DEPARTMENT OF HEALTH ANI) HUMAN	SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES		
	MEDIC	CARE/MEDICAI	D CERTIFIC	ATION A	AND TRANSMITTAL	ID: JMFW		
	PART I	- TO BE COMP	LETED BY T	HE STAT	TE SURVEY AGENCY	Facility ID: 00108		
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245434		3. NAME AND AD (L3) BETHANY H (L4) 1020 LARK	HOME	LITY		 TYPE OF ACTION: <u>7</u>(L8) Initial 2. Recertification 		
2.STATE VENDOR OR MEDICAID NO. (L2) 568340800		(L5) ALEXANDR			(L6) 56308	3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERS (L9)	HIP	7. PROVIDER/SUI 01 Hospital	PPLIER CATEGOF 05 HHA	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 08/19/2013 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	:				
From (a):		A. In Compliar	nce With		And/Or Approved Waivers Of Th	e Following Requirements:		
To (b):			Requirements		2. Technical Personnel	6. Scope of Services Limit		
	83 (L18)		ce Based On: Acceptable POC			 7. Medical Director 8. Patient Room Size 9. Beds/Room 		
13.Total Certified Beds	83 (L17)		mpliance with Progr ents and/or Applied		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
83 (L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS (II	F APPLICABL	E SHOW LTC CANCE	ELLATION DATE)	:				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL Date:			
Gail Anderson, Unit Sup	ervisor	(09/27/2013	(L19)	Shellae Dietrich, Program Specialist 12/20/2013			
PART	II - TO BE	E COMPLETED	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE ST.	ATE AGENCY		
 DETERMINATION OF ELIGIBILITY <u>1</u>. Facility is Eligible to Participa 2. Facility is not Eligible 	te		IPLIANCE WITH (GHTS ACT:	CIVIL	 Statement of Finar Ownership/Contro Both of the Above 	l Interest Disclosure Stmt (HCFA-1513)		
2. Pacinty is not Englote	(L21)							
22. ORIGINAL DATE 23. I	LTC AGREEM	IENT 24	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION 02/01/1987	BEGINNING	DATE	ENDING DATI	E	VOLUNTARY 00 01-Merger, Closure 00	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	ent 06-Fail to Meet Agreement		
25. LTC EXTENSION DATE: 27.	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER		
	A. Suspensior	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind Sus	spension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	CARRIER NO.		30. REMARKS			
		03001			D 110/01/001			
(L	.28)			(L31)	Posted 12/31/201	.3 CU.		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION (OF APPROVAL DA	ATE	JMFW			
(L	32)	06/20/2013		(L33)	DETERMINATION APPR	OVAL		

C&T REMARKS - CMS 1539 FORM

CCN: 24-5434

A standard OTC survey was completed at this facility on April 25, 2013. The most serious deficiencies were cited at a S/S level of F.

In addition, on May 16, 2013, a FMS survey was completed and deficiencies were found, the most serious at a S/S level of F. On May 30, 2013, the CMS RO notified the facility of the following:

- Mandatory DOPNA, effective July 25, 2013
- A loss of NATCEP for a two year period beginning July 25, 2013 if DOPNA were to go into effect _

A PCR of the health deficiencies was completed on June 11, 2013. A PCR of the LSC and FMS deficiencies was completed August 19, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

Mandatory DOPNA, effective July 25, 2013, be rescinded _

This would also mean that the facility would not be subject to a loss of NATCEP.

Please refer to the CMS 2567B.



Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5434

December 20, 2013

Mr. Patrick McDonald, Administrator Bethany Home 1020 Lark Street Alexandria, Minnesota 56308

Dear Mr. McDonald:

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

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

Effective July 24, 2013 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone #: (651) 201-4106 Fax #: (651) 215-9697 cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

September 27, 2013

Mr. Patrick McDonald, Administrator Bethany Home 1020 Lark Street Alexandria, Minnesota 56308

RE: Project Number S5434022; F5434024

Dear Mr. McDonald:

On May 9, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 25, 2013. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required.

In addition, on May 16, 2013, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS) completed a Life Safety Code Federal Monitoring Survey (FMS) of your facility. As you were informed during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required.

On May 30, 2013, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective July 25, 2013. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of May 30, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 25, 2013.

On June 11, 2013, the Minnesota Department of Health completed a Post Certification Revisit by review of the facility's plan of correction, and on August 19, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on April 25, 2013 and Federal Monitoring Survey completed on May 16, 2013. We

Bethany Home September 27, 2013 Page 2

presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 24, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey completed on April 25, 2013 and the FMS completed on May 16, 2013, as of July 24, 2013. As a result of the PCR findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in their letter of May 30, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 25, 2013, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 25, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 25, 2013, is to be rescinded.

