stated on numerous occasions, R32 wandered into R15's room and got into R15's bed, underneath the covers. R15 said that staff was supposed to watch R32 for wandering, but that they did not do it.	F 689	1. R32 is provided appropriate supervision and the care plan was updated to reflect the needs of the resident. Action as it applies to others: 2. All residents who wander have been reviewed to ensure appropriate supervision and care plan are up to date and followed. Education was provided to staff on appropriate supervision of residents who wander. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit residents who wander to ensure appropriate supervision is provided per care plan. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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A late entry progress note, entered 1/18/18, described an incident involving R32's wandering. Staff observed R32 wandering in the hallway, holding a container of soda that did not belong to R32. Staff knew who the soda belonged to, and returned the soda to the proper resident. Staff left the room after returning the soda, and began to walk R32 back to the proper room, when the owner of the soda unexpectedly came out of the room and hit R32 on the back. The resident attempted to hit R32 again screaming, "[R32] was in my room again," before staff intervened. Staff assessed R32 and found no injury, bruising, redness, tenderness, or pain. Fifteen minute checks were initiated on R32.

Review of R32's current orders in the electronic medical record (EMR) revealed an order initiated on 1/8/18, "Staff to monitor resident location every 15 minutes and ensure resident is safe."

During observation on 2/5/18, at 6:11 p.m. R32 was seated at a dining table, waiting to be served. R32 stood up and began wandering down the hall, until staff immediately brought R32 back to the table. At 6:21 p.m. R32 stood up from the table again, and staff approached to request the resident sit back down. At 6:26 p.m. R32 stood up and began walking down the hall again until staff immediately returned R32 to finish supper.

On 2/7/18, at 7:55 a.m. LPN-F stated R32 was confused, and would wander without always knowing where R32 was going.

Continuous observation on 2/7/18, beginning at 9:17 a.m. R32 stood up from a table in the dining area, walked down the hall, and entered another resident's room. The door was open, no one was

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in the room at the time. R32 climbed onto the first bed inside the doorway, laid down, and closed eyes. The resident was in full view from the hallway, through the open doorway. At 9:23 a.m. cleaning staff entered the room and cleaned the floor in the threshold of the doorway, however, did not say anything to R32. Another staff worked at the medication cart in the hallway nearby. A nursing assistant passed the room twice in the hallway, with an unobstructed view of R32 sleeping in another resident's bed. The nursing assistant did not identify the concern with R32 either time. At 9:28 a.m. R32 was still asleep in the wrong bed, in the wrong room. At 9:46 a.m. LPN-F passed in the hallway and noticed R32. LPN-F woke R32 and assisted the resident to the correct room and bed. LPN-F said R32 was on 15 minute checks because of the wandering. LPN-F said if R32 was not in the dining room, or in bed, staff need to find R32. LPN-F clarified that R32 does not go into the elevators, but does wander the hall and will go into any door that is open, and get in the bed. LPN-F pointed to another resident's room, and asked, "You see that door?" The door was closed, and there was yellow tape across the doorframe, approximately 5 feet up from the floor, creating a barrier. LPN-F continued to explain how R32 previously wandered into the room, and upset a resident by getting in their bed, so R32 was placed on 15 minute checks.

On 2/8/18, at 9:28 a.m. health unit coordinator (HUC)-F was aware of R32's wandering. When asked. HUC-F said R32 would wander into any open door and lay down on the bed and fall asleep.

On 2/8/18, at 10:07 a.m. nursing assistant (NA)-E

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F 689	Continued From page 59 described being aware of R32's wandering behavior. NA-E said R32 always wandered, and wondered if R32 might wander more when experiencing pain. NA-E explained that staff were directed to just bring R32 back to the resident's room when wandering was observed. NA-E was worried about R32's potential unmet needs, such as discomfort, when wandering was observed. NA-E felt that staff should address potential pain, not just put R32 back in bed. When asked if NA-E ever found R32 in other residents' rooms before, NA-E emphatically responded, "Oh yeah!" NA-E said R32 wandered into other rooms and got into bed, and said that R32 had even been hit before by other residents who became upset upon finding R32 in their beds. When asked if there was enough staff present to monitor R32's wandering, and keep R32 safe. NA-E shook head back and forth, and replied, "No."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		3/20/18

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F 690	Continued From page 60 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R62) who was identified as incontinent of urine received the necessary care and services to manage incontinence. Findings include: R62's Resident Face Sheet, indicated diagnoses including acute and chronic respiratory failure, morbid (severe) obesity, chronic kidney disease and diabetes. The Care Area Assessment (CAA) dated, 11/20/17, included possible complications related to elevated BMI (body mass index) include skin breakdown. It also indicated R62 needed assist of 2 for dressing, pericare's, turning and position changes, and incontinence cares of bowel and	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Immediate corrective action: 1. R62 receives toileting needs as directed in the care plan. Action as it applies to others: 2. All residents who require assistance with toileting needs will be reviewed to ensure their care plans accurately reflect their needs. The Policy on Incontinence Care remains current. The DON/designee will educate nursing staff on the ensuring resident's toileting needs are provided per their plan of care.	

