Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 19, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

RE: CCN: 245427
Cycle Start Date: October 25, 2024

Dear Administrator:

On November 27, 2024, we notified you a remedy was imposed. On December 6, 2024 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 12, 2024.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 25, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 27, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 12, 2024 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 12, 2024, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 6, 2024

Administrator
Bethesda
901 Southeast Willmar Avenue
Willmar, MN 56201

RE: CCN: 245427
Cycle Start Date: October 25, 2024

Dear Administrator:

On October 25, 2024, 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:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

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 January 25, 2025 (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 April 25, 2025 (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)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING _____ B. WING _____	C 10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(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 10/21/24-10/25/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT 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 with no deficiency issued: H54279586C (MN00100490) H54279571C (MN00102102) H54279585C (MN00107039) H54279459C (MN00107286) 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 onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		11/27/24

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

Electronically Signed | 11/15/2024

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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F 584	Continued From page 1 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident wheelchairs were kept in a clean and sanitary manner to promote resident well-being for 1 of 2	F 584	Corrective Action for Residents Affected by Deficient Practice: R17's wheelchair was replaced with a fully intact wheelchair and cleaned.	

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F 584	Continued From page 2 residents, (R17), observed for positioning. Findings include: R17's annual Minimum Data Set (MDS) of 5/24/24 identified R17 was dependent on staff to move from lying to sitting, sitting to standing, and chair/bed to chair transfer. The MDS indicated R17 no longer walked. R17's medical diagnoses included progressive neurological conditions, Parkinson's (a movement disorder of the the nervous system that impacts physical movement, which worsens over time), polyneuropathy (a disease that causes damage to multiple nerves in different areas of the body which impacts communication between the central nervous system, which included the brain and the spinal cord, and the rest of the body), low back pain, and repeated falls. R17's care plan, last revised 6/21/24, indicated R17's mode of locomotion (mobility) was a wheelchair. R17 had a potential for impaired skin Integrity related to uncontrolled movements of Parkinson's disease. R17 used a gel cushion in his rock-n-go wheelchair (a wheelchair which allowed a rocking type movement while wheelchair remains in a stationary position). R17's care plan identified R17 received altered texture diet with soft and bite size food. The care plan indicated R17 liked finger food snacks. On 10/21/24, at 1:50 p.m. R17 was observed seated in his wheelchair in the day room. On R17's wheelchair, on the fabric of outer aspect of the right side of the wheelchair, there was a worn area measuring 1/6 of the wheel (approximately 12 inches in an curved pattern) observed on the chair corresponding to the wheel of the	F 584	Identification of Other Residents Having the Potential to be Affected by Deficient Practice: Replacement side panels were purchased and replaced for all rock-n-go wheelchairs that were identified to need repair during the facility's initial audit. Facility identified that a systematic change was needed for the cleaning of all resident wheelchairs. This alleged deficient practice has the potential to impact all residents with wheelchairs. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Wheelchair Cleaning and Maintenance Policy was created to include weekly cleaning schedules. Housekeeping and nursing will be monitoring and assessing wheelchair physical structure and will report any maintenance or repair needs as needed. Training and re-education will be provided to all staff responsible for cleaning and maintaining wheelchairs. Training and re-education will be provided to all nursing and environmental services staff beginning November 2024 and will be completed by the completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur:	

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F 584	Continued From page 3 wheelchair. The width of this area was noted to be 1/2 to one inche in width. In this worn area, approximately eight inches of the curve was noted to be no longer intact and shredded in appearance, with the fabric split and open areas present. On the left side of the wheelchair, a wear pattern of approximately eight inches in a curved pattern was noted, however, the fabric remained intact. On 10/22/24, at 6:44 p.m., interview was held with registered nurse (RN)-E following observation of cares. During the observation of cares, RN-E was observed removing a napkin of soft food from the seat of the wheelchair prior to attempting transfer with R17. Upon review of the physical appearance of the wheelchair, RN-E identified the wheelchair had wear on both sides of the wheelchair and identified the right side was worse than the left. RN-E identified there was potential for impact of the wheelchair function, as well as potential injury to R17 on the shredded fabric. Upon review of the fabric, RN-E acknowledged the area not being intact limited the capability for cleaning well. RN-E acknowledged R17 fed him self independently at times, with food going onto the chair and the fabric not being intact posed a difficulty to maintain cleanliness. RN-E stated she was unaware of specific cleaning or maintenance schedule for wheelchairs. On 10/23/24, at 3:34 p.m. R17 was noted to remain in the same wheelchair previously viewed, which lacked repair to the impaired area. On 10/24/24, at 10:20 a.m., the director of nursing stated the wear on the wheelchair R17 posed a potential for injury to resident. DON also identified a concern regarding the ability to clean	F 584	Environmental Services Director is completing an initial audit of wheelchair cleaning throughout the building. Environmental Services Director or designee will complete continued audits 8x/month x 4 months beginning November 2024 for both cleaning and maintenance of wheelchairs. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 584	Continued From page 4 the wheelchair adequately, as cleaning of the fabric where it was no longer intact would be difficult. DON stated there were no current policies for routine cleaning and maintenance of wheelchairs. A review of an undated document, titled CNA (Certified Nursing Assitant) Day Shift Duties, directed staff to "Clean wheelchairs after meals if needed." A second undated document, titled CNA Evening Shift Duties, also directed staff to "Clean wheelchairs after meals if needed." A document, titled Bethesda Housekeeper Job Description, revised 9/01 indicated the housekeeping staff was to wash resident wheelchairs. All documents reviewed lacked indication as to ongoing maintenance and repair of wheelchairs in regards to physical structure.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §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 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	F 656		11/27/24

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F 656	Continued From page 5 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive, person-centered care plan was developed and readily available to promote acceptable pain management for 1 of 4 residents (R199) reviewed for care planning. Findings include: R199's quarterly Minimum Data Set (MDS), dated	F 656	Corrective Action for Residents Affected by Deficient Practice: R199's pain care plan was developed. Identification of Other Residents Having the Potential to be Affected by Deficient Practice An audit of all active resident care plans was conducted to identify any missing or	

