DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 26, 2023

Administrator
Bethany On The Lake Llc
1020 Lark Street
Alexandria, MN 56308

RE: CCN: 245434
Cycle Start Date: April 27, 2023

Dear Administrator:

On May 16, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 8, 2023

Administrator
Bethany On The Lake, LLC
1020 Lark Street
Alexandria, MN 56308

RE: CCN: 245434
Cycle Start Date: April 27, 2023

Dear Administrator:

On April 27, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota. 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 27, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by October 27, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE LLC	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/24/23, to 4/27/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. 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 the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/24/23, to 4/27/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed. The following complaints were reviewed with no deficiency issued. H54341321C (MN00087539), H54341320C (MN00089684), H54341268C (MN00086991), and H54341269C (MN00083558). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/09/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide maintenance services to ensure a clean and safe kitchen for 1 of 2 kitchenettes and the main kitchen observed during the kitchen tour. This deficient practice had the potential to affect all 76 residents currently residing in the facility and staff who worked in the kitchen. Findings include: During the initial tour of the kitchen on 4/24/23, at 6:32 p.m. with the dietary cook (DC)-A the following was observed: The three compartment sink located in the back kitchen area had a heavy build up of white/green lime scale on the inside of the sink half way up the sidewalls of the third sink area and all around the faucet area. The water leaked from the sink area and ran onto the water heater located below the sink area and into a gray plastic basin located on the floor. The water heater and the gray basin had a heavy build up of white lime scale which	F 921	F-921 Safe/Functional/Sanitary/Comfortable Environment 1. All Areas identified to have lime-scale build on them were cleaned/repaired to proper working conditions per policy. Areas identified were 3 compartment sink in back kitchen area, sidewalls, faucet, ice machine and counter area. 2. All kitchen areas identified to have potential for lime-scale build up were assessed and cleaned daily per policy. 3. All Dietary staff have been educated with cleaning lime-scale per policy, completed 5/10/23 4. Dietary Director/Designee will audit for lime-scale build up in the x3 per week for 2 weeks, x2 per week for 2 weeks, x1 per week for 2 weeks, and x1 per month. Audit results will be reviewed by QAPI committee for further recommendations.	5/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 921	Continued From page 2 ran onto the entire floor area underneath the sink area and towards the back of the wall. - the counter area next to the three compartment sink and the plastic drying rack with pots and pans on it had a moderate amount of lime scale build up present and was unclean. DC-A confirmed the facility used the three compartment sink on a daily basis to soak pots, pans, knives and such utensils. - the ice machine located in the front of the kitchen area had a moderate amount of white lime scale build up on the sides of the ice machine and above the cover area. The flooring located under the ice machine towards the back of the wall area had a moderate amount of white lime scale build up present and was unclean. - at 6:51 p.m. a tour of the kitchenette on the first floor was completed with licensed practical nurse (LPN)-A. The sink area was noted to have a moderate amount of white lime scale on the inside of the silver sink and on the entire faucet area. During the follow-up kitchen tour on 4/26/23, at 11:05 a.m. with the dietary manager (DM) the following continued to be observed: The three compartment sink located in the back kitchen area had a heavy build up of white/green lime scale on the inside of the sink half way up the sidewalls of the third sink area and all around the faucet area. The water leaked from the sink area and ran onto the water heater located below the sink area and into a gray plastic basin located on the floor. The water heater and the gray basin had a heavy build up of white lime scale which ran onto the entire floor area underneath the sink area and towards the back of the wall. - the counter area next to the three compartment sink and the plastic drying rack with pots and	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	C 04/27/2023

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F 921	Continued From page 3 pans on it had a moderate amount of lime scale build up present and was unclean. - a heavy build up of white lime scale was noted underneath the convection oven and several Combi (combination of steam and convection) ovens and was present on the shelves below the ovens and on the flooring behind the oven area. - the ice machine located in the front of the kitchen area had a moderate amount of white lime scale build up on the sides of the ice machine and above the cover area. The flooring located under the ice machine towards the back of the wall had a moderate amount of white lime scale build up present and was unclean. The DM indicated her staff were expected to wipe down the ice machine nightly and maintenance did a complete cleaning every week. The DM indicated the facility had de-limer that they used to clean the areas with lime scale on it and indicated she had asked the maintenance supervisor (MS) what she could use to remove the lime scale from these areas and had not heard back. The DM indicated she did not have any documentation of when or how often the kitchen areas were being cleaned in the kitchen. During an interview on 4/27/23, at 9:44 a.m. the DM confirmed the above findings and indicated her expectation of staff were to clean these areas daily when they were able to. The DM stated she used to have staff designated to clean these areas and no longer had someone to clean the lime scale due to staffing issues. The DM indicated she expected all staff ensured the kitchen areas were clean. During a tour of the kitchen on 4/26/23, at 12:04 p.m. the MS confirmed the above findings and stated the build up of lime scale was an infection	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	C 04/27/2023