In the CMS letter dated May 30, 2013, they advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 25, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 24, 2013, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Colleen Jeach

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring PO Box 64900 Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure Licensing and Certification File Copy

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245434	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/11/2013
Nam	e of Facility		Street Address, City, State, Zip Code	
BE	THANY HOME		1020 LARK STREET ALEXANDRIA, MN 56308	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y	(5) D	ate
		Correction Completed			Correction Completed				Correction Completed
ID Prefix	F0282	05/24/2013	ID Prefix	F0311	05/24/2013	ID Prefix	F0323		05/24/2013
	483.20(k)(3)(ii)			483.25(a)(2)			483.25(h)		-
		Correction			Correction				Correction
ID Prefix	F0371	Completed 05/30/2013	ID Prefix		Completed	ID Prefix			Completed
	483.35(i)		Reg. #						-
LSC			LSC			LSC			
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #			Reg. #			-
LSC			LSC			LSC			-
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #			Reg. #			Reg. #			-
LSC			LSC			LSC			-
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix			Completed
Reg. #									
LSC			LSC			LSC			
Reviewed I	By Rev	iewed By	Date:	Signature	of Surveyor:		[Date:	
State Agen	cy P]	K/cl	09/27/1	3 2803	34			06/1	1/13
Reviewed I CMS RO	By Rev	iewed By	Date:	Signature	of Surveyor:		C	Date:	
Followup	to Survey Comple				Uncorrected Defi		Ale Cesting		
	4/25/201	3		Uncorrecte	d Deficiencies (CM	13-2307) Sent to	The Facility?	YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245434	(Y2) Multiple Construction A. Building B. Wing 01 - NUF	(Y3) Date of Revisit 8/19/2013	
Name of Facility		Street Address, City, State, Zip Code	
BETHANY HOME		1020 LARK STREET ALEXANDRIA, MN 56308	

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

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item		(Y5)	Date
		C	Correction			Correction				Correction
ID Prefix			Completed 94/25/2013	ID Prefix		Completed 04/27/2013	ID Pre	əfix		Completed 04/25/2013
Reg. #	NFPA 101				NFPA 101	_	Reg). # NFPA 101		
LSC	K0046			LSC	K0054	-	L	SC K0056		
		C	Correction			Correction				Correction
ID Prefix			Completed 4/25/2013	ID Prefix		Completed	ID Pre	efix		Completed
Reg. #	NFPA 101			Reg. #						
LSC	K0147			LSC		-	L	sc		_
		(Correction			Correction				Correction
ID Profiv		(Completed	ID Profix		Completed		ofix		Completed
						-		efix		
Reg. # LSC				Reg. # LSC		-	Heg L	9. # SC		
		C	Correction			Correction				Correction
ID Dustin		(Completed	ID Due fee		Completed		<i>c</i>		Completed
						-		efix		
Reg. # LSC				Reg. # LSC		-	Reg	9. # SC		
ID Prefix		(Correction Completed	ID Prefix		Correction Completed	ID Pre	əfix		Correction Completed
Reg. # LSC				Reg. # LSC		-	Reg L	9. # SC		
Reviewed I	By Rev	iewed l	Ву	Date:	Signature of Su	rveyor:			Date:	
State Agen	cy P:	S/sd		09/27/1	3 272	00			08	/19/13
Reviewed I CMS RO		iewed I	Ву	Date:	Signature of Su				Date:	
Followup t	o Survey Complet 4/24/201				Check for any Unco Uncorrected Defi				YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245434	(Y2) Multiple Construction A. Building B. Wing 02 - SUI	(Y3) Date of Revisit 8/19/2013	
Name of Facility		Street Address, City, State, Zip Code	
BETHANY HOME		1020 LARK STREET ALEXANDRIA, MN 56308	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
		(Correction				Correction					Correction
ID Prefix			Completed)5/17/2013	ID Prefix			Completed 04/27/2013		ID Prefix			Completed 04/25/2013
	NFPA 101			-	NFPA 101					NFPA 101		
LSC	K0011			LSC	K0038				LSC	K0046		
		(Correction				Correction					Correction
ID Prefix			Completed 04/27/2013	ID Prefix			Completed 04/25/2013		ID Prefix			Completed 04/25/2013
	NFPA 101				NFPA 101					NFPA 101		
	K0054				K0056					K0072		
		(Correction				Correction					Correction
ID Prefix			Completed	ID Profix			Completed		ID Profix			Completed
Reg. #										·		
				LSC					LSC			
		(Correction				Correction					Correction
ID Prefix		(Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #								
LSC				LSC					LSC			
		(Correction				Correction					Correction
ID Prefix		(Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #					Rea #			
LSC				LSC					LSC			
Reviewed I	By Rev	iewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
State Agen		S/sd		09/27/1								/19/13
Reviewed I CMS RO	By Rev	iewed	Ву	Date:	Signature	of Sur	veyor:				Date:	
Followup	o Survey Comple 4/24/201		:		Check for any Uncorrected					Summary of the Facility?	YES	
	7/29/201	5					`		,		163	NO

Loveland, Jim (MDH)

From:	Suzuki, Jan M. (CMS/CQISCO) <jan.suzuki@cms.hhs.gov></jan.suzuki@cms.hhs.gov>
Sent:	Thursday, August 08, 2013 1:38 PM
То:	Loveland, Jim (MDH)
Cc:	Absolon, Mary (MDH); Kerssen, Pam (MDH); King, Maria (MDH)
Subject:	Acceptable POC for Bethany Home, #245434
Attachments:	Scanned_document_31-05-2005_18-28-57.pdf

We have an acceptable POC for the LSC FMS deficiencies found at subject facility. (See attachment). Please conduct a revisit per CMS policy.