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F 690	Continued From page 61 bladder, assist of 1 for personal hygiene cares. In addition, the CAA indicated skin conditions present, bilateral posterior thigh excoriation. Facility form titled, Brief Interview for Mental Status (BIMS) dated 11/17/17, indicated R62 was assessed as cognitively intact. The plan of care initiated 9/27/17, read, "I am incontinent of bowel and bladder. I require total assistance with incontinence management. Staff assistance of 2 with incontinence care. Staff offer bedpan after meals." Observations were made of R62 on 2/5/18, at 1:00 p.m., 2:00 p.m., 3:00 p.m., 4:00 p.m., 5:00 p.m., 6:00 p.m., and 7:00 p.m., seated in a specialty power wheel chair in the day room and was not observed to receive any incontinence care. During an interview on 2/5/18, at 7:00 p.m. R62 stated, "Once I get up about noon there is no one to change my brief until I get into bed at night." During observation of wound care on 2/7/18, at 11:00 a.m. R62 was able to turn self to the right side in the bed. R62 was incontinent of urine. During continuous observation on 2/8/18, from 12:00 p.m. until 4:00 p.m. the following observations were made. R62 was observed seated in the motorized wheel chair in the bedroom eating lunch and visiting with roommate. At 1:15 p.m. R62 independently propelled self in the power chair to the day room and remained in the day room visiting with other residents. During that time there was no offer to provide any check and change for incontinence. nor was education	F 690	Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit random residents to ensure their toileting needs are provided per their plan of care. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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F 690	Continued From page 62 offered regarding the importance of incontinence care. When interviewed on 2/8/18, at 4:00 p.m. R62 verified no staff offer to check and change for incontinence once up in the wheel chair for the day because it requires 2 staff and the mechanical device. R62 stated, "It takes two staff to move me, and that does not happen very often." During an interview on 2/8/18, at 3:00 p.m. nursing assistant (NA)-A was asked when R62 would have a check and change for incontinence and NA-A stated, "I wait for [R62] to ask." NA-A verified R62 was not offered assist with a check and change for incontinence care. On 2/8/18, at 3:30 p.m., RN-B reported the facility expectation for incontinence care would be for staff to encourage and assist R62 to receive incontinence care or a check and change for incontinence at least every two hours. Facility policy Bowel and Bladder Assessment dated 2012, indicated, "To assure all residents receive timely and adequate assistance with toileting as determined by their Assessment and Plan of Care."	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial	F 725		3/20/18

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F 725	Continued From page 63 well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have sufficient nursing staff to provide the services required for the resident population on the second and third floor.This had the potential to affect 24 residents on the second floor and 30 residents on the third floor. Findings include: Refer to F686: The facility failed to ensure repositioning assistance was provided as directed by the plan of care for 1 of 3 residents (R62) observed for timely positioning and pressure ulcer care. Refer to F690 The facility failed to provide	F 725	F725 Sufficient Nursing Staff Immediate corrective action: 1. Staffing level are reviewed and adjusted as needed. (See corrections for F686, F690, F565) Action as it applies to others: 2. Staffing levels are reviewed and adjustments made per unit based on census and acuity. A new scheduler has been hired as of 2/1/18 and the facility has an active recruitment plan which includes sign on bonus, referral bonuses, and	

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F 725	Continued From page 64 incontinence care and services as directed by the plan of care for 1 of 3 residents (R62) observed for timely incontinence care. During an interview on 2/6/18, at 2:00 p.m. R62 expressed "serious concern about the staffing at Bethel." R62 stated the staff have said there are not enough staff to take R62 into the shower because they do not have time. R62 stated, "I want my hair shampooed and they tell me they do not have enough staff or the time to wash my hair." R62 said has asked many times for showers and hair washing but the staff say they are short staffed and cannot get it done because R62's shower and hair is not a priority. R62 said is supposed to have position changes and incontinence care because of the numerous open areas on buttocks and the back of the thighs. R62 said the areas were almost healed when in the hospital and now at the facility the open areas got worse because of not getting the care . The roommate is R37 and was present during the interview and stated, "I see it, [R62] is telling you the truth, they do not have enough staff here and my roommate [R62] is not getting the care should." Observations were made of R62 on 2/5/18, for over six hours and on 10/8/18, for over 4 hours where R62 did not receive and did not have an offer for a position change, did not receive and did not have an offer for incontinence care, and was not educated on the importance of receiving those cares by any staff person. Refer to F565 The facility failed to promptly respond to grievances for 5 of 5 residents (R5, R394, R78, R37, R1) expressing concerns.	F 725	bonus pay for staff working extra shifts. Date of completion: 3/20/18 Recurrence will be prevented by: 3. Staffing levels will be reviewed and adjustments made as necessary. The Administrator/Designee will meet with the scheduler to review staffing each business day. The Administrator will have weekly calls with the recruiter and update recruitment and retention plans as necessary. This will be an ongoing process as long as needed. Staffing will be discussed with staff at their all staff meetings to keep them informed of recruitment and hiring updates. The correction will be monitored by: Administrator/Designee	

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F 725	Continued From page 65	F 725		

During an interview on 2/5/18, at 3:00 p.m. R5 expressed concern about running out of oxygen in the portable tank because it has happened before.

During an interview with R62 on 2/6/18 at 11:46 a.m. said there are often situations of residents running out of oxygen. R62 uses oxygen and has heard the resident across the hall [R5] complain to staff that the portable oxygen tank is running lower than R5 is comfortable with. R62 stated, "I heard a nurse a week ago tell [R5] we can't get your oxygen now, it is dinner time and then that night [R5] fell real low and was down in the eighties and finally [R62] told the nurse to get the oxygen or [R62] would call 911." Furthermore R62 explained the oxygen tanks are suppose to be filled downstairs for safety but, "sometimes the staff cheat" and fill the small tanks in the bedrooms if there is a large tank available, and that is because, "they do not have enough staff here."

R394 voiced a concern related to the timely administration of pain medication every four hours and missed two doses on the day shift 1/17/18, with complaints of pain in the 8-10 range.

