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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CFEH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/03/2016** (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 **114** (L18)
13.Total Certified Beds **114** (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
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NEII 06/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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.
00140 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
05/23/2016 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245500

July 12, 2016

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

Dear Mr. Cerney:

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 16, 2016 the above facility is certified for:

114 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 114 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 8, 2016

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500026

Dear Mr. Cerney:

On April 19, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 14, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On June 3, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 9, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 14, 2016, effective May 16, 2016 and therefore remedies outlined in our letter to you dated April 19, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245500 Y1	A. Building B. Wing Y2	6/3/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0242	Correction	ID Prefix F0279	Correction	ID Prefix F0309	Correction
Reg. # 483.15(b)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25	Completed
LSC	05/16/2016	LSC	05/16/2016	LSC	05/16/2016
ID Prefix F0312	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(a)(3)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	05/16/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	06/08/2016	32981	06/03/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245500	A. Building 01 - MAIN BUILDING B. Wing	5/9/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 05/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 06/08/2016	SIGNATURE OF SURVEYOR 27200	DATE 05/09/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
4/13/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CFEH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**

2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/14/2016** (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 **114** (L18)

13.Total Certified Beds **114** (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
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Yvonne Switajewski, HFE NE II 04/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 05/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 19, 2016

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500026, H5500038

Dear Mr. Cerney:

On April 14, 2016, 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 April 14, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5500038. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the April 14, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5500038 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), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 May 24, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2016 (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.

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

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Investigation of complaint H5500038 was also completed. The complaint was not substantiated.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure choices related to bathing frequency was honored for 2 of 3 residents (R99, R65) who had requested and did not receive two baths per week.	F 242	1.Resident # 99 and 65 have been bathed two times a week as requested. 2.All residents are at risk for not being bathed according to their individualized	5/6/16

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

Electronically Signed | 04/27/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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F 242	Continued From page 1 Findings include: R99 had not received two baths per week, as requested. R99's Diagnosis Report dated 4/14/16, indicated R99's diagnoses included hemiplegia (paralysis of one side of the body), dementia with behavioral disturbance, atrophy of the central nervous system, and history of traumatic brain injury. R99's quarterly Minimum Data Set dated 1/27/16, indicated R99 was totally dependent on staff for transfers and bathing. The bath schedule for the unit R99 lived on, was reviewed and showed that R99 was scheduled for a bath every Wednesday morning. R99's care plan revised on 12/9/13, indicated R99 required two staff assistance for bathing. However, the plan had not included how often or when R99 preferred bathing. On 4/11/16, at 7:19 p.m. R99 stated she was not offered a choice regarding how many baths she would prefer each week. R99 also stated she had told many nursing staff members she wanted at least two baths a week, but was told there wasn't enough time to provide her with more than one bath a week.	F 242	plan of care. Residents were all asked about their bathing preference and their care plans were updated to reflect current bathing preferences. 3.Initiated a communication sheet to ensure residents bathing is completed according to their individualized plan of care. Mandatory nursing in-service completed on 4/25/2016 and 4/27/2016. Staff were educated on the importance of following the resident's individualized plan of care, communication on bathing preferences, communication of bathing refusals, documentation of bathing, and care planning of bathing preferences. 4.Staff to randomly audit resident bathing completion, documentation, and care planning of bathing 3x/wk for 4 weeks with results to QAPI committee for further review/recommendation.	

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F 242	Continued From page 2 On 4/13/16, at 7:35 a.m. nursing assistant (NA)-D was observed to enter R99's room and remind R99 it was her bath day (Wednesday) and she was getting the tub ready. At this time, NA-D confirmed R99 had told her on numerous occasions that she wanted a bath at least twice a week. NA-D stated she had reported this request to registered nurse (RN)-B the previous week. NA-D stated RN-B had not made any revisions to R99's bath schedule. On 4/13/16, at 12:48 a.m. RN-B stated she had not been made aware of R99's request for more than one bath a week. RN-B stated last Friday (4/8/16) NA-D had reported to her that some residents' were requesting more than one bath a week but didn't specifically name R99. RN-B confirmed the bath schedule had not been revised to allow R99 two baths a week. R65 had not received two baths per week, as requested. R65's quarterly MDS dated 1/25/16, indicated R65 was cognitively intact and had diagnoses of chronic pain, chronic ulcer of left foot and a history of left tibia (a bone in the lower leg) fracture. The MDS indicated R65 required supervision with transfer, dressing and personal hygiene. The MDS indicated bathing had not occurred during the MDS reference period. R65's quarterly MDS dated 10/27/15, indicated R65 required supervision with bathing. The interview for daily preferences on R65's admission MDS,	F 242		