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F 656	Continued From page 6 9/20/24, identified R199 had intact cognition and was admitted to the care center on 6/10/24 from the acute care hospital. The MDS outlined R199 was independent to setup assistance for most activities of daily living (ADLs) and had multiple medical conditions including malignant neoplasm of the left lower lung lobe, repeated falls, essential hypertension and bilateral primary osteoporosis of the knees. On 10/24/24 at 1:07 p.m., R199 was interviewed. R199 explained she admitted to the care center after being treated in the hospital for severe chest pain, and was diagnosed with the left lower lobe lung mass. R199 was noted to have tubes of Voltaren Gel (a nonsteroidal anti-inflammatory gel) on her bedside stand. R199 stated she had pain in both her knees, which she had been treating with the creams prior to her Hospitalization. R199 stated she has been self-administering the creams, however, has the nurses apply it to areas when she is unable to reach them. R199 further stated she has had increasing pain in her left chest and shoulder due to her lung mass, and is receiving tylenol and tramadol, which helps. R199's initial Nursing Admission Assessment - Day 1 Club, dated 6/10/24, identified R199 had voice her pain level at a "0" on a scale of 0 - 10 (0 being no pain, 10 being excruciating pain. This assessment further documented "resident reports occasional bilateral knee pain, recent cortisone injections [a synthetic hormone injected into the body to reduce pain, inflammation, and swelling] to knees." This assessment was supplemented with the Nursing Admission Assessment - Day 2 Club, also dated 6/10/24, due to R199 reporting history of pain. R199	F 656	incomplete documentation regarding pain management interventions and to ensure a comprehensive care plan is in place for pain. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Care Planning Policy was reviewed and revised. Training and re-education will be provided to all staff responsible for creating comprehensive care plans beginning November 2024 and will be completed by completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: DON, ADON, or designee will complete 8 random audits/month x 3 months to ensure comprehensive care plans accurately reflect pain. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 656	Continued From page 7 reported her pain to be chronic and intermittent. In review of R199's significant change MDS (dated 6/28/24), the facility completed a Annual & Significant Change Assessment - 3.0 (dated 6/27/24, which indicated no change is pain reported. However, in review of R199's Quarterly Nursing Assessment - 2.0 (dated 9/19/24), the registered nurse (RN) Analysis for pain documented the following: "resident did state that she has had occasional back pain, in the middle of her left side, over the past 5 days. The worst her pain has been is a 8 on a scale of 1-10. Does receive scheduled Tylenol as orders. Has also received Tramadol (a combination of a synthetic opioid and monoamine re-uptake inhibitors used to relieve moderate to moderately severe pain) PRN (as needed) as ordered. Both of them have been effective for her." A review of R199's current physician ordered medication listing (print date of 10/24/24) documented the following pain medication interventions: 8/08/24 - Diclofenac Sodium (Voltaren) External Gel 1% (Topical) - apply to left and or right knee topically as needed for pain. Apply 4 grams (g) up to 4 times a day. 8/08/24 - Diclofenac Sodium (Voltaren) External Gel 1% (Topical) - apply to left wrist topically as needed for pain. Apply 2g up to 4 times a day. 9/24/24 - traMADOL HCL oral table 25 milligrams (mg) - give 25 mg by mouth every 6 hours as needed for pain rated 6-10. Max Daily Amt: 100	F 656		

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F 656	Continued From page 8 mg. 9/27/24 - Acetaminophen 8 hour Oral Tablet Extended Release - give 1300 mg by mouth two times a day related to malignant neoplasm of lower lobe, left bronchus or lung. Maximum acetaminophen dosing of 4000 mg / day. 9/27/24 - Acetaminophen 8 hour Oral Tablet Extended Release - give 650 mg by mouth as needed for pain related to malignant neoplasm of lower lobe, left bronchus or lung. Maximum acetaminophen dosing of 4000 mg / day. BID (twice a day), PRN. In review of R199's Care Plan (print date of 9/24/24), noted the facility failed to identify R199's pain issues and interventions to assist in reducing pain. In an interview on 10/24/24 at 10:14 a.m., registered nurse / case manager (CM)-A reviewed R199's careplan and verified R199's pain issues had not been addressed on her care plan. CM-A stated it would be important to have R199's pain address on the care plan for continuity of care. During an interview on 10/24/24 at 10:21 a.m., assistant director of nursing for R199's unit (ADON)-A reviewed R199's physician's orders and care plan. ADON-A stated R199's pain issues should have been addressed on her care plan due to the diagnoses listed. In a further interview on 10/25/24 at 11:38 a.m., the director of nursing (DON) stated it would be her expectation that any resident with pain issues with interventions, be addressed in the care plan.	F 656		

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F 656	Continued From page 9 DON further stated this was important so that the care plan and care sheets educate the direct care staff to the issues of pain and interventions prescribed. In review of the facility's policy, entitled: Bethesda Care Planning (dated 2/2024) documented the following: "Purpose: To provide an individualized and comprehensive interdiction plan of care for each individual, that promotes quality of care and life." "Responsibility: Interdisciplinary care team including: resident, family, physician and other appropriate medical professionals, nursing, social services, culinary, recreation, therapy and hospice when appropriate." Policy: > A plan of care is initiated for all residents within 48 hours of admission > A comprehensive care plan is developed within 21 days of admission date. > A registered nurse develops and oversees the resident's care plan. > The plan of care is discussed during the resident's initial care conference, quarterly and with significant changes. >Each discipline is responsible for the following and established format for care planning. > Care plan reviews completed with OBRA [Omnibus Budget Reconciliation Act] assessments. > The initial 48 hour care plans are on paper. The comprehensive 21 day care plans are kept in the electronic record."	F 656		