During an interview with registered nurse (RN)-D verified the facility should have discussed the findings with R394 and validated the resident concerns with a follow up investigation to the concern and stated, "We just don't have the staff or the time to check into everything."

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R32 was identified to wander and required fifteen minute checks to be initiated for R32's safety. R32's undated face sheet identified R32 had a primary diagnosis of Alzheimer's disease. The most recent annual minimum data set (MDS) assessment, dated 10/23/17, revealed R32 was severely cognitively impaired, and wandered daily. The care plan, revised 11/16/17, confirmed R32 wandered, and needed supervision to keep from wandering into other residents' rooms.

Interview with R15 on 2/7/18, at 8:58 a.m. identified R32 wandered into R15's room and climbed into bed on numerous occasions. R15 said staff was supposed to monitor R32 for wandering, but they didn't.

A late entry progress note, entered 1/18/18, described R32 observed by staff in the hallway, holding a container of soda that did not belong to R32. Staff returned the soda to the proper resident, who unexpectedly hit R32 on the back, and attempted to hit R32 again before staff intervened. The resident screamed, "[R32] was in my room again," Fifteen minute checks were initiated for R32.

Review of R32's current orders in the electronic medical record (EMR) revealed the following order, started on 1/8/18: "Staff to monitor resident location every 15 minutes and ensure resident is safe."

During continuous observation on 2/7/18, beginning at 9:17 a.m. R32 wandered into another resident's room, laid down on the bed, and quickly fell asleep. Multiple staff from different departments passed the resident many times before the problem was identified and R32

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F 725	Continued From page 67	F 725		

was brought back to the correct room at 9:46 a.m., 29 minutes after leaving the dining room. Licensed practical nurse (LPN)-F explained that R32 previously wandered into another resident's room, and upset the resident by getting in their bed, so R32 was placed on 15 minute checks.

On 2/8/18, at 10:07 a.m. nursing assistant (NA)-E acknowledged being aware of R32's wandering behavior, and stated R32 always wandered. NA-E had found R32 in other residents' rooms before, and was aware of another resident hitting R32 for wandering into their bed. NA-E acknowledged there was not enough staff to monitor R32's wandering and ensure safety.

On 2/5/18, at 6:46 p.m. nursing assistant (NA)-I said all the problems the facility had stemmed from short staffing. NA-I said it was frustrating that staff could not do the quality of work they would like, because they were short staffed all the time. NA-I said if the staff was short, one nursing assistant may have responsibility for up to 17 residents, and needed to scramble to get cares done, which resulted in not being able to spend much time with residents. NA-I felt being short staffed reflected poorly on them, and gave an example of being able to smell body odors and urine while running to try and get the work done, while having families look at you like it is your fault. NA-I said sometimes residents looked at you with tears in their eyes, but you may be in the middle of something you could not leave to help the resident immediately, and there was nobody else available to help at the time. NA-I reported being able to see the residents were distressed, and it was frustrating that these problems stemmed from staffing. Additionally, NA-I said there needed to be a restorative aide in the

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F 725	Continued From page 68	F 725		

evening to assist.

During interview on 2/7/18, at 8:44 a.m. R58 stated the facility staff was good, and worked incredibly hard, but they needed more help. R58 described wearing a brief, and said that when the brief was wet with urine, R58's skin burned. R58 reported not even calling for help in the afternoon and evening anymore, because the staff was too busy. R58 said in the past it wasn't a problem getting changed out of a wet brief, but said that one day staff told R58 they did not have time to change the resident's wet brief, "and that was that." R58 reiterated not even bothering to call staff for help with a wet brief after going to bed, even though it burned. R58's routine was to wait until the staff on the night shift checked in with the resident, and asked to be changed at that time.

On 2/7/18, at 11:24 a.m. registered nurse (RN)-C said the floor was fully staffed during the day shift when there were four nursing assistants, two nurses, and one trained medication aide. RN-C did not believe there was enough staff on the floor, even at full staffing levels. RN-C said there were about 20 people requiring transfer with a full body lift or a body stand, or who needed total assist from staff with cares. RN-C explained even if staff did not have to use a lift to transfer, people requiring total assist needed staff to perform all personal hygiene and dressing, which took time. RN-C noticed a lot of staff call ins. RN-C thought this was due to burnout. This meant even if the original schedule had four nursing assistants assigned to work, the shift might end up with only two or three nursing assistants actually working on the floor. RN-C tried to tell nursing assistants to document all the cares performed for the

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F 725	Continued From page 69 residents, but if they were short staffed and too busy, they did not have time to document because the priority was just to get people out of bed, dressed, and to meals and activities. RN-C added the facility stressed how important documentation was, but wondered how the documentation could be good enough when staff were unable to provide the care. When asked about bathing, RN-C said the floor had no bath, so residents who wanted a bath instead of a shower had to be brought to another floor. On busy days, staff might ask residents if they were okay having a bath or shower on the evening shift when staff are not as busy. RN-C described often jumping in to help nursing assistants complete resident cares and baths. RN-C said the high priority after meals was to lay people down who were unable to independently transfer, and check and change their briefs. RN-C was worried about the skin of residents who were unable to reposition themselves, and worried about whether low staffing levels may lead to facility acquired pressure ulcers. RN-C reported many of the residents did not have any family, and felt staff was their only family. RN-C wanted to give the best care, and the care that was needed, but said staff couldn't do it with the current staffing levels. RN-C said staff was told by administration that more help would be coming, but so far nothing had changed. RN-C said about the staff, "They work so hard, but we need help."	F 725		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 756		3/20/18

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F 756	Continued From page 70 §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon pharmacist recommendation for 1 of 5 residents (R84) reviewed for unnecessary medications.	F 756	F756 Drug Regimen Review, Report Irregular, Act On Immediate corrective action:	