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F 242	Continued From page 3 dated 7/30/15, indicated it was very important for R65 to choose between a tub bath, shower, bed bath or sponge bath but did not indicate R65's preference for bathing frequency. R65's care plan revised on 2/3/16, indicated R65 had decreased mobility secondary to left tibia fracture and required assistance with bathing. The plan indicated R65 required two staff assistance to bath, as staff able, due to behaviors. No whirlpool bath, shower only for bathing, and male staff only for baths, as able. The plan also indicated R65 had a history of refusing baths and staff was to reapproach if baths were refused. On 4/11/16, at 7:36 p.m. R65 stated he was supposed to get a shower twice a week but was lucky if he got one shower a week. R65 stated he wanted to received two showers per week as he had a sore on his left foot and he indicated the baths had been ordered by the person taking care of his wound. The undated Schedule for Bathing form indicated R65 was scheduled for a shower on Thursday and Sundays evenings. On 4/14/2016, at 10:43 a.m. the Documentation Survey Report for bathing dated 3/1/16, to 4/14/16, was reviewed with RN-A. The report revealed R65 received the following: Week of 3/20: 1 bath received, 1 not applicable Week of 3/27: 1 bath received, 2 not applicable	F 242		

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F 242	Continued From page 4 Week of 4/3: 1 bath received, 1 not applicable Week of 4/10: 0 baths received, 1 not applicable RN-A verified R65 was to receive a shower rather than a whirlpool bath, required two staff to bathe and required male staff to assist due to behaviors. RN-A indicated the "not applicable" designation on the report indicated R65 had not received a shower on the date designated. RN-A stated the times the shower did not occur could have been because male staff were not available to assist. RN-A confirmed R65 only received one shower per week from 3/20/16 to the present date and he preferred two showers per week. RN-A stated staff should have offered a shower on another day to meet R65's preference. On 4/14/2016, at 2:01 p.m. NA-F and NA-H verified R65 was to receive two showers per week. On 4/14/16, at 2:45 p.m. the director of nursing (DON) confirmed R65 should have received two showers per week according to his preference. The Bathing Procedure dated 6/2014, indicated the purpose was to promote cleanliness and general hygiene, to stimulate circulation of the skin, to promote comfort and relaxation and well-being to observe the resident's condition and to assist the resident with personal care. The procedure did not address resident bathing preferences.	F 242		

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F 242	Continued From page 5 A policy regarding resident choices with bathing was requested but not provided	F 242		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop an individualize care plan which included the appropriate bathing schedule and/or behaviors/interventions related to bathing for 2 of 2 residents (R107, R65) in the sample reviewed for bathing whose care plans did not address individual bathing frequency.	F 279	1.Resident # 107 and 65's care plan has been revised to include appropriate bathing schedule and interventions for refusals, specifically listing bathing frequency. 2.All residents are at risk for not having bathing preferences listed on the care plan. Audited all resident care plans and	5/6/16

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F 279	Continued From page 6 Findings include: R107's care plan was not developed to include bathing frequency and behaviors/interventions related to refusals to bathe. R107's quarterly Minimum Data Set (MDS) dated 2/15/16, indicated R107's diagnoses included non-Alzheimer's dementia, acute kidney failure and osteoporosis. The MDS indicated R107 had moderately intact cognition, required extensive assist with transfers, dressing, personal hygiene and utilized a wheelchair and a walker for mobility. R107's care plan printed on 4/13/2016, indicated R107 required assist of one staff for bathing and directed staff to encourage R107 to participate. However, the plan failed to address R107's refusal of baths or how many baths/showers R107 was to be receiving each week. On 4/11/16, at 7:05 p.m. R107 was observed in his room. A strong urine/body odor was noted in his room. At this time, R107 stated he was supposed to get a shower once per week but had not received one and thought it had been a couple of weeks since he last had a shower. On 4/13/16, at 12:10 a.m. nursing assistant (NA)-E stated R107's bath day was weekly, on Saturday and was given by the evening shift staff.	F 279	updated them to reflect the resident's preferences including refusals to bathe and staff interventions r/t the refusals. 3.Education completed for nursing staff addressing the need to care plan bathing preferences appropriately. Mandatory nursing in-service completed on 4/25/2016 and 4/27/2016. Staff were educated on the importance of following the resident's individualized plan of care, communication on bathing preferences, communication of bathing refusals and interventions if refusal occurs, and care planning of bathing preferences. 4.Staff to randomly audit resident care planning of bathing 3x/wk for 4 weeks with results to QAPI committee for further review/recommendation.	