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F 684	Continued From page 10	F 684		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive supports or assistive devices to ensure upright positioning for 1 of 2 residents, (R17), reviewed for positioning. In addition, the facility failed to ensure medications were administered per physician's order for 1 of 2 residents (R480) reviewed for respiratory care. Findings include: R17's annual Minimum Data Set (MDS) of 5/24/24 identified R17 had moderate cognitive impairment. The MDS identified R17 received substantial to maximum assistance with dressing, grooming, and bathing. R17 was dependent on staff to move from lying to sitting, sitting to standing, and chair/bed to chair transfer. The MDS indicated R17 no longer walked. R17's medical diagnoses included progressive neurological conditions, Parkinson's (a movement disorder of the the nervous system that impacts physical movement, which worsens over time), polyneuropathy (a disease that causes damage to multiple nerves in different areas of the body	F 684	Corrective Action for Residents Affected by Deficient Practice: A therapy screen was completed for R17 to ensure proper wheelchair positioning. R480 received medication as scheduled. Identification of Other Residents Having the Potential to be Affected by Deficient Practice Facility identified that all residents using a wheelchair need to have proper wheelchair positioning. A facility audit has been completed to identify residents that have documentation of drug/item unavailable. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Wheelchair Positioning Policy and Procedure was reviewed and revised. Training and re-education will be provided	11/27/24

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F 684	Continued From page 11 which impacts communication between the central nervous system, which included the brain and the spinal cord, and the rest of the body), low back pain, and repeated falls. R17's care plan, last revised 6/21/24, indicated R17 functional abilities varied, and at times, required assistance not at their usual level of performance. The care plan indicated R17's mode of locomotion (mobility) was a wheelchair. R17 had a potential for impaired skin Integrity related to uncontrolled movements of Parkinson's disease. R17 used a Gel cushion in his rock-n-go wheelchair (a wheelchair which allowed a rocking type movement while wheelchair remains in a stationary position). The care plan failed to identify positioning concerns while seated in the rock-n-go wheelchair, or potential positioning aides to be implemented. On 10/21/24, at 1:50 p.m. R17 was observed seated in a wheelchair in the day room area. R17 was leaning to the left side of the wheelchair, with his head resting on the arm rest. R17's eyes were closed, and R17 was not interacting with others. The wheelchair lacked lateral (side) support to maintain upright position, or to support R17's head, neck, and upper body. R17's wheelchair was tilted back at approximately a 45 degree angle, but lacked support of upper body, head and neck. On 10/22/24, at 10:06 a.m. R17 was observed to be seated in his wheelchair and was leaning to the left side of the chair, with no visible lateral support observed. R17 had his eyes closed, and was not interacting with others around him. During interview on 10/22/24, at 6:44 p.m.,	F 684	to all nursing staff beginning November 2024 and will be completed by completion date. Administration of Medications Policy and Pharmacy Services Policy – Ordering and Receiving Medications from the Dispensing Pharmacy were reviewed. Training and re-education will be provided to all staff responsible for passing medications beginning November 2024 and will be completed by completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: RN Case Managers will complete an initial audit to identify any residents with wheelchair positioning concerns. DON, ADON, or designee will complete 8 random audits/month x 3 months to ensure resident positioning is upright. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained. DON, ADON, or designee will complete 8 random audits/month x 3 months to ensure medications were administered per physician's order. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 684	Continued From page 12 registered nurse (RN)-E stated R17 had been fitted with this rock-n-go wheelchair "for a while". RN-E commented with R17's increased ataxic (poor muscle control that causes clumsy movements) the chair allowed R17 the opportunity for safe movement. When viewing R17 in the chair, RN-E acknowledged the potential need for lateral support, and identified there was no lateral support available for use. On 10/23/24, at 11:49 a.m., R17 was observed seated in his rock-n-go wheelchair, with a pillow placed on his left side to help maintain R17 in an upright position. On 10/24/24, at 8:28 a.m. RN-E stated a referral had been sent for a therapy screen for positioning. On 10/24/24, at 10:20 a.m., the director of nursing (DON) stated it was her expectation for residents to be positioned in an upright position to promote comfort. If indicated, it was her expectation for a therapy referral to be submitted. The facility policy, titled Wheelchair Positioning Policy and Procedure, revised 1/24, indicated residents were to be positioned in good body alignment. The policy identified it was the responsibility of nursing staff to ensure resident was positioned properly. A Therapy screen was to be completed as needed to ensure proper wheelchair positioning. R480's quarterly Minimum Data Set (MDS) dated 10/18/24, identified R480 had severe cognitive impairment and required assistance with all activities of daily living (ADL)'s. R480's diagnoses included non-traumatic brain dysfunction,	F 684		

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F 684	Continued From page 13 vascular dementia, hypertension, septicemia, non-Alzheimer's dementia, depression, psychotic disorder (other than schizophrenia), asthma (COPD) or chronic lung disease, insomnia, auditory and visual hallucinations, myalgia, and hypothyroidism. During review of R480's electronic health record (EHR), signed physician's order indicated an order for Advair HFA inhalation aerosol 115-21 mcg (microgram) two puffs inhale orally two times a day related to chronic obstructive pulmonary disease in the morning and in the evening. Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 10/22/24, indicated seven doses were documented as drug/item unavailable and four doses were documented as administered from 10/19/24 to 10/24/24. During interview on 10/24/24 at 7:37 a.m., trained medication aide (TMA)-A stated 480's Advair was not available as it had not been delivered from pharmacy yet. TMA-A stated she had faxed the pharmacy and ordered R480's Advair four times in the past several days and that she was going to place a call to the pharmacy today to see why medication had not been delivered. TMA-A stated she probably should have called pharmacy to follow up on it sooner and notified nurse. TMA-A confirmed she had documented on R480's MAR as not administered due to medication not being available. TMA-A stated it was important for R480 to receive medication to help her with breathing. During interview on 10/24/24 at 2:08 p.m., registered nurse (RN)-E stated TMA-A had updated her about R480's missing Advair inhaler, that it was unavailable however pharmacy is	F 684		