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F 756	Continued From page 71 Findings include: Document review revealed the consulting pharmacist had noted on a Consultation Report dated 11/20/17, that a consent for the use of venlafaxine (generic for the anti-depressant Effexor) was missing for R84. The Consultation Report was signed, but not dated indicating the consent had been obtained. However, a review of R84's record did not reveal a consent for the use of the venlafaxine. On 2/8/18, at 1:26 p.m. registered nurse (RN)-C stated she had signed the consulting pharmacists Consultation Report on 11/20/17, and had obtained the consent. RN-C noted R84's medical record had been thinned on 12/8/17, and she would look in the thinned medical record for the consent. By 2/8/18, at 7:45 p.m. RN-C had not been able to find R84's consent for the use of the venlafaxine. The facility's 11/28/16, policy titled Medication Regiment Review (MMR) indicated the facility should encourage the physician or other responsible parties receiving the MRR and the director of nurses to act upon the recommendations contained in the MRR.	F 756	1. Proper communication with the resident or representative will be documented or a consent will be obtained for R84's anti-depressant. Action as it applies to others: 2. All residents who receive an anti-depressant will have documented communication with the resident or representative or a consent for medication have been obtained. The Psychotropic Medication Use Policy is current. Education was provided to the IDT staff on obtaining consents or documentation with the resident or representative will be obtained when necessary. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/Designee will audit random resident charts each week for consents or documented communication with the resident or representative. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		3/20/18

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F 761	Continued From page 72 §483.45(g) Labeling of Drugs and Biologicals 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. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) 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. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were stored properly for 4 of 7 residents (R87, R45, R80, R82) reviewed for medication storage. In addition, the facility did not remove expired stock medications from medication storage, which had the potential to affect residents residing on the fourth floor. Findings include:	F 761	F761 Label/Store Drugs and Biologicals Immediate corrective action: 1. Medications were disposed of for R87, R45, R80, and R82 at the time of the survey. Action as it applies to others: 2. Medication carts and storage rooms	

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F 761	Continued From page 73 During observations of multiple medication storage areas throughout the facility, medications for R87, which included eye drops and liquid medications, lacked dates to indicate when they were opened, or when the medications expired. On 2/6/18 at 12:23 p.m., the fourth floor medication cart B was observed to contain one bottle of Timolol Maleate 0.25 % (for glaucoma) eye drop bottle was opened, used, and was undated. In the fourth floor medication cart B, a bottle of Geri-Lanta regular strength was observed to be opened, used and dated 11/20/17 with expired date of 1/18. On 2/6/18 at 12:31 p.m., licensed practical nurse (LPN)-E verified the medications needed to be labeled and stored properly, and removed them from the medication cart. LPN-E indicated, "I agree with you. As for geri lanta we cannot use because is expired and as for Timolol Maleate, I will talk with director of nursing about it." During medication storage review of the 2nd floor C wing medication cart on 2/5/18, at 6:37 p.m. with licensed practical nurse (LPN)-C, the following medications were found to be expired. - Aspirin 325 milligrams (mg) 100 tablet bottle, half full. This was stock medication and LPN-C indicated no residents were currently receiving this medication. - Saline sodium citrate liquid laxative, ¾ full bottle. LPN-C indicated this medication was not being given. - Zytiga 150 mg, 1 tablet for R45.	F 761	were audited and are free from expired or unlabeled medications. The Policy Medication Storage remains current. The DON/designee will educate all nurses and medication aides regarding labeling and discarding expired medications when needed. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will observe medication observation in medication, treatment carts, and medication storage areas to ensure there are no medications that are expired or unlabeled. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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F 761	Continued From page 74 During medication storage review of the 2nd floor medication room with LPN-B, the following medications were found to be expired. - Liquid Vancomycin, 2.5 milliliters (ml) p.o. QID for R80. This medication was unopened with an expiration date of 12/6/17. - Liquid Vancomycin 2.5 ml p.o. BID for R82. This medication had 200 milliliters (ml) remaining with an expiration date of 12/8/17. - Liquid omeprazole 10 ml via G-tube daily for R82. 52 ml remained with an expiration date of 1/23/17. R45's current physician orders indicated R45 had an order for 1000 mg Zytiga by mouth at bedtime. R45's February medication administration record (MAR) indicated R45 received this medication. R80's current physician orders did not indicate R80 currently had an order for Vancomycin. R82's current physician orders indicated R82 had an order for 20 mg delayed release omeprazole capsule by mouth in the morning for constipation. R82's February MAR indicated R82 received this medication. On 2/8/18 at 4:29 p.m., registered nurse (RN)-A stated the expectation was for staff to follow facility policy and remove expired medications from the medication carts. Policy and procedure titled, MEDICATIONS: STORAGE OF dated January 2017, read: "3. No discontinued, outdate, or deteriorated medications/solutions are available for use in this facility. All such medication/solutions are destroyed. 7. Stock bottles/solutions are dated	F 761		

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F 761	Continued From page 75 when opened".	F 761		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of	F 791		3/20/18