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F 279	Continued From page 7 On 4/13/16, at 12:30 a.m. registered nurse (RN)-A verified R107's care plan was not developed to include bathing frequency, resident refusals to bathe and staff interventions related to the refusals. R65's care plan lacked indication of bathing frequency. R65's quarterly Minimum Data Set (MDS) dated 1/25/16, indicated R65 was cognitively intact and had diagnoses which included chronic pain, chronic ulcer of left foot, and a history of left tibia (a bone in the lower leg) fracture. The MDS indicated R65 required supervision transfer, dressing and personal hygiene. The MDS indicated bathing did not occur during the entire look back period. The quarterly MDS dated 10/27/15, indicated R65 required supervision with bathing. The interview for daily preferences on R65's admission MDS, dated 7/30/15, indicated it was very important for R65 to choose between a tub bath, shower, bed bath or sponge bath but did not indicate R65's preference for bathing frequency. R65's care plan dated 2/3/16, indicated R65 had an activities of daily living (ADL) self care performance deficit related to decreased mobility secondary to left tibia fracture and R65 required assistance with bathing. The plan directed two staff to assist with bathing as able due to behaviors. In addition, the care plan indicated R65 was to receive a shower only, no whirl pool bath. Male staff only for baths, as able. The Care Plan also indicated R65 had a history of	F 279		

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F 279	Continued From page 8 refusing baths and staff was to reapproach if baths were refused. The Care Plan did not address R65's bathing frequency. The undated Schedule for Bathing identified R65 was scheduled for Thursday p.m. and Sunday p.m. On 04/14/2016, at 2:40 p.m. RN-A verified the care plan did not address R65's bathing frequency preference. On 4/14/16, at 2:45 p.m. director of nursing (DON) confirmed R65's care plan should have addressed his bathing frequency preference. The Care Plan Policy dated 9/2012, indicated each resident would have an individualized comprehensive plan of care that would include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional spiritual, emotional, psychosocial and educations needs.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		5/6/16

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F 309	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure there was coordination of care for 1 of 1 resident (R4) reviewed for hospice services. Findings include: R4's significant change Minimum Data Set (MDS) dated 3/29/16, indicated R4 diagnoses included chronic obstructive disease (COPD) and dementia. The MDS indicated R4 was cognitively intact and required extensive assist with all activities of daily living and was on Hospice. R4's admission Hospice initial coordination note dated 3/21/16, indicated R4 was admitted to hospice services due to diagnosis of COPD and was to received hospice services which included: skilled nursing (SN), home health aide (HHA), Chaplin, and social worker. The hospice plan was to provide R4 the following: -a registered nurse (RN) would visit two times per week times one week. -a home aide (HHA) would visit two times a week times one week. -a Chaplin would visit one time in five days. -a social worker would visit one time in five days. However, no care plan had been developed related the identified hospice services. On 4/14/16, at 9:05 a.m. RN-A verified there was	F 309	1.Hospice was called and a copy of the schedule for R4 was obtained and placed at the nurses station in the 3 ring binder so staff were aware of the schedule for the resident. 2.All current and future residents receiving Hospice Services will have schedule provided to the center. This schedule will be placed in the 3 ring binder at the nurses station and also scanned into resident spaces. The resident care plans were updated to direct staff to 3 ring binder for the most current schedule for hospice visits. 3.All nursing staff were re-educated where to find the most current schedule for hospice care. This mandatory training for all nursing staff took place on 4/25/2016 and 4/27/2016 4.Audits will be done on all residents receiving hospice services weekly for two months. The review of the schedule will be audited and also staff will be audited to determine if they are aware of when hospice is coming in to care for residents. Results will be reviewed at the QAPI committee meeting for further recommendations.	

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F 309	Continued From page 10 no care plan related to hospice services in R4's medical record. At this same time, the unit coordinator stated the care plan should have been in R4's hospice designated, three ring binder along with all the other hospice paperwork because the facility did not scan hospice information into their computer system, therefore, R4's hospice care plan and hospice paperwork would be located in the three ring binder. R4's facility care plan dated 4/14/16, failed to identify R4 received hospice services and the cares and services hospice would be provided by the hospice agency. On 4/11/16, at 4:40 p.m. R4 was observed in bed sleeping. On 4/14/16, at 8:30 a.m. R4 stated she had been on hospice for about two weeks and had received two SN visits a week and two HHA visits a week. Adding, the HHA came either on Monday and Fridays or Tuesdays and Thursdays. R4 stated the HHA gave R4 a tub bath. R4 stated now she gets her baths because before she was on hospice, her baths were a hit and miss situation. On 4/14/16, at 9:10 a.m. nursing assistant (NA)-E stated she worked on the 300 wing and cared for R4 and did not know what days R4 received HHA services. NA-E stated the HHA would visit, then would let the facility staff know what care and services were provided. NA-E stated she did not know the day of when the hospice HHA came to see R4.	F 309		