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F 684	Continued From page 14 stating that it was delivered. During interview proceeded to check on available supply in medication and RN-E confirmed Advair inhaler was delivered by pharmacy and was available in medication cart. RN-E stated inhaler was the generic brand, so it had looked different than the previous inhaler. RN-E stated if a medication was unavailable, she would expect staff to fax the refill request to pharmacy and then would follow up with pharmacy to see if medication was available. If TMA was on the medication cart and medication was unavailable, RN-E would expect the TMA to update the nurse on duty and/or come and update the case manager. RN-E confirmed medication was signed off in MAR as administered three times, confirmed inhaler was dispensed from pharmacy on 10/10/24, and confirmed that cannister had not been used/medication administered since arrival from pharmacy RN-E viewed the cannister outside of the delivery system, which indicated there were 121 actuations available and the label stated 120 actuations were dispensed. RN-E stated this was a medication error as it had not been administered. During interview on 10/24/24 at 2:33 p.m., director of nursing (DON) stated if medication was not available, she would first expect staff to check facility's supply to see if it is available in house and then would expect staff to call the pharmacy to order a refill of medication. DON confirmed documentation in the MAR was inaccurate and would be a medication error. The facility's Medication Administration policy and procedure was requested but was not received. The facility's Pharmacy Services policy, dated	F 684		

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F 684	Continued From page 15 10/22, indicated medications and related products are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. During regular pharmacy hours, nursing will fax the emergency or "stat" order to the pharmacy and then call to alert the pharmacy that a "stat" order was just faxed. Such medications are delivered as soon as possible.	F 684		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to coordinate with dialysis, the nephrologist, and the primary physician when dialysis was discontinued for 1 of 1 resident (R102). This resulted in the potential for complications when R102 continued to maintain his dialysis central line with no routine dressing changes to prevent infection and continued on phosphorus binding medication, renal diet, and fluid restrictions. Findings include: R102's admission Minimum Data Set (MDS) dated 9/13/24, identified R102 had intact cognition and diagnoses of anemia, atrial fibrillation, hypertension, renal insufficiency, and depression. MDS also indicated R102 was	F 698	Corrective Action for Residents Affected by Deficient Practice: Facility contacted dialysis center on 10/24/24 and received signed orders effective 10/24/24 to hold Sevelamar, discontinue fluid restrictions, discontinue renal diet, and sent resident to urgent care for evaluation of low blood pressure and labs. Facility contacted dialysis center on 10/24/24 and 10/25/24 requesting orders for site care, order received to change central line dressing weekly until port is removed. Dietician completed a new nutrition assessment and educated resident on diet order change on 10/24/24. Primary physician's on-call was contacted on 10/25/24 on resident's discharge from dialysis and updated orders. Daily weights and vitals	11/27/24

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F 698	Continued From page 16 receiving hemodialysis. R102's Physician's Order Sheet, print date of 10/22/24, included the following physician's orders: -Renal (dialysis) diet which consisted of regular texture, regular/thin consistency, low phosphorus, low potassium, and no added salt. -Dialysis: Check site - central line right (R) upper chest for bleeding and signs and symptoms of infection every shift -Fluid restriction (2000 mL (milliliter/day) Document all fluid intake from meals and what is given from nursing. -Sevelamer Carbonate (phosphorus binding medication) oral tablet 800 mg (milligram) two tablets by mouth with meals related to acute kidney injury. R102's mediation administration record (MAR) and treatment administration record (TAR) indicated all above orders and treatments were signed off as completed from 10/9/24 to 10/24/24. R102's progress note, dated 10/4/24, indicated facility received call from the dialysis clinic and was informed R102's kidney function had returned, and he would not need a dialysis treatment on 10/5/24 and 10/8/24. R102 would need lab work completed on 10/8/24 and pending those results may be able to discontinue port and dialysis. R102's progress note, dated 10/9/24, indicated facility received call from the dialysis clinic and was informed R102 was discharged from dialysis and would need to follow up in the clinic in three months.	F 698	were implemented on 10/25/24. Blood pressure monitoring that was already in place was continued. Identification of Other Residents Having the Potential to be Affected by Deficient Practice DON identified all residents who are currently receiving Dialysis. Audit was completed and no other current residents had been discharged from Dialysis due to improvement in condition. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: The Dialysis Policy and Procedure was reviewed and revised to include: residents who come off dialysis, implementing dialysis for new admissions or new dialysis residents, and communication with dialysis center. The Physician Services Policy and Procedure was reviewed and revised. Dialysis Policy and Procedure training and re-education was provided to all nursing staff. Physician Services Policy education was provided to all licensed nurses. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: DON completed daily dialysis audits from 10/25/2024 - 11/1/2024. DON, ADON, or designee will complete 8 random	