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F 791	Continued From page 76 dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to obtain routine dental services for 3 of 3 residents (R24, R31, R15) identified with dental issues and receiving Medicaid services. Findings include: On 2/5/18, at 4:25 p.m. R24 stated she had no upper or lower teeth/dentures. R24 thought the last time there had been a dental visit was about five years ago. There was no documentation found in the consult or assessment section of the medical record to indicate when R24 had last seen the dentist. On 2/8/18, at 9:34 a.m. registered nurse (RN)-C checked R24's oral cavity and noted broken teeth on the upper and lower gums. R24, stated at this time some of her teeth were broken down to the gum. The person-centered care plan revised on 2/8/16, addressed the following: R24 had poor dentition with no upper teeth and some of own teeth on the lower jaw. Teeth were broken and gray and there was no oral pain. Last dental visit was on 1/21/16. Staff were to ensure R24 brushed teeth regularly and was assisted in scheduling dental appointments, as needed.	F 791	F791 Routine/Emergency Dental Services in NFs Immediate corrective action: 1. R24, R31, and R15 have dental appointments scheduled. Action as it applies to others: 2. All resident oral screening forms will be reviewed to see if dental services are needed and appointments made as necessary. The DON/designee will educate the IDT on the Routine Dental Care Services policy. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit random residents each week to ensure any dental needs are addressed and appointments made as needed. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings.	

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F 791	Continued From page 77 A review of the "Profile" tab in R24's electronic health record (eHR) revealed R24 was to be seen by the facility's house dentist. On 2/7/18, at 9:00 a.m. a copy of the 2/8/16, dental visit referenced in the care plan was requested, as well as any other dental visits. At this time the health unit coordinator (HUC)-F checked R24's paper medical record and verified there was no dental visit found in the record. At 9:18 a.m. HUC-F stated she would reach out to the house dentist regarding the last time R24 had been seen by the dentist. At 9:55 a.m. HUC-F stated no documentation of a 2/8/16, dental visit was found in R24's thinned medical record. HUC-F also stated the house dentist had no record of having seen R24 since admission to the facility on 1/14/16. On 2/5/18, at 12:51 p.m. R31 was observed to be edentulous, with no dentures present. At this time R31 stated teeth were needed and R31 thought the facility was working on the issue. The care plan dated 12/28/17, verified R31 had no teeth or dentures, but did not indicate R31 did not want dentures or did not want to be seen by a dentist. The "Profile" tab of the eHR did not indicate R31 had a dentist; and there was no documentation fond in R31's medical record of having been seen by a dentist since admission on 10/15/15. On 2/7/18, at 9:54 a.m. RN-C stated she would review R31's medical record for dental visit documentation and at 11:16 a.m. HUC-F stated she had checked with the house dentist and R31	F 791	The correction will be monitored by; DON/Designee	

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F 791	Continued From page 78	F 791		

had not been seen. HUC-F also stated there was no consent found in R31's medical record regarding consent for dental visits.

On 2/8/18, at 8:13 a.m. R31 told RN-C he wanted teeth and stated"I ain't got no teeth." and showed RN-C his mouth, which was void of all teeth.

On 2/5/18, at 3:54 p.m. R15 confirmed not having dentures and wanting a dental appointment scheduled. R15 was told R15 could see the dentist but was not informed of the scheduled date. There was no documentation found in the consult or assessment section of the medical record to indicate when R15 had seen the dentist.

The care plan indicated R15 had his own teeth and interventions included assisting R15 with a dental appointment as needed. An additional care plan entry indicated R15 was edentulous and in the process of obtaining dentures. Interventions included monitor and report mouth irritation or pain for follow up.

On 2/7/18, at 2:02 p.m. registered nurse (RN)-B indicated R15's dental care plan was incorrect. RN-B confirmed R15 did not have teeth and indicated the care plan needed to be updated.

On 2/7/18, at 3:34 p.m. health unit coordinator (HUC) stated R15 had been in the process of scheduling a dental appointment prior to admission and would ask R15 if he wanted an appointment at this facility. HUC confirmed no appointment had been scheduled yet, and planned to follow up with R15.

On 2/8/18, at 9:40 a.m. RN-B stated the expectation was for the HUC or administrative

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F 791	Continued From page 79 person to ask residents if they wanted an appointment with Door Step Dental. The facility Routine Dental Care Services policy dated 2014 indicated: "This facility will assist residents in obtaining routine and 24-hour emergency dental care for each resident based on routine and emergency oral assessments and the resident's and/or representative stated needs."	F 791		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure eating items and food preparation items were air dried and not stored wet. This had the potential to affect 79 of	F 812	F812 Food Procurement Store/Prepare/Serve Sanitary Immediate corrective action:	3/20/18

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F 812	Continued From page 80 91 residents currently residing at the facility. Findings include: On 2/8/18, at 3:50 p.m. the final kitchen tour was conducted with the dietary account manager (D-AM). During the tour 54 of approximately 66 clear plastic dessert bowls were stacked and stored wet on a shelf near the dish machine. Also on this shelf approximately five (5) of 20 dessert plates were stacked and stored wet, and two (2) of 6 pitchers stored upright were noted to be wet inside. In an enclosed stainless steel cupboard near the stove there were three large gallon beverage pitchers which were stored upside down and were wet inside. The D-AM stated the large pitchers were used for ice. In an open rack shelving unit near the 3-compartment sink approximately 22 of 35 stainless steel steam pans and prep pans were stacked together. The inside of the 22 stainless steel containers were either wet inside or had dried on food debris. Observed on two floor tray carts, plastic trays were noted on individual shelves and ready for the supper meal. Some of the coffee cups and clear plastic glasses placed directly on the trays were noted to have water droplets inside, and which left a wet round ring on the plastic tray. At 4:15 p.m. on this date the D-AM stated items should be air dried before being stored. Review of the facility's 5/14, revised policy titled Ware Washing revealed the food services	F 812	1. Desert bowls, plates and pitchers in question were immediately washed, dried and stored in a sanitary manner. Action as it applies to others: 2. Dietary staff were educated on proper drying of dishes prior to stacking them on one another. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The ADM/designee will conduct random weekly audits to ensure that all food service and food preparation items are washed, dried and stored in such a fashion to meet all sanitary standards. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility□s QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: ADM/Designee	

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F 812	Continued From page 81 director was to ensure all dishware was air dried and properly stored.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		3/20/18

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F 880	Continued From page 82 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to utilize proper handwashing for 1 of 1 residents reviewed for dressing changes. Findings include:	F 880	F880 Infection Prevention and Control Immediate corrective action: 1. LPN-A was educated verbally at the time of the survey on proper handwashing techniques with dressing changes.	