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F 921	Continued From page 4 control issue. The MS indicated staff were expected to clean the ice machine every other week. The MS stated the ice machine was professionally cleaned once a year. The MS indicated staff were expected to clean the three compartment sink and water heater weekly. The MS confirmed there was no documentation to reveal the equipment and areas had been cleaned as directed. The MS indicated he was not aware the lime scale had built up to the level as described above. The MS stated he expected staff to ensure the equipment and areas were cleaned on a regular basis and further expected staff to follow facility policy. Review of the facility policy titled, Lime Scale Build Up revised on 4/2023, indicated the culinary director and maintenance director would ensure all areas would be clean and free from lime scale build up. The culinary director would contract professional cleaning of lime scale build up as needed. Review of facility policy titled, Ice Machine Cleaning revised on 4/2023, indicated the maintenance director would ensure all ice machines were clean and fully operational per manufactures guidelines bi-weekly and cleaned professionally yearly.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**04/26/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE LLC	**1020 LARK STREET ALEXANDRIA, MN 56308**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 26, 2023. At the time of this survey, Bethany on the Lake Building 01 was found 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Bethany Home facility was surveyed as 2 buildings as follows: Bethany on the Lake was originally constructed in 1964 and has gone through several additions and has had one remodel in 2012. Building One, the long and short term care is mainly a two story building. It had a 3 story addition constructed in 2003, with nursing home care on the first level only. The entire structure is of type II (111) construction and the three story section is separated by two 2 hour fire barriers. One located along the assisted living and the other along the south end separating the 2 & 3 story sections. Building Two, the chapel area, was constructed in 2003 and is one level, type V (111) construction. This building is separated with a 2 hour fire barrier from the main building. The buildings are fully sprinkled with a monitored	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**04/26/2023**

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K 000	Continued From page 1 fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. Level one is separated by two smoke barriers and two 2 hour fire barriers creating 5 smoke compartments. Level two is separated by 4 two hour fire barriers and two smoke barriers creating 7 smoke compartments. The facility has a capacity of 83 beds and had a census of 76 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**04/26/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on April 26, 2023. At the time of this survey, Bethany on the Lake Building 02 was found 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Bethany Home facility was surveyed as 2 buildings as follows: Bethany on the Lake was originally constructed in 1964 and has gone through several additions and has had one remodel in 2012. Building One, the long and short term care is mainly a two story building. It had a 3 story addition constructed in 2003, with nursing home care on the first level only. The entire structure is of type II (111) construction and the three story section is separated by two 2 hour fire barriers. One located along the assisted living and the other along the south end separating the 2 & 3 story sections. Building Two, the chapel area, was constructed in 2003 and is one level, type V (111) construction. This building is separated with a 2 hour fire barrier from the main building. The buildings are fully sprinkled with a monitored	K 000		

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K 000	Continued From page 1 fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. Level one is separated by two smoke barriers and two 2 hour fire barriers creating 5 smoke compartments. Level two is separated by 4 two hour fire barriers and two smoke barriers creating 7 smoke compartments. The facility has a capacity of 83 beds and had a census of 76 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 8, 2023

Administrator
Bethany On The Lake Llc
1020 Lark Street
Alexandria, MN 56308

Re: Event ID: ELC911

Dear Administrator:

The above facility survey was completed on April 27, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING: _____ B. WING _____	C 04/27/2023

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BETHANY ON THE LAKE LLC	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/24/23, to 4/27/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure. In addition, a complaint survey was conducted.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING: _____ B. WING _____	C 04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE LLC	1020 LARK STREET ALEXANDRIA, MN 56308

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2 000	Continued From page 1 The following complaints were reviewed with no licensing order issued. H54341321C (MN00087539), H54341320C (MN00089684), H54341268C (MN00086991), and H54341269C (MN00083558). Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		