Thanks,

Jan Suzuki Principal Program Representative Centers for Medicare & Medicaid Services RO V, Chicago Midwest Division of Survey and Certification LTC Certification and Enforcement Branch (P) 312-886-5209 (F) 443-380-6602 jan.suzuki@cms.hhs.gov

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FAX	to:
-----	-----

Number of Pages:

		·	
	CCN	:245434	DPNA Date:07/25/2013_
	Name	: Bethany Home	Termination Date: 10/25/2013
C	City, State	: Alexandria, MN	
			FMS Survey Date: 05/16/2013
		POC Date or Temporary Waiver	Fed Surveyor: 32897
S/S	Tag	("TW") Date or Waiver ("AW")	Contr Surveyor:
Bld-1			
F	K18	POC 7/24/13	
E	K25	POC 6/24/13	
E	K38	POC 7/24/13	
F	K51	POC 7/24/13	
F	K62	POC 6/4/13	

F	K62	POC 6/4/13
E	K69	POC 6/7/13
E	K73	POC 6/3/13
E	K74	POC 6/5/13
E	K147	POC 6/7/13
Bld-2		
E	K14	POC 6/7/13
E	K62	POC 6/4/13
E	K103	POC 7/24/13
Bld-3		· · · ·
E	K15	POC 6/7/13
E	K38	POC 7/24/13
E	K73	POC 6/3/13
Bld-4		
E	K11	POC 7/7/13
E	K14	POC 6/7/13
E	K38	POC 7/24/13
E	K45	POC 6/3/13
F	K51	POC 7/24/13
<u> </u>		

Approved: YES

By: David Fliess

Date: 08/08/2013

.

ECUMEN[®] Bethany Community

Senior Living: Services: 1020 Lark Street Alexandria, MN 56308 phone 320-762-1567 fax 320-762-5316 EcumenBethany.org

Fax Transmittal

Date 8/7/13	
Total Pages	(including cover)
To Daviel Hiss	
Fax Number 1-443-380-720	
From Fatrick Manabu	
Telephone/Fax 1-320-762-53	16

Comments

Confidentially Notice: The document accompanying this fax may contain confidential information, which is legally privileged. If you receive this fax in error, or this transmittal is not received in good condition or is not complete, please notify us immediately at 320-762-1567.

innovate empower honor™

Ø 002

PRINTED: 05/24/2013

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 01 - N		(X3) DATE SURVEY COMPLETED		
		245434	B, WING		05	/16/2013	
AME OF PR	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STAYE, ZIP CODE 1020 LARK STREET				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST DE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	XANDRIA, MN 56308 PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) Çompletion Date	
K 000	INITIAL COMMENTS	;	K 000				
	for Medicare & Medic 5/16/13 following a M Public Safety survey Comparative Federal Home was found to b compliance with the r in Medicare/Medicaid 483.70(a), Life Safety National Fire Protect standard 101 - 2000	as conducted by the Centers said Services (CMS) on Innesota Department of on 4/24/13. At this Monitoring Survey, Bethany be not in substantial requirements for participation I at 42 CFR subpart y from Fire, and the related ion Association (NFPA) edition.					
	buildings as follows: Building-0104 Nursin	y was surveyed as four g Home, is 1-story structure Type II (000) constructed in					
	no basement of Type Building-0204 is com separated by a 2-hou is also connected to a that was not surveys	cute, is 3-story structure with II (111) constructed in 2003. nected to Building-0104 and Ir Fire Barrier. Building-0204 an assisted living occupancy d because it was separated ng occupancy by a 2-hour					
	Building-0304 Chape no basement of Type constructed in 2002.	l, is a 1-story structure with IV (Heavy Timber)					
	purposes, Building-0 east wing of Building	s Building-0404 for survey 404 is the 1-st floor of the -0104 and the South ding-0204 that were both					
ORATORY I	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR		TITLE		(X6) DATE	
100	5 A/1.1A			Saute Dit	Lat.	9/13	

other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings atated above are disclosable 80 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 regulate to continued program participation.

..... FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility (0; 00108

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PRINTED: 05/24/2013 FORM APPROVED

		ID HUMAN SERVICES MEDICAID SERVICES					MAPPROVE 2 <u>.0938-03</u> 9
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			onstruction Nursing Home	(X3) DATE SURVEY COMPLETED	
		245434	8, WNG			05	/16/2013
IAME OF PRI	OVIDER OR SUPPLIER			102	TADDRESS, CITY, STATE, ZP CODE		
r		ATEMENT OF DEFICIENCIES		ALI	EXANDRIA, MN 56308		T
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAĜ		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ulo Be	(X5) COMPLETION DATE
K 000	fully renovated in 2012. CMS adopted NFPA 101-2000 Edition effective March 2003. Due to the major renovation of this area that took place after 2003, it must meet the requirements for New Health care as outlined in Chapter 18 of the Life Safety Code. All buildings are fully sprinklered and there are supervised smoke detectors located in the corridor and spaces open to the corridors, as well as in all resident rooms. Bethany Home facility has 83 certified beds. All 83 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 77. The requirement at 42 CFR, subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD		. K	000			
K 018 88≍F			к	018			

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P.09/25

PRINTED: 05/24/2013

		nd Human Services			Form OM8 NC	APPROVEL 0. 0938-039
TATEMENT O	5 FOR MEDICARE & If DEFICIENCIES CORRECTION	MEDICAID SERVICES		le construction 61 - Nurraing Home	(Ca) DATE	
		245434	B. WING		015/	16/2013
	ame of Provider or Supplier			TREET ADDRESS, CITY, STATE, ZIP CODE 1929 LARK STREET ALEXANDRIA, MN 55308		
(X4) ID PREFIX TAG	REFIX (RACH DEFICIENCY MLIST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDENCE PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	ulio be	(RA) COMPLETION DATE
K 018	Continued From pag	e 2	K 01	8		
	Besed on observati failed to provide con requirements of NFF Sections 19.3.6.3, 11 19.3.6.4. This defici the 77 residents and staff and visitors. Findings include: 1. On 5/16/13 at 3:5 that the double door into the Community latch properly becau poordinator on them 2. On 5/16/13 at 4:4 that the double door would not shut and did not have a courd 3. On 5/16/13 at 5:3 that the double bi-to Room 2128 do not a 4. On 5/16/13 at 6:2	5 pm, observation revealed is leading into the STR Room latch properly because they finator on them. 5 pm, observation revealed ld doors on the linen closet by automatically latch. 18 pm, observation revealed old doors on the A-05 Linen atically latch.		 K018 SS=F 1. Door coordinator was door. Date of Complete 2. Door coordinator was door. Date of Complete 3. Heinz construction condoor replacement access completed by 7/24/201 4. Heinz construction condoor replacement access completed by 7/24/201 5. Heinz construction condoor replacement access completed by 7/24/201 5. Heinz construction condoor replacement access completed by 7/24/201 6. Heinz construction condoor replacement access completed by 7/24/201 6. Heinz construction condoor replacement access completed by 7/24/201 6. Heinz construction condoor replacement access completed by 7/24/201 7. Heinz construction condoor replacement access completed by 7/24/201 6. Heinz construction condoor replacement access completed by 7/24/201 6. Heinz construction condoor replacement access completed by 7/24/201 6. Heinz construction condoor replacement access completed by 7/24/201 6. Heinz construction condoor replacement access completed by 7/24/201 7. Heinz construction condoor replacement access completed by 7/24/201 7. Heinz construction condoor replacement access completed by 7/24/201 7. Heinz construction condoor replacement access completed by 7/24/201 7. Heinz construction condoor replacement access completed by 7/24/201 	ion: 6/8/201 placed on ion:6/8/201 ntacted bid i pted. To be 3. ntacted bid i pted. To be 3. ntacted bid i pted. To be 3. ntacted bid i pted. To be 3.	3 for for for

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AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG 61 - NURSING HOM		(CS) DAT	io, 0938 E Survey IPLETED
		245434	8, WING				
NAME OF P	Rovider or Supplier Y Home			STREET ADDRESS, CHT 1020 LARK STREET ALEXANDRIA, MIN	I	0	V16/201
(X4) ID PREFIX TAG	(CACH DEFICIEN	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	UD PREFIX 7AG	PROV (EACH C	DER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)	BE	COLUMN COLUMN
\$8=2 	a coordinator on ther 6. On 5/16/13 at 6:37 that the double bi-fok near Room A-13 did This deficient practice Mainternance Coordin Coordinator at the tim NFPA 101 LIFE SAFE Smoke barriers are co- least a one half hour (accordance with 6.3. terminate at an atrium protected by fire-rated panels and steel frame separate compartment floor. Dampers are not penetrations of smoke heating, ventilating, an 19.3.7.3, 19.3.7.5, 19. This STANDARD is no Based on observation alled to provide proper amiers in accordance his deficient practice of seidents, as well as an baff and visitors, indings include;	ch because they did not have n. 7 pm, observation revealed d doors on the linen closet not automatically latch. 2 was confirmed by the lator and the Education the of discovery. ETY CODE STANDARD Postructed to provide at fire realstance rating in Smoke barriers may wall. Windows are I glazing or by wired glass 25. A minimum of two is are provided on each t required in duct barriers in fully ducted and air conditioning systems. 1.6.3, 19.1.6.4	K 02	K025 S 1. 2. Contrac will be codes b mainter		SC 7-5 F Silicon ompletion th ASTN SC 7-5 F Silicona ompletion equipma essary fin The uspect the	ME ME Alame an: ent re