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F 698	Continued From page 17 During interview on 10/21/24 at 4:05 p.m., R102 stated he had stopped dialysis about a month ago. During interview on 10/21/24 at 4:06 p.m., registered nurse (RN)-G stated R102's dialysis treatments had ended approximately one to two weeks ago and stated the droplet magnet on R102's door indicated R102 was on fluid restrictions. During interview on 10/23/24 at 8:58 a.m., nursing assistant (NA)-A stated she thought R102 had quit dialysis so she would have to check with the nurse. NA-A stated R102 was currently on fluid restrictions where he was only able to have a certain number of fluids each day. During interview on 10/23/24 at 12:02 p.m., dialysis registered nurse (DRN)-A stated R102 was not receiving dialysis any longer as R102 had recovered. DRN-A stated R102 ended dialysis on 10/3/24 and a referral for the surgeon was sent for the removal of the central line and port. During interview on 10/23/24 at 4:42 p.m., R102 stated the central line and port was still in place and he thought it was getting removed on 10/24/24 or 10/25/24. During interview on 10/24/24 at 8:20 a.m., RN-A stated when dialysis gets discontinued for a resident the facility gets the okay from the dialysis clinic and lab work would be completed to confirm that discontinuation of dialysis could still occur. The facility would need to then set up appointment for resident's central line and port to be removed. RN-A stated R102's central line and port is scheduled to be removed on 10/29/24.	F 698	audits/month x 3 months to ensure coordination of Dialysis care is in compliance. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 698	Continued From page 18 RN-A could not think of anything else that would need to be done. When surveyor asked about the care plan and care sheet, RN-A stated she should probably check R102's and make changes on them. RN-A stated it would be important for the information on the care sheets was accurate for communication purposes with the staff. The nurses continue to check the central line site for signs and symptoms of infection. RN-A stated R102 is probably still on fluid restrictions and a renal diet, and he may not need to be. She would have to check with the dialysis center and provider about his fluid restrictions, renal diet orders and dressing change orders. She confirmed these should have been addressed by now, should have been addressed immediately after discontinuation of dialysis. RN-A stated R102 was the only resident that she had come off of dialysis and was not aware of the process. During interview on 10/24/24 at 8:36 a.m., assistant director of nursing (ADON)-A stated when dialysis is discontinued it is initiated by the provider/nephrologist. The dialysis clinic contacted the facility to make aware resident's dialysis was discontinued. That was taken as an order. Follow-up labs were done determine if port could be removed. ADON-A stated she was not sure of anything else that would need to be done as she has never had anyone come off of dialysis. The port should have been removed as soon as possible to minimize risk of complications and infections. ADON-A stated nephrologist should have been notified immediately following discontinuation of dialysis for medication orders, clarification of fluid restriction and renal diet orders. During interview on 10/24/24 at 9:16 a.m.,	F 698		

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F 698	Continued From page 19 director of nursing (DON) stated when a resident's dialysis is discontinued, communication should be done with the provider, resident, and family. She expected case managers to follow through with recommendations for follow-up. Case manager should have reached out to dialysis for any changes in orders at the end of dialysis such as port removal and site care, fluid restrictions, diet, and medication orders. DON stated removal of the port should be as soon as possible as it is an infection source and with the port not being used regularly, it could have caused complications and/or infections. During interview on 10/24/24 at 10:06 a.m., RN-A stated she received the referral for the port to be removed on the day R102 was discharged from dialysis. RN-A confirmed R102 was discharged from dialysis on 10/9/24. RN-A stated she was not sure if the facility called to set up the appointment or if the surgeon's office called as she handed it off to the medical secretary who scheduled all appointments. During interview on 10/24/24 at 10:18 a.m. medical secretary (MS) stated she was responsible for scheduling appointments for the transitional care unit (TCU). On 10/17/24 she received an email from RN-A stating, RN-A called the dialysis center in regard to removal of the port. RN-A informed her the order for the referral was in EPIC (medical software) and asked MS to call and schedule appointment. MS stated she called to make appointment and the soonest appointment available was on 10/29/24. During interview on 10/24/24 at 11:10 a.m., DRN-A stated Sevelamer should have been discontinued at the end of dialysis as it helps	F 698		

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F 698	Continued From page 20 control calcium levels and could cause R102's calcium to become too low. When a resident came off dialysis, the resident no longer needed to be on fluid restrictions, renal diet and medications relating to dialysis. DRN-A stated a follow-up appointment at the dialysis clinic with the nephrologist is determined and nephrologist stated he would like to see R102 in three months. DRN-A confirmed R102 was discharged from dialysis on 10/9/24 and the removal of the port is scheduled for 10/29/24. During interview on 10/24/24 at 12:01 p.m., nephrologist stated orders that go with dialysis should be discontinued at the time of discontinuation of dialysis such as fluid restriction, renal diet, and medications. Sevelamer should have been discontinued when R102 was discharged from dialysis and would recommend that it be discontinued now if it had not been. Nephrologist stated R102 should be seen by provider (emergency room or urgent care), if R102 had not been eating a lot of protein, that could cause low albumin, and if R102's phosphorus level was low and he continued to not have adequate intake, medication could cause serious harm to R102. During interview on 10/24/24 at 12:15 p.m., RN-H stated R102's primary provider was contacted and informed facility that R102 should be sent to urgent care. RN-H stated family was transporting R102 to urgent care. When R102 was discontinued from dialysis, orders were not received to discontinue medications, change in diet or to stop fluid restrictions. RN-H stated on 10/18/24, R102 blood pressures started dropping and the physician discontinued amlodipine and ordered blood pressure monitoring, however, did	F 698		

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F 698	Continued From page 21	F 698		

not order any other medications to be held or discontinued. RN-H stated orders were received this morning from Nephrology to hold the Sevelamer.

During interview on 10/24/24 at 12:36 p.m. consultant pharmacist (CP) stated side effects from the Sevelamer are usually stomach related. It would be important to monitor potassium and phosphate levels. Sevelamer was usually discontinued with discontinuation of dialysis. Symptoms depended on what R102's phosphorus level was, the medication binds the phosphorus. CP expected the provider to do labs to check level.

During interview on 10/24/24 at 12:58 p.m. DRN-A stated site care of the port should be changed weekly and cleansed with betadine or chlorhexidine and then left to dry before recovering it with a sterile dressing. If dressing changes were not being done, an infection could occur. No treatment was required for the port, such as flushing, as it did not need to remain patent as it was no longer going to be used.

During interview on 10/24/24 at 1:44 p.m., medical director (MD)-A stated he expected the facility to follow up with the provider via fax with any clarification of orders such as port removal, changes in medication, when to check labs. He expected follow-up occurred within a few days of dialysis discontinuation and confirmed approximately four weeks would be too long to wait. He would not be concerned with treatment to the port but expected site cares to be completed until port is removed. If site cares were not completed, concern would be local infection risk. As long as there is a port, there is a

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F 698	Continued From page 22	F 698		

theoretical entry point for bacteria. MD-A stated there was a risk medically if dialysis medications were received when not receiving dialysis, but it should be caught on rounds. MD-A stated he needed to refer to his nephrology colleagues for further side effects from Sevelamer.