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F 880	Continued From page 83 R46 was observed to receive wound drainage dressing change with hand hygiene practices not consistent with accepted standards of practice. During an observation of R46's wound care and dressing change on 2/6/18, at 10:05 am licensed practical nurse (LPN)-A washed hands for eight seconds, dried hands with a paper towel, turned off the faucet with a paper towel and donned gloves. LPN-A next used the remote control on to raise the bed up to a workable level for the dressing change, moved a pillow from the bed and, wearing the same gloves, removed the soiled dressing from the coccyx, then disposed it into the trash. LPN-A doffed gloves and washed hands for eight seconds, donned gloves and obtained dressings from the container sitting on the bedside stand. LPN-A did not place a protective barrier on the tray table before setting the supplies on the tray table. LPN-A took more supplies out of the wound tray. LPN-A opened the dressing for the wound, opened a tube of medicine and applied with gloved finger to the wound. LPN-A picked up a spray bottle of wound cleanser, sprayed it onto a dressing, cleansed the wound and set the spray bottle on the contaminated bed linen. LPN-A applied the dressing to the wound, took a pen out of her uniform pocket to mark the date on the dressing, then returned the pen to the uniform pocket. While continuing to wear the same contaminated gloves, LPN-A put the spray bottle that had been on the bed linen back into the clean dressing container before throwing packages and used dressing into the trash. LPN-A doffed gloves and washed hands for 14 seconds. Nursing assistant (NA)-C was present assisting R46 to lay on left side for the dressing change to	F 880	Action as it applies to others: 2. Education to nursing staff on proper handwashing techniques was completed with dressing changes. The Handwashing Policy remains current. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The DON/designee will audit random residents each week to ensure proper handwashing techniques are followed with dressing changes. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based off of the findings. The correction will be monitored by: DON/Designee	

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F 880	Continued From page 84	F 880		

the coccyx. NA-C washed hands for six seconds before donning gloves. After the dressing change to the coccyx, NA-C doffed gloves to the trash, took out the plastic trash bag, tied closed before placing a new plastic liner into the trash can. NA-C then left the room with the trash and did not sanitize or wash hands.

LPN-A washed hands for eight seconds and donned gloves to complete a dressing change to the left foot wounds secondary to toe amputations. LPN-A removed the spray cleaner from the dressing bin, sprayed on the gauze dressings and sprayed on the wounds. LPN-A put the spray bottle back into the supply bin, doffed gloves and washed hands for 12 seconds. LPN-A donned gloves and applied skin prep, then reached into the supply bin and retrieved a tube of Bacitracin before applying the Bacitracin wearing the same gloves. LPN-A then doffed the gloves, washed hands for seven seconds, donned gloves, took out new supplies, removed a pen from uniform pocket and wrote the date on the wound dressing before returning the pen to the same pocket. Wearing the same contaminated gloves, LPN-A retrieved from the clean dressing bin a pack of 4 x 4's and Telfa with kerlix wrap for the multiple wounds to the left foot and taped the kerlix in place. LPN-A doffed gloves and washed hands for 12 seconds.

When interviewed after the dressing change LPN-A verified a clean barrier should have been placed on the tray table for the dressing supplies. LPN-A verified the wound cleanser should not have been placed on the contaminated linen and LPN-A verified the dressings and ointments should have been set out before the treatment so that the other supplies would not be

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F 880	Continued From page 85 contaminated. LPN-A verified she did not know how long the hand washing procedure was or for how many seconds the handwashing was to be completed. Document review of the facility policy titled Handwashing and dated 2013 read, a minimum of ten to fifteen (10-15) second handwashing (longer if necessary) must be performed under the following conditions: f. After handling used dressings, specimen containers, contaminated tissues, linen etc. and g. After contact with blood, body fluids,secretions,mucous membranes and broken skin. Furthermore the procedure directed to Vigorously lather hands with soap and rub them together, creating friction to all surfaces. Document review of the facility policy titled Dressing Clean/Aseptic dated 2013 directed under procedure to Clean the bedside stand or place barrier/towel down to establish a clean field. Place the clean equipment on the barrier.. Tape a biohazard or plastic bag on the bedside stand or place container within reach to dispose of soiled materials, arrange the supplies so they can be easily reached. Pull strips of tape adequate for securing dressing at the end of the procedure and add date, time and initials. Place on edge of bedside table to enable easy access when needed. When interviewed on 2/6/18, at 10:30 am LPN-A was not aware of the Minnesota Department of Health current standard of practice for 20 second handwashing.	F 880		
F 917 SS=E	Resident Room Bed/Furniture/Closet CFR(s): 483.10(i)(4), 483.90(e)(2)(3)	F 917		3/20/18

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F 917	Continued From page 86 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (i) A separate bed of proper size and height for the safety and convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident. §483.90(e)(3) CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (e)(1) (i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to provide individual closet space for 8 of 8 residents (R53, R83, R46, R5, R37, R62, R393 and R394) who have shared closet space. Findings include: Residents sharing a room on the transitional care unit did not have a private closet space for hanging clothes. There was one wardrobe for hanging clothes that was 36 inches wide by 48	F 917	F917 Resident Room Bed/Furniture/Closet Immediate corrective action: 1. No immediate correction occurred at the time of the survey. Action as it applies to others: 2. The facility will provide dividers to	