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STATEMENT	i of deficiencies of correction	MEDICAID SERVICES (X1) PROMOERSUPPLIER/CLIA IDENTIFICATION MUNISER:	(X2) MULTIPLE (X A. GUILDING (7) -	onstruction Nursing Home	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
	Rovider or supplier				
BETHAN	YHOME			Exandria, MN 68308	
(744) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(C) PREFIX YAG	PROVIDERS PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
K 038 S9=5	2" by 3" hole, 2" diam hole above the drop of between the Kitchen 2. On 5/16/13 at 3:37 5" by 4" hole and a 6" passing through in the of the Staff Dining Ro These deficient practi Maintenance Coordini Coordinator at the tim NFPA 101 LIFE SAFE Exit access is anahge	eter hole, and a 1" diameter stiling on the lower level and the Locker Room. pm, observation revealed a diameter hole with a 4" pipe e smoke compariment wall om. ces were confirmed by the ator and the Education e of discovery.	K 025	 K038 SS=E I. Fleinz construction comove door accepted. completed by 7/24/20 2. Signs were placed on Kalina dining room. I complete: 6/4/2013 3. Alexandria Electronic one handed door syste installed by 7/24/2013 4. Dashbalt look wate wate ore 	To be 13. doors in Date s contacted m to be
	Sased on observation failed to provide mean with the requirements	e 77 residents and an		 Deadbolt lock was can one handed door open installed. Date comple 6/7/2013 Deadbolt lock was can one handed door open installed. Date comple 6/7/2013 	ation was eted: ped and new ation was
	Findings Include:	m, observation revealed		There are no other electric: doors exiting into a stair sh handed operating locks will the size of the	aft. Two
	that the Electrical Roor Sheft 13.	n apened directly into Stair		The signs are corrected.	
	2. On 5/16/13 at 4:48 p	m, observation revealed			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION		TE SURVEY	
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A, BUILDIN	ig 01 - NURSING HOME	co	COMPLETED	
		245434	B. WING _			05/16/2013	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADORESS, CITY, STATE, ZIP CODE			
BETHAN	/ HOME			1020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	Should be	(XS) COMPLETIO DATE	
K 038	Continued From page	• 5	ко	38			
		lina Dining Room could					
		as exit doors but were not					
	as not an exit.	doors and were not marked					
:	3. On 5/18/13 at 6:10	pm, observation revealed					
		t stair door by the E-Dining					
		ng a button in on the frame at					
		while turning the lever por. This door required two					
	operations to open.						
		pm, observation revealed					
		loor had a Dead Boit lock at and a locking lever handle					
	at approximately 3 high operations to open.	gh. This door required two					
		pm, observation revealed					
		s Office door had a Dead					
	lever handle at approxim	ately 5' high and a locking ximately 4' high. This door					
	required two operatio	ns to open.					
		ices were confirmed by the					
		ator and the Education					
K 051	Coordinator at the tim	e of discovery. ETY CODE STANDARD	ко	54			
SS=F		TT OUDE DIMINIAND					
	•	th approved components,				1	
		t is installed according to					
		re Alarm Code, to provide re in any part of the building.				1	
	Activation of the com	plete fire alarm system is by					
		ation, automatic detection or					
	exanguishing system	operation. Pull stations in a may be omitted provided					
		ons are within 200 feet of				1	

FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID: TEO821

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Feclility ID: 00108

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NTERS FOR MEDICARE (1111111				
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION	OMB	CM APPR(
		A BUILDIN	(g of - Nursing Home		e Survey
OF PROMOSE OD SUDDA	246434	B. WING_			
		1	STREET ADDRESS, CITY, STATE, ZIE CODE		/16/20/13
	,		1020 LARK STREET		
		ID			
IG REGULATORY OR	LSC ADENTIFYING INFORMATION)	PREFIX TAG		5 A.m.	COMPLET DATE
051 Continued From page	đ				
nurse's stations, Put	Stations are beaution to a	KOS	11		
/ PPPAPI 10 U(UVICIBO, MA					
(**** *******************************					
	central station. 19.3,4,		1		
0.0					
				1	
			K051 SS=F		
			1. Fire Fighter & Detect Alarm	Company	
			Will install smoke detector or main fire slarm page. Date	er the	
This STANDARD is not	mat an outdown of t		Completed:7/24/2013		
			Fire Fighter & Devent 41		
accordance with the rea	ann system in		tour facility and install any other	pany will nissing	
			alarms.		
This deficient practice or	ns 2-1.3 and 2-1,3,2,			ſ	
			·		
www.wervisiand visit	NB.			.	
Findings include:		1			
Qn 5/16/13 at 4:14 pm. o	Sevation reuncied in			1	
				1	
objector located over the	Main Fire Alarm panel				
This deficient practice was	s confirmed by the				
Coordinator at the time of	and the Education				
NFPA 101 LIFE SAFETY	CODE STANDARD				
	Fix (PACH DEFICIENCY G REGULATORY OR I 051 Continued From page nurse's stations. Pull path of egress. Electric tests are available. A power is provided. Fix maintained in accorda racords of maintenand There is remote annur system to an approved 9.6 This STANDARD is not Based on observation a failed to install the fire al accordance with the req. 2000 edition, Sections 1: 72 - 1998 edition, Sections 1: 73 - 1998 edition, Sections 1: 74 - 1998 edition, Sections 1: 75 - 1998 edition,	Ger PROVIDER OR SUPPLIER HANY HOME 100 SUMMARY STATEMENT OF DEFICIENCES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LSG DENTIFYING INFORMATION) 051 Continued From page 8 nurse's stations. Pull stations are located in the path of egress. Electronic or written records of bests are available. A reliable second source of power is provided. Fire alarm systems are meintained in accordance with NFPA 72 and racords of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1998 edition, Sections 2-1.3 and 2-1.3.2. This deficient practice could affect approximately ail of the 77 residents and an undetermined number of staff and visitors. Findings include: Cn 5/16/13 at 4:14 pm, observation revealed in the Boller Room that there was no emoke detector located over the Main Fire Alarm panel This deficient practice was confirmed by the Meintenance Coordinator and the Education Coordinator at the time of discovery.	Ger PROVIDER OR SUPPLIER In mid- transmission In mid- second process of the second participation of the second participation of the second participation of the second participation parecipation participating participation partis participation pareci	OF PROVIDER OR SUPPLIER If the state is a state ista state is a state is a state is a state istat	Gr PROVIDER OR SUPPLIER 0 AAVY HOME START ADDRESS.CTT, STATE, 2P CODE AAVY HOME STARTADORSS.CTT, STATE, 2P CODE AD Standy Stratement or DEFORNCES S REGULATORY ON LOC DENTIFIEND BY FULL B REGULATORY ON LOC DENTIFIEND BY FULL B Regulatory of Loc DENTIFIEND BY FULL D PERF Path of Egrees. Electoric or written records of betse are available. A reliable second source or power is provided. From page 6 This STANDARD is not mat as evidenced by: Based on observation and Interview, the Socialy failed to Install and the free damm system in abactrance with the requirements of NFPA 101- 2000 edition, Sections 13.4 and 9.6 and NFPA 72 - 1968 editors, Sections 2-1.8 and 2-1.3.2. This deficient practice could affect approximately al of the 77 residents and a undetermined number of staff and vision. Findings include: Conditionated practice was confirmed by the Maintenance Coordinator and the Exclusion Coordinator at the fine of abovery, NPPA 101 LIFE SAFETY CODE STANDARD

Event ID: TEO821

Facility ID: 00108

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PRINTED: 05/24/2013 FORM APPROVED

CENTER	S FOR MEDICARE 8	MEDICAID SERVICES			OMB NO. 0938-0891
STATEMENT C	P DEFICIENCIES	(X1) PROVIDER/SLIPPL/ER/CLIA (DENTIFICATION NUMBER:		i Construction 1 - Nursing Hôme	COMPLETED
		245434	B. WING		05/16/2013
NAME OF PR	OVIDER OR SUPPLIER			EET AODRESS, CITY, STATE, ZP CODE 020 LARK STREET	
BETHANY	'HOME			LEXANDRIA, IIN 56308	
(X4) ID PREFix TAG	REACH DEFICIEN	TAREMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ed Prefix Tag	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROBS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLEMEN
K 062 SS=F	Required automatic	- sprinkler systems are	K 062		
	continuously mainted condition and are in	ined in reliable operating			
	Based on observal review, it was deter test and maintain its in accordance with Sections 19.3.5 and edition, Sections 2. Table 2-1. This def 77 residents and ar staff and visitors. Findings include: 1. On 5/16/13 at 3: that a spinkder in th	s not met as evidenced by: tion, interview, and record mined that the facility failed to a automatic sprinkler system NFPA 101 - 2000 edition, d 9.7 and NFPA 25 - 1998 2.1.1, 2-4.1.4, 9-7, 9-7.1 and incient practice could affect all a undetermined number of 51 pm, observation revealed be Women's Restroom by the had foreign material.		K062 SS=F 1. Sprinkler head was completed: 6/4/20 2. Plastic bag was re completed: 6/4/20 3. Escutcheon ring w completed: 6/4/20 4. Boxes removed as down to stop stors sprinkler head. D complete: 6/4/201	13 moved: Date 13 vas replaced. Date 13 nd top shelf taken age blocking pate 3
	2. On 5/18/13 at 4: that a sprinkler in the piece of a clear plat 3. On 5/16/13 at 4: that a sprinkler in the missing the escutor 4. On 5/16/13 at 4: the Kitchen Chemin	97 pm, observation revealed he Soiled Utility Room had 6 atic bag hanging from it. 20 pm, observation revealed he Kitchen Hallway was		Sprinkler heads are placed committee's inspection she painted sprinkler heads wi maintenance and cleaned. are going to be placed on s monthly audit sheets and r reported to maintenance an shelving won't allow stors of a sprinkler head.	on safety set; any dirty or Il be reported to Escutcheon rings safety committee nissing will be ad replaced. New