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F 309	Continued From page 11 On 4/14/16, at 9:15 a.m. RN-A verified the facility NA schedule lacked the time the HHA would be at the facility. RN-A stated she did not know what time the hospice HHA came to the facility to see R4. On 4/14/16, at 9:30 a.m. the hospice RN was contacted via telephone and was made aware of R4 lacking a hospice care plan. The RN stated the care plan was faxed to the facility and should have been placed in the three ring binder. The RN stated she reviewed the binder when she visited R4. The RN stated it was her mistake R4's hospice care plan was not in the binder and she would follow-up on the issue. In addition, the RN stated the HHA staff member called the facility the day she planned to visit R4 as well as the time she would be there. On 4/14/16, at 9:45 a.m. RN-E stated the hospice RN would periodically call the facility regarding any changes and any other communication needed, but was unaware of the hospice HHA calling the facility with the date and time she would arrive. On 4/14/16, at 10:20 a.m. the unit coordinator stated she had not received a call each time HHA visited R4. On 4/14/16, at 10:30 a.m. RN-E verified coordination of care was lacking between the facility and hospice staff members and would be	F 309		

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F 309	Continued From page 12 contacting the hospice agency. On 4/14/16, at 1:10 p.m. the director of nursing (DON) verified R4's lack of coordination of care between the facility and the hospice agency. At 2:00 p.m. the DON provided the surveyor with a faxed copy of R4's hospice care plan. The Hospice Services Provided in a Skilled Nursing Facility policy, revised 8/15, indicated hospice provider's care plan would be integrated with the facility's comprehensive care plan in order to create a "joint plan of care."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide bathing services for 1 of 3 residents (R107) in the sample reviewed for bathing assistance and had not received the services. Findings include:	F 312	1.Resident #107 has been bathed according to his individualized plan of care. 2.All residents are at risk for not being bathed according to their individualized plan of care. Residents were all asked about their bathing preference and their care plans were updated to reflect current	5/6/16

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F 312	Continued From page 13 R107's quarterly Minimum Data Set (MDS) dated 2/15/16, indicated R107 was diagnosed with dementia and acute kidney failure. The MDS also indicated R107 had moderately intact cognition, required extensive assist with transfers, dressing and personal hygiene, R107 utilized a wheelchair and a walker for mobility and had not received a bath during the MDS reference period. R107's significant change MDS dated 11/19/15, indicated R107 required total assistance of one staff member for bathing. On 4/11/16, at 7:05 p.m. upon entering R107's room, a strong urine/body odor was noted. R107 stated he was supposed to get a shower once a week but had not had one and thought the last time he received a shower was a couple of weeks ago. On 4/13/16, at 8:00 a.m. R107's daughter stated she had asked her dad when he received a shower and he had told her he did not know. On 4/13/16, at 12:10 a.m. NA-E stated R107's bath day was on Saturday and was given by the evening shift staff. At this same time, registered nurse (RN)-A reviewed R107's bathing documentation which revealed the following: -2/13/16, R107 refused bath. No re-offering of a bath was noted in the record. -2/18/16, "NA" was noted. RN-A stated "NA" meant the bath did not occur. RN-A also stated "NA" should not be a documentation option.	F 312	bathing preferences. 3.Initiated a communication sheet to ensure residents bathing is completed according to their individualized plan of care. Education included the need to document care delivered appropriately. Mandatory nursing in-service completed on 4/25/2016 and 4/27/2016. Staff were educated on the importance of following the resident's individualized plan of care, communication on bathing preferences, communication of bathing refusals, documentation of bathing and refusals of bathing and interventions if refusal occurs, and care planning of bathing preferences. 4.Staff to randomly audit resident bathing completion, documentation, and care planning of bathing 3x/wk for 4 weeks with results to QAPI committee for further review/recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 14 -2/20/16, "NA" noted -2/27/16, "NA" noted -2/28/16, shower. -3/5/16, "NA" noted. -3/12/16, shower. -3/19/16, "NA" noted. -3/22/16, had a whirlpool tub. -3/26/16, "NA" -4/2/16, "NA" -4/9/16, R107 refused bath. RN-A stated R107 should have been re-offered a bath. According the bath schedule, R107's next scheduled bath was Saturday 4/16/2016. (35 days from previous bath) R107's care plan dated 4/13/2016, indicated R107 required assist of one staff to bathe and directed staff to encourage R107 to participate in the task. However, the care plan lacked identification of R107's bathing frequency or refusals and staff interventions related to R107 refusals in order to attempt improved hygiene. R107's medical record lacked any notation related to R107's refusals to bathe and interventions attempted. R107's progress notes from 2/6/16, also lacked any notation related to the bathing refusals. RN-A also reviewed R107's medical record and confirmed it lacked documentation related to R107's bathing refusals or why the weekly bath schedule was not followed. RN-A stated R107 had received hospice services however those services were discontinued on 11/13/15.	F 312		