During interview on 10/24/24 at 1:45 p.m., CNA-D stated R102's appetite was poor when he first was admitted. However, since admission, R102 ate most of breakfast and 50% of most lunch and supper and that R102 did not drink many fluids.

During interview on 10/24/24 at 2:03 p.m., RN-A confirmed there was no discussion with the dialysis clinic and/or the nephrologist in regard to site care/catheter care when R102's dialysis was discontinued. RN-A did not think about the site care as the facility was not supposed to touch it when R102 was receiving dialysis. When RN-A was asked what the facility does for other central lines, RN-A stated they changed the dressing as ordered. The orders for site care should have been clarified and/or addressed with dialysis clinic and/or provider but "things fell through the cracks."

Received additional information from nephrologist on 10/29/24 at 4:02 p.m., the letter included the following: this letter is to amend an earlier conversation I had last week in regard to R102's medication and clinical status. In our discussion, I mentioned that there was a potential harm for R102 to be receiving the medication Sevelamer while not eating. I would like to amend my assessment. Upon further investigation, two factors have come up that makes this medication prescription safe and appropriate. 1) R102 has been consistently eating his meals, When I first

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F 698	Continued From page 23 discussed this with the Department of Health, I had incorrectly received information that he was not eating. However, I was able to verify with the nursing staff at Bethesda that he is eating. 2) The medication is ordered appropriately to be given with meals. This is the appropriate way to order the prescriptions to avoid complications and time with meals. Received additional information from medical director on 10/29/24 at 4:02 p.m., the letter included the following: this letter is generated to further amend and/or clarify our previous conversation. I have had a chance to speak with our local (Willmar-based) nephrologist this weekend, to get his impression of this specific situation (understanding that we both had limited details) and on the standard management of patients coming off hemodialysis or peritoneal dialysis. We agreed that it is the responsibility of the clinician/nephrologist that discontinues the dialysis to manage and/or direct the care of those orders that are bundled with dialysis. If the nephrologist or nephrology APP does not communicate transitional orders directly to the care facility, they should communicate to the primary care physician to manage those medical orders based on the clinical situation and communicate/document those changes. In the interval, the preceding or previous orders would be expected to be followed. From what you told me during our conversation, these included a renal diet (which would likely be continued, as the patient remains a renal patient), a fluid restriction (which may be continued or discontinued based on objective medical assessment of fluid status renal/cardiac output), the monitoring of the access catheter (which is the primary means to detect a skin or soft tissue	F 698		

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F 698	Continued From page 24 infection which should prevent the risk of a systemic infection), and the management of phosphate binders to protect against hyperphosphatemia & secondary hyperparathyroidism. As you may know, these would be a very low risk medicines to continue as long as the patient is eating and drinking. Certainly, a laboratory evaluation of calcium/phosphate homeostasis could direct the continuation or discontinuation (more likely) of this non-absorbed medication. Other medication changes could also be indicated based on goals of care & nephrology opinion. Again, these would not be based on nursing assessment but on clinical status (medical) & nephrology opinion. From the information that has been given to you and others, the patient was NOT placed at significant risk of harm through this process. The facility's Dialysis policy, dated 2/24, indicated hemodialysis is performed to remove toxic wastes from the blood of residents in renal failure. Residents requiring hemodialysis may be admitted to Bethesda with the hemodialysis being done at Fresenius Kidney Care Outpatient Hemodialysis Unit. A copy of the agreement with is maintained in the administrator's office. A physician's order is required for hemodialysis. A plan of care will be developed and implemented on all residents receiving hemodialysis. 1. Dialysis schedule will be up with the dialysis unit. Every effort will be made to utilize Bethesda Transportation to and from dialysis appointment. 2. Each resident on hemodialysis has a communication book. This book is used to communicate between the facility and the Hemodialysis Unit. 4. Most hemodialysis residents are on a fluid restriction. The physician in conjunction with the	F 698		

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F 698	Continued From page 25 hemodialysis dietician determines the amount of restriction. These guidelines will be on the eMAR. 5. Notify the Dialysis Unit of all medication changes. This can be done in the communication book.	F 698		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented	F 758		11/27/24

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F 758	Continued From page 26 in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor orthostatic blood pressures with the use of an antipsychotic medication for 1 of 5 residents (R134) reviewed for antipsychotic medications. Findings include: R134's quarterly Minimum Data Set (MDS) dated 10/8/24, identified R134 had severe cognitive impairment and required supervision/assistance with all activities of daily living (ADL)'s. R134's diagnoses included cancer, hypertension, non-Alzheimer's dementia, psychotic disorder (other than schizophrenia) and delusional disorders. MDS indicated R134 needed supervision with transfers and ambulation. R134's physician orders included orders for Quetiapine Fumarate (antipsychotic) 25 milligram (MG) by mouth in the morning and 50 mg by	F 758	Corrective Action for Residents Affected by Deficient Practice: Orthostatic blood pressures were obtained for R134. Identification of Other Residents Having the Potential to be Affected by Deficient Practice A facility audit was completed on all residents who receive antipsychotic medication to ensure that monthly orthostatic blood pressures are being obtained. This alleged deficient practice has the potential to impact all residents who receive antipsychotic medication. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Antipsychotic Medication Policy &	