FORM CMS-2587(02-99) Previous Vacsions Obs

Event ID: TER

Facility (D; 001GE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/24/2013 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OME_NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA O(2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND FLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING Of - NURSING HOME COMPLETED 245434 6. WING 05/16/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE. ZIP CODE 1020 LARK STREET **BETHANY HOME** ALEXANDRIA, MIN 56308 SLIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEC IDENTIFYING INFORMATION) 0040 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE AFPROPRIATE 1D (14) COMPLETION DATE PREFIX PREFIX TAG TAG DEFICIENCY) K 062 Continued From page 8 K 062 This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery. K 069 NFPA 101 LIFE SAFETY CODE STANDARD K 069 SG=F Cooking facilities are protected in accordance with 9.2.3. 19.3.2,6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain cooking equipment in accordance with the requirements of NFPA 101 -K069 SS=F 2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 1. Telephone was moved. Date 96 - 1998 edition, Section 3-2.2. This deficient complete: 6/7/2013 practice could affect 28 of the 77 residents and No shelving or telephones will be installed an undetermined number of staff and visitors. in front of a pull station. Findings include: On 5/16/13 at 4:30 pm, observation revealed that a telephone was mounted under the kitchen hood auppression system pull station obstructing access to the pull switch. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD K 073 K 073 SS=E No furnishings or decorations of highly flammable character are used. 18.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was free of FORM CMS-2657(02-95) Previous Varsions Obsolets Event JD; TEOB21 Facility ID: 00108 If continuetion sheet Fage 3 of 12

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				ON	FORM APPROVED (B. NO. 0838-039)
F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA) DATE SURVEY COMPLETED
CORRECTION	Identification Number:	A, BUILDING	ol - Mursing Home		
	245434	8. WING			05/16/2013
omder or supplier		51			
HOME			ALEXANDRIA, NN 58308		
X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE FRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	n Shoulo be Eappropriate	(AS) COMPLETION (MITE
combustible decorati NFPA 101 - 2000 edi could affect approxim	ions in accordance with ition, Section 19.7.5.4. This nately 20 of the 77 residents	K 07	3		
combustible decorations in accordance with NFPA 101 - 2000 edition, Section 19.7.5.4. This could affect approximately 20 of the 77 residents and an undetermined number of staff and visitors. Findings include: 1, On 5/16/13 at 1:21 pm, observation revealed that 5 candles with vicks were used for decoration in the Kalina Dining Room. 2. On 5/16/13 at 6:40 pm, observation revealed that 2 candles with wicks were used for decoration in the Kalina Dining Room. 2. On 5/16/13 at 6:40 pm, observation revealed that 2 candles with wicks were used for decoration in the Darling Springs Dining Room. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery. K 074 SS=E Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furniahings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly Introduced upholistered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13		K 07	Complete: 6/3 2. Candle wick v Complete: 6/3 Housekeeping is g facility and room i candles with wick wicks, they will be	/13 vas clipped. /13 oing to add nspections, s are allowed	Date candles to no d with
	S FOR MEDICARE & CORRECTION CONDER OR SUPPLIER CONTRECTION CONDER OR SUPPLIER MOME SUMMARY SI (EACH OEFICIENC REGULATORY OR Continued From pag combustible decorati NFPA 101 - 2000 edi could affect approxim and an undetermined Findings include: 1. On 5/16/13 at 1:2: that 5 candles with v decoration in the Ka 2. On 5/16/13 at 6:44 that 2 candles with v decoration in the Da This deficient practic Maintenance Coordi Coordinator at the th NFPA 101 LIFE SAF Draperies, curtains, and other loosely has serving as furnishing care occupancies an provisions of 10.3.1 the installation of Sp curtains are in accord Newly Introduced up health care occupan specified when tests methods cited in 10, NFPA 13 Newly introduced m	CORRECTION LIDENTIFICATION NUMBER: 245434 CONDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENTIONS (EACH DEPICTENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 combustible decorations in accordance with NFPA 101 - 2000 edition, Section 19.7.5.4. This could affect approximately 20 of the 77 residents and an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 1:21 pm, observation revealed that 5 candles with wicks were used for decoration in the Kalina Dining Room. 2. On 5/16/13 at 5:40 pm, observation revealed that 2 candles with wicks were used for decoration in the Darling Springs Dining Room. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1,	S FOR MEDICARE & MEDICAID SERVICES IF DEPURINCES (x1) PROVIDER/SUPPLEMENTUR (x2) MULTIPL CORRECTION (x1) PROVIDER/SUPPLEMENTUR (x2) MULTIPL 245434 I. WING	S FOR MEDICARE & MEDICAID SERVICES IF GENERATES IF GENERATES (A1) PROVIDERUNA LEVEN 285424 285424 IF MARKET 285424 SUMMARY STATEMENT OF DEPOINNERS SUMMARY STATEMENT OF DEPOINNERS ISLINGARY STATEMENT OF DEPOINNERS SUMMARY STATEMENT OF DEPOINNERS SUMMARY STATEMENT OF DEPOINNERS SUMMARY STATEMENT OF DEPOINNERS SUMMARY STATEMENT OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINNERS REGULARCY OR LSC DEMITY IN A MET OF DEPOINT IN A MET	S FOR MEDICARE & MEDICALD & SERVICES On W GENURATES (C1) PROVIDER/UPURCLAL LISTIFICIARON MAREEN (C2) MULTIPLE CONSTRUCTION (C2) A BUILDING OF ADDRESS, CITY, STATE, 2P CODE CONDER OR BURFLER 255634 If WRST MORE STREET ADDRESS, CITY, STATE, 2P CODE INCARE STREET ADDRESS, CITY, STATE, 2P CODE INCARE OF INFORMATION DEPORTATION PREVALUES INCARE OF INFORMATION PREVALUES INCARE OF INFORMATION PREVALUES INCARE OF INFORMATION PREVALUES INCARE OF INFORMATION SECOND PREVALUES INFARATE STREET SECOND INCARE OF INFORMATION SECOND PREV