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F 312	Continued From page 15 On 4/13/16, at 12:30 p.m. NA-A stated she worked the evening shift and if a resident refused a bath, the staff were to chart "refused" and not "NA. On 4/13/16, at 1:30 p.m. licensed practical nurse (LPN)-B stated if a resident refused a bath, the bath needed to re-offered that same day or was to be passed on to the next shift to re-offer/complete. On 4/13/16, at 1:45 p.m. R107 stated he had not received a bath in almost a month and had not refused a bath because the baths offered at the facility, were few and far between each other. R107 stated he had never received a whirl pool bath (as indicated on 3/22/16). Adding, he always took a shower and did not know he could have anything else. R107 stated he thought he was not getting his weekly shower because the evening shift was short on staff. R107 also stated since he was discontinued from hospice services, he really did not know when he was to get a bath, but would like one weekly. At 1:50 p.m. NA-B stated he worked the evening shift and confirmed R107 usually took a shower. NA-B stated if "NA" was documented, it meant the bath did not happen. NA-B stated if the evening shift had only two staff working, it was tough to get the baths done in addition to trying to complete makeup baths when those baths were not completed when scheduled. NA-B stated he thought "NA" was documented because they were short of staff and the bath was not provided.	F 312		

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F 312	Continued From page 16 On 4/13/16, at 12:30 a.m. RN-A verified R107's care plan was correct and lacked identification of bathing frequency, refusals and interventions. On 4/14/16, at 1:15 p.m. the director of nursing (DON) verified R107 should have received one bath per week. The Bathing Procedure dated 6/2014, indicated the purpose was to promote cleanliness and general hygiene, to stimulate circulation of the skin, to promote comfort and relaxation and well-being to observe the resident's condition and to assist the resident with personal care. The procedure did not address resident bathing preferences.	F 312		

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/13/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Bethany 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to both:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/27/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and, Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as one building. Good Samaritan Society Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1- story and was determined to be of Type II(000) construction. In 1974, two, 1-story additions were constructed, one to the south west and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2- hour fire barriers form the existing building. In 1980 an 1- story addition was constructed to the south and east of the 1974 south addition, was determined to be Type II (111) construction and is separated with a 2- hour fire barrier. In 1983 a small 1- story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V (000) construction. This link is not separated from the facility but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy	K 000		

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K 000	Continued From page 2 1- story addition was added to the north of the original building and was determined to be Type II (111) construction. In 1998 an 1- story addition was constructed to the north of the 1960 building and 1974 addition, was determined to be Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90 minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with quick response heads in the 1998 addition and standard response heads in all other areas. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas and in all sleeping rooms that is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for automatic fire department notification. Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 124 beds and had a census of 109 at the time of the survey.	K 000		
K 147 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by:	K 147		5/6/16

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K 147	Continued From page 3 Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect 20 of 109 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 9:00 AM and 1:00 PM on 04/13/2016, observations revealed the following deficient conditions: 1. There is combustible materials being stored next to and up against the breaker panels located in the Station 1 mechanical room, and 2. There are two power strips daisy chained in a cubical located in the administration suite. This deficient practice was confirmed by the Maintenance Supervisor.	K 147	1.The facility moved combustible materials that were stored next to the breaker panel. The facility removed the two power strips that were daisy chained in the cubical area of the administration suite. 2. Audited breaker panels to ensure no combustible materials were stored next to them. Audited power strips to ensure no others were daisy chained. 3. All Staff educated on storage near breaker panels and proper use of power strips. Education took place on 4/27/2016. 4. Audits to be completed 3x/wk for 4 weeks to ensure no combustible items stored near breaker panels and to ensure not power strips are daisy chained together.	