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F 758	Continued From page 27 mouth in the afternoon and at bedtime for delusional disorders. R134's medical record was reviewed and lacked any evidence orthostatic blood pressures had been obtained for R134 in the past six months. During observation on 10/22/24 at 4:36 p.m., R134 was independently ambulating around her room, hanging clothing on the back of her recliner. No staff present in room. During observation on 10/24/24 at 7:34 a.m., R134 was independently ambulating around her room fidgeting with different items. No staff present in room. During interview on 10/24/24 at 12:36 p.m., consultant pharmacist (CP) stated any resident on an antipsychotic medication should have orthostatic blood pressures obtained monthly. Pharmacist stated orthostatic blood pressures were important to monitor due to postural hypotension being one of the major side effects, especially in an older person, and would put the resident at a higher risk for falls when taking these medications. During interview on 10/24/24 at 2:08 p.m., registered nurse (RN)-E stated orthostatic blood pressures are to be obtained monthly for use of antipsychotic medications. RN-E stated R134's Quetiapine was started on 7/26/24 and confirmed orthostatic blood pressures had not been obtained for R134. RN-E stated it was important to monitor orthostatic blood pressures for side effects that could affect mobility. During interview on 10/24/24 at 2:33 p.m.,	F 758	Procedure was reviewed and revised. Training and re-education will be provided to all staff responsible for putting in orders beginning November 2024 and will be completed by completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: DON, ADON, or designee will complete 8 random audits/month x 3 months to ensure orthostatic B/P order is in place in resident chart. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 758	Continued From page 28 director of nursing (DON) stated antipsychotic medications could cause side effects such as sleepiness, dizziness, and orthostatic hypotension. DON stated orthostatic blood pressures are to be done monthly to monitor for side effects. DON stated it should have be identified by the consulting pharmacist and/or the nurse manager. A facility Antipsychotic Medications policy, dated 4/2024, indicated all resident has the right to be free from unnecessary medications. Residents have the right to be from antipsychotic medications used for purposed of discipline or convenience and not require to treat medical symptoms.	F 758		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		11/27/24

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F 883	Continued From page 29 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 residents (R88) reviewed for immunizations was provided the pneumococcal vaccine series as recommended	F 883	Corrective Action for Residents Affected by Deficient Practice: R88 was provided the pneumococcal vaccine.	

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F 883	Continued From page 30 by the Centers for Disease Control (CDC) to help reduce the risk of associated infection(s). Findings include: A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/15/2023, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 65 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R88's face sheet, print date 10/24/24, indicated she was 83 years old. The immunization record, print date 10/24/24, indicated she received a PCV13 on 4/21/15 followed by the PPSV23 on 12/12/18 and that R88 refused the PCV20 on 12/20/23. During record review, vaccination consent form, signed on 8/19/24, indicated R88 gave consent to receive the PCV20 as she became eligible or was advised, however the record lacked evidence that R88 received PCV20. During interview on 10/24/2024 at 9:28 a.m., infection preventionist (IP) indicated immunizations are reviewed upon admission. IP stated she reviewed immunization record and eligible immunizations with resident upon admission and would administer any wanted vaccines/immunizations once reviewed with the	F 883	Identification of Other Residents Having the Potential to be Affected by Deficient Practice A facility audit was completed on all residents who had previously refused the pneumococcal vaccine to identify if any had changed their decision to receive the pneumococcal vaccine. Measures or Systemic Changes Made to Ensure the Deficient Practice Will Not Recur: Vaccine Consent procedure was adjusted so that IP reviews all vaccine consents. Pneumococcal Vaccination Policy was reviewed. Training and re-education will be provided to all staff responsible for vaccine consents beginning November 2024 and will be completed by completion date. How the Facility Will Monitor Corrective Actions to Ensure the Deficient Practice is Being Corrected and Will Not Recur: IP or designee will complete 3 random audits/month x 3 months to ensure pneumococcal vaccine was administered per consent. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 883	Continued From page 31 provider. IP stated R88 had refused the PCV20 on 12/20/23 and during the facilities annual fall immunization fair, R88 must have changed her mind and now consented for the PCV20. IP stated RN case managers obtained the consent forms and notified her regarding the influenza and COVID-19 booster consent, but IP stated she was not notified of the updated consent for the PCV20. IP stated it was important to ensure residents are offered and provided all available and requested vaccinations to prevent hospitalization and the risk of developing symptoms to lead to acute illness as R88 is at a high risk. During interview on 10/25/24 at 11:38 a.m., director of nursing (DON) stated her expectation was that when RN case managers completed the annual vaccination consents with residents, all vaccination requests should be relayed to the IP. DON stated it was important for residents to receive the requested vaccinations as they are important for their health and to follow their request. The Pneumococcal Vaccination policy, dated 9/24, indicated all residents will be offered the Pneumococcal conjugate vaccines (PCV12, PCV15, or PCV30) and/or the pneumococcal polysaccharide vaccine (PPSV23), to aid in preventing pneumococcal infections (e.g. pneumonia). This will be a shared clinical decision between the resident and the resident's medical provider.	F 883		

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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 10/23/2024. At the time of this survey, Building 01 of Bethesda Nursing Home 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/15/2024

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
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 01 of Bethesda Nursing Home is a one-story building with a full basement that was constructed as type II (111) in 1979. In 1994 two gazebos of type II (111) construction were added to the original building at the common areas adjacent to the east and west resident wings. In 1999 a link was constructed between the memory care wings, which was constructed as type II (111). In 2014 two additions were added off the south ends of the two North/South wings that were constructed as type V (111), one was a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 000	Continued From page 2 six-bed addition, and the other was a dining area, and one 36 bed single story with a partial basement of type V (111) was added on the east end. Due to the lack of a 2-hour fire barrier between the two types of construction, building 01 was downgraded to a Type V (111) as allowed by NFPA 101 (12) section 8.2.1.3 (3). The building is fully sprinkled per NFPA 13 and has a fire alarm system with smoke detectors in the corridors and spaces open to the corridors. The facility has a capacity of 244 beds and had a census of 223 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	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 any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 353	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.7, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(5), and 5.2.2.2. These deficient findings could have a widespread impact on residents within the facility. Findings include: 1. On 10/23/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that there are three lint covered sprinkler heads in the laundry room. One located in behind the dryers and 2 in front of the dryers. 2. On 10/23/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that a ground wire was zip tied to the sprinkler pipe in the basement boiler room. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	Corrective Action for Residents Affected by Deficient Practice: The three sprinkler heads in the laundry room were cleaned. The zip tie was cut loose so the ground wire is not touching the sprinkler pipe. Measures to Ensure the Deficiency does not Reoccur: Training and re-education on sprinkler heads and pipes remaining free of debris will be provided to all maintenance staff responsible for maintaining the fire sprinkler system. How Facility will Monitor Performance to Ensure Solutions are Sustained: Administrator or designee will complete 8 random audits/month x 3 months to ensure that sprinkler heads and sprinkler pipes are free of debris.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective	K 374		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/23/2024**