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F 917	Continued From page 87 inches tall with no divider to separate individual clothes. During an interview on 2/5/18, at 1:30 p.m. R53 expressed concern about having to share hanging closet space with a roommate who was discharged today. R53 was concerned since the hanging clothes were mixed together and thought there should have been a individual storage space or divider. Document review of R53's form titled Face Sheet indicated R53 was admitted 7/11/17, and assessed on 1/17/18, as cognitively intact. When interviewed on 2/5/18, at 6:47 p.m. R83 stated his roommate was recently discharged but expressed concerned about getting a new roommate because they have to share the same closet space for hanging clothes. R83 did not think it was a good idea to share closet space and felt uncomfortable about the situation. Document review of R83's form titled face sheet indicated R83 was admitted 11/29/17, and assessed on 12/8/17, as cognitively intact. When interviewed on 2/6/18, at 10:00 a.m. R46 pointed out the broken missing door on the wardrobe which was located on R46's side of the room. R46 expressed dissatisfaction that the roommate was going through the clothes because both of them had clothes in the same space. Roommate R5 was present and agreed with R46 that the shared hanging space was not a good idea but the staff told them it was temporary because of the renovation. Document review of R46 form titled Face Sheet	F 917	separate resident clothing in all instances when two residents share the same closet space for hanging clothes. Date of completion: 3/20/18 Recurrence will be prevented by: 3. The ADM/designee will audit random residents each week to ensure that dividers are installed in all instances where two residents share the same closet space for hanging clothes. Audits will occur weekly for the next 90 days. The results of these audits will be shared with the facility's QAPI Committee for input on the need to increase, decrease, or discontinue the audits based on the findings. The correction will be monitored by: ADM/Designee	

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F 917	Continued From page 88	F 917		

indicated admission 11/11/17, and assessed on 11/29/17, as cognitively intact.

Document review of R5 form titled Face Sheet indicated admission 8/25/17, and assessed on 9/1/17, as cognitively intact.

When interviewed on 2/6/18, at 10:39 a.m. R37 was sitting up in the wheelchair and was assigned bed A in the room, but had to go to bed B side because the wardrobe was there. R37 explained both residents shared the hanging closet space and there was no separation of the hanging clothes. Roommate R62 was also present and expressed there is not enough room to accommodate both their hanging clothes together. R62 stated that staff were aware and agreed it was not a good situation but that because the room was just renovated for one person eventually there would only be one person in the room, not two like there is now. R37 and R62 expressed dissatisfaction with sharing hanging closet space.

Document review of R37's form titled Face Sheet indicated admission 1/22/18, and assessed on 2/1/18, as cognitively intact.

Document review of R62's form titled Face Sheet indicated admission 9/17/17, and assessed on 11/17/17, as cognitively intact.

During an observation and interview on 2/6/18, at 12:15 p.m. roommates, R393 and R394 complained about having to share the same hanging closet space because there was only one small wardrobe in the room. Both residents verified the staff told them it was because the room was renovated to accommodate one

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F 917	Continued From page 89	F 917		

resident but during the project two residents were assigned the room. R393 and R394 said they did not like the situation but were making it work out for them at this time.

Document review of R393 form titled Face Sheet indicated admission 1/23/18, and was currently in the assessment process for cognition but the temporary plan of care addressed mentation as alert and oriented to person, place and time.

Document review of R394's form titled Face Sheet indicated admission 1/12/18, and was currently in the assessment process for cognition but the temporary plan of care addressed mentation as alert and oriented to person, place and time.

A Policy was requested for closet space but not received at the time of the survey.

When interviewed on 2/7/18, at 3:00 p.m. the administrator verified the wardrobe was to accommodate one resident. The administrator verified there needed to be a separation of hanging clothing when two residents share the same hanging space.

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K 000	INITIAL COMMENTS 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Bethel Care Center) was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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 (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/10/2018

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 Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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 building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 116 beds and had a census of 92 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 200	Continued From page 2	K 200		
K 200 SS=F	Means of Egress Requirements - Other CFR(s): NFPA 101 Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 19.2 Means of Egress Requirements, This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observation and documentation reviewed revealed the following: The Facility does not have a Fire door inspection policy. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 200	K-200 The facility will comply with Life Safety Code 19.2 Means of Egress Requirements by providing for a policy for Fire Door Inspection and related documentation of those inspections. The Director of Maintenance will develop policy, audit tools and implement Fire Door Inspections in the facility. Corrective actions were completed on 2-13-2018. The Director of Maintenance will ensure ongoing compliance and report findings to the QAPI committee.	2/13/18
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying	K 345		2/14/18

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K 345	Continued From page 3 with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observations and staff interview revealed the following: During the inspection found the fire alarm is trouble mode, panel shows Ground fail and ID Net card This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 345	K-345 The facility will comply with Fire Alarm System □ Testing and Maintenance requirements as found in 9.6.1.3,9.6.1.5, NFPA 70 and NFPA 72 by having a vendor correct the trouble mode signaling Ground Fail and ID Net Card. Corrective actions were completed by vendor on 2-14-2018 and Fire Alarm System is no longer in trouble mode. The Director of Maintenance will monitor for ongoing compliance with Fire Alarm Testing and Maintenance requirements.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.	K 346		2/12/18