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BETHESDA	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

(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 374	Continued From page 4 plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke and fire barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, 8.3.3.3, and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/23/2024 between 9:00 AM and 1:00 PM it was revealed by observation that the following smoke barrier doors did not close completely leaving a gap between the door leaves: 1. Lower level West Hallway 2. Smoke Barrier doors by room 332 3. Both sets of smoke barrier doors on either side of the dining room in the Memory Care unit. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	Corrective Action for Residents Affected by Deficient Practice: Lower level west hallway, smoke barrier doors by room 332, and both sets of smoke barrier doors on either side of the dining room in the memory care unit had the door closure adjusted to ensure they close completely. Measures to Ensure the Deficiency does not Reoccur: Training and re-education on maintaining smoke and fire barrier doors to ensure they close completely will be provided to all maintenance staff responsible for maintaining the smoke and fire barrier doors. How Facility will Monitor Performance to Ensure Solutions are Sustained: Facility Director or designee will complete 8 random audits/month x 3 months to ensure that smoke and fire barrier doors close completely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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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 10/23/2024. At the time of this survey, Building 02 of Bethesda Nursing Home 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/15/2024

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
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 02 of Bethesda Nursing Home consists of one structure of type II (111) construction that was added on in 2014. It is a three-story 84-bed unit that is separated from the original building by a 2-hour fire barrier. The building is fully sprinkled and has a fire alarm system with smoke detectors in the resident rooms, corridors, and spaces open to the corridors. The facility has a capacity of 244 beds and had a census of 223 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**10/23/2024**

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 321	Corrective Action for Residents Affected	11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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K 321	Continued From page 3 facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. This deficient findings could have an isolated impact on the residents within the facility. Findings include: On 10/23/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that the clean linen room door near the A North elevator did not positively latch when closed using the self-closing device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	by Deficient Practice: Clean Linen door self-closing device was repaired so that the door positively latches when closed. Measures to Ensure the Deficiency does not Reoccur: Training and re-education on maintaining self-closing devices to ensure they close completely will be provided to all maintenance staff. How Facility will Monitor Performance to Ensure Solutions are Sustained: Environmental Services Director or designee will complete 8 random audits/month x 3 months to ensure that doors with self-closing devices close completely in hazardous areas.	
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 any non-required or partial automatic sprinkler system.	K 353		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING _____	**10/23/2024**

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K 353	Continued From page 4 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.2. This deficient finding could have an isolated impact on residents within the facility. Findings include: On 10/23/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that items were being stored on the top shelf of the 1N Activity Storage closet within 18 inches of the sprinkler head. An interview with the Maintenane Director verified this deficient finding at the time of discovery.	K 353	Corrective Action for Residents Affected by Deficient Practice: Top shelf was removed from 1N Activity Storage Closet. Measures to Ensure the Deficiency does not Reoccur: Training and re-education on not storing items within 18 inches of sprinkler head will be provided to all departments. How Facility will Monitor Performance to Ensure Solutions are Sustained: Administrator or designee will complete 8 random audits/month x 3 months to ensure that storage rooms do not have items within 18 inches of sprinkler head.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum	K 374		11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 374	Continued From page 5 clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke and fire barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8, 8.3.3.3, and 8.5.4.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/23/2024 between 9:00 AM and 1:00 PM it was revealed by observation that the smoke barrier doors in the East Hallway by the link did not close completely leaving a gap between the door leaves. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	Corrective Action for Residents Affected by Deficient Practice: Smoke barrier doors in the East hallway by the link had the door closure adjusted to ensure they close completely. Measures to Ensure the Deficiency does not Reoccur: Training and re-education on maintaining smoke and fire barrier doors to ensure they close completely will be provided to all maintenance staff responsible for maintaining the smoke and fire barrier doors. How Facility will Monitor Performance to Ensure Solutions are Sustained: Facility Director or designee will complete 8 random audits/month x 3 months to ensure that smoke and fire barrier doors close completely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **03 - CHAPEL EXPANSION/15 BED ADDITION** B. WING _____	**10/23/2024**

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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 10/23/2024. At the time of this survey, Building 03 of Bethesda Nursing Home 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 03 of Bethesda Nursing Home is a 100 square foot chapel expansion and a raised ceiling constructed in 2018 as a Type V (111). In 2023 a 15-bed addition and remodel that added two neighborhood kitchens was completed and is constructed as a Type V (111). The building is fully sprinkled per NFPA 13 and has a fire alarm system with smoke detectors in the corridors and spaces open to the corridors. The facility has a capacity of 244 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 223 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: *residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2. *cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or *cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 18.3.2.5.3(8), and NFPA 96 (2011 edition), Ventilation Control and Fire Protection of Commercial Cooking Operations, section 10.10. These deficient findings could have a widespread	K 324	Corrective Action for Residents Affected by Deficient Practice: East, West, and Grand Gardens neighborhood kitchens replaced ABC extinguishers for K-extinguishers. Measures to Ensure the Deficiency does	11/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **03 - CHAPEL EXPANSION/15 BED ADDITION** B. WING _____	**10/23/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 324	Continued From page 3 impact on residents within the facility. Findings include: On 10/23/2024 between 9:00 AM and 1:00 PM, it was revealed by observation the East, West and the Gardens neighborhood kitchens had ABC extinguishers and not the required K-Extinguisher. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	not Reoccur: Training and re-education on K-extinguishers provided to all maintenance staff. How Facility will Monitor Performance to Ensure Solutions are Sustained: Environmental Services Director or designee will complete 8 random audits/month x 3 months to ensure that smoke detectors in kitchen areas are K-extinguishers.	