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K 346	Continued From page 4 9.6.1.6 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 9.6.1.6 This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observation and documentation reviewed revealed the following: The Facility does not have a current out of service policy for fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 346	K-346 The facility will comply with Life Safety Code 9.6.1.6. Fire Alarm System – Out of Service requirements by developing and implementing a policy on actions to be taken by staff in the event the Fire Alarm System is Out of Service. Corrective actions were completed by Director of Maintenance on 2-12-18 who developed and implemented the new policy. The Administrator will monitor for ongoing compliance with Life Safety Code 9.6.1.6. Fire Alarm System – Out of Service requirements.	
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for	K 353		2/13/18

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K 353	Continued From page 5 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This deficient practice could affect the safety of all (92) the residents, staff and visitors within the facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observations and staff interview revealed the following: Observation during the inspection found missing ceiling tiles in office on the main floor. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 353	K-353 The facility will comply with Life Safety Code 9.7.5,9.7.7,9.7.8, and NFPA 25 Sprinkler System – Maintenance and Testing by replacing damaged, stained, or missing ceiling tiles. Corrective action was completed on 2-13-2018 by the Director of Maintenance who replaced all damaged, stained or missing ceiling tiles. The Director of Maintenance will ensure ongoing compliance with this requirement.	
K 354 SS=F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service.	K 354		2/12/18

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K 354	Continued From page 6 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This deficient practice could affect the safety of all (92) the residents, staff and visitors within the smoke compartment/ Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observation and documentation reviewed revealed the following: The Facility does not have a current out of service policy for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 354	K – 354 The facility will comply with Life Safety Code 18.3.5.1,19.3.5.1,15.5.2 and NFPA 25 by developing and implementing a policy on actions to be taken by staff in the event the Fire Alarm System is Out of Service. Corrective actions were completed by Director of Maintenance on 2-12-18 who developed and implemented the new policy. The Director of Maintenance will report on Fire Alarm System Out performance to the QAPI committee. Administrator will monitor for ongoing compliance with the requirement.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors	K 363		3/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2018**

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
K 363	Continued From page 7 complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observations and staff interview revealed the following: The inspection found doors to physical therapy are 20 minute rated door with door stops on them and do not have magnet holders for the doors.	K 363	K-363 The facility will comply with Life Safety Code 19.3.6.3, 42 CFR Parts 403,418,460,482,483, and 485 Corridor - Doors by providing for the installation of door magnetic holders with fire alarm system interface for physical therapy department doors. Corrective action will be performed by outside vendor and completed by 03-20-2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2018**

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
K 363	Continued From page 8 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 363		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 19.3.7.3, 8.6.7.1(1) This deficient practice could affect the safety of all (17) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observations and staff interview revealed the following: The inspection found doors the 3rd floor smoke barrier doors do not close with tested by rooms 310 & 319. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 372	K-372 The facility will comply with Life Safety Code 19.3.7.3,8.6.7.1(1) Smoke Barrier by adjusting 3rd floor smoke barrier doors to ensure doors close as designed. The facility engaged a vendor and corrective action was completed by 02-20-2018. Director of Maintenance will monitor for ongoing compliance and report on performance to the QAPI committee.	2/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2018**

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
K 372	Continued From page 9 discovery.	K 372		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 19.7.1.4 through 19.7.1.7 This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observation and documentation reviewed revealed the following: The Facility is missing the September fire drill. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712	K-712 The facility will comply with Life Safety Code 19.7.1.4 through 19.7.1.7 Fire Drills by holding fire drills at expected and unexpected times under varying conditions, at least quarterly on each shift. The Director of Maintenance will schedule and implement fire drills in- compliance with this requirement. The Director of Maintenance will also report fire drill performance to the QAPI committee. Administrator will monitor for ongoing compliance. Corrective action was completed on 02-12-2018.	2/12/18
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters	K 781		2/13/18

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	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2018**

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
K 781	Continued From page 10 Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 18.7.8, 19.7.8 This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observation and documentation reviewed revealed the following: The Facility does not have a current space heater policy. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 781	K-781 The facility will comply with Life Safety Code 18.7.8,19.7.8 Portable Space Heaters by developing and implementing a space heater policy. The corrective action was completed by the Director of Maintenance on 02-13-2018. The Director of Maintenance will conduct monthly audits and report findings to QAPI Committee.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance	K 918		2/28/18

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	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2018**

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
K 918	Continued From page 11 with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observation and documentation reviewed revealed the following: The Facility does not have a current monthly load test completed.	K 918	K-918 The facility will comply with Life Safety Code 6.4.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Essential Electric System Maintenance and Testing by ensuring that a monthly load test is performed on the emergency generator. The Director of Maintenance completed corrective action on 02-28-2018. The Director of Maintenance will report load test performance to the QAPI committee for review and additional corrective action as needed.	

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	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/07/2018**

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

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K 918	Continued From page 12 This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 918		
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code 11.5.2.1 (NFPA 99) This deficient practice could affect the safety of all (92) the residents, staff and visitors within the Facility. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 2/7/2018, observation and documentation reviewed revealed the following: The Facility does not have a current medical gas training policy. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 926	K-926 The facility will comply with Life Safety Code 11.5.2.1 (NFPA 99) Gas Equipment – Qualifications and Training by developing and implementing a medical gas training policy. The Director of Maintenance shall complete the corrective action by 03-20-2018. The Director of Maintenance will monitor for ongoing compliance and report findings to the QAPI committee.	3/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245479	A. BUILDING _____ B. WING _____	02/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY RESIDENCE ON HUMBOLDT	**514 HUMBOLDT AVENUE SAINT PAUL, MN 55107**

(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 On January 29, 30,31 and February 1, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/20/2018

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.