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EATEMENT (S FOR MEDICARE & F DERCIENCIES CORRECTION	MEDICAID SERVICES (21) PROVIDENSUPPLENCLIA (DENTIFICATION NUMBER:		ple construi 15 61 - Nursin			
		245454	EL WANG			1 05	46/9013
ame of Pr Bethany	ovider or supplier Home		STREET ADDRESS, CITY, STATE, 20 CODE 1920 LANK STREET ALEXANDRIA, NN 56368				
(X4) ID PREFIX TAS	(EAGH DEFICIENC	atement of deficiencies Y Must be precieded by full .5C IDENTIFYING INPORMATION)	ed Prefix TAG		PROVIDERS PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(KB) COMPLET CM(TE
K 074	Continued From page	10	ĸø	74			
	Based on observation falled to provide cubic materials meeting the - 2000 edition, Section deficient practice could residents and an under and visitors. Findings include: 1. On 5/16/13 at 3:48 (that the cubicle curtain did not have tags indic retardant. The facility the fire retardant natur fabric and when asked fire retardant the Meins replied. "I don't know." 2. On 5/16/13 at 6:05 (that the window draper 2216, 2116, 2210, 220 2104, 2105, 2108, 210 (Id not have tags indic retardant. The facility if the fire retardant natur	requirements of NPPA 101 to 19.7.5.1 and 10.3.1. This d affect 10 of the 77 stermined number of staff pm, observation revealed is located in room WWHO sating that they were fire had no documentation on the cubicle curtains lif the cubicle curtains tenance Coordinator			 K074 SS=E Documentation on cub has been located. Only curtains are used in our Products are Click ezy, Healthcare Products lait permanently flame reta cubical curtains. Fire r were top left corner. D complete: 6/5/2013 Window curtains are get treated for fire rating permanential Cleaners w curtains in our resident facility that do not have spread ratings. Date con 7/1/2013. Curtains purchased or replative for fire rated or treated. Docum will be stored for fire marsh to review. 	2 types o facility. & Creative beled as rdant ating label ate bing to be rotection. will treat al rooms and flame nplete bed will be uentation	f ve Is I I
ר	We don't have any infi This deficient practice (Asintenance Coordinat	was confirmed by the					

P.17/34

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TEMENT C	F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING 01 -	DNSTRUCTION NURBING HOME		SURVEY PLETED
		245434	8. WING		06	/16/2013
ME OF PR	OVIDER OR BUPPLIER		1020	Y ADDRESS, CIYY, STATE, ZIP CODE) LARK STREET EXANDRIA, MN 56308		
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ratement of deficiencies 27 Must be preceded by full LSC identifying information)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X&) Còmpletiq Daté
K 074 K 147 SS=E			K 074 K 147	 K147 SS=E 1. Office fan war wall. Complete 2. Junction box y Complete: 6/7 3. Outlet is cove fault in the cin 6/7/13 Staff were educated al equipment allowed fo quality committee wil sure they are used processors 	tte: 6/7/13 was covered. 7/13 red by first gra- reuit. Complet bout proper r power strips. 11 audit to make	5:

FORM CM5-2567(02-99) Previous Versions Obsolete

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Event ID: TEO821

Facility ID: 00108

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PRINTED: 05/24/2013

ND PLAN ÓF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	Construction 2 - SUB ACUTE		re survey Mpleted
		245434	8. WNG		0	5/16/2013
JAME OF PR	ovider or supplier		10	EET ADDRESS, CITY, STATE. ZIP CODE 220 LARK STREET		
				LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ið Prefix TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(XS) COMPLETH DATE
K 000	INITIAL COMMENTS	5	K 000			
	Monitoring Survey w for Medicare & Media 5/16/13 following a M Public Safety survey Comparative Federa Home was found to I compliance with the in Medicare/Medicaid 483.70(a), Life Safet National Fire Protect standard 101 - 2000 Bethany Home facilit buildings as follows: Building-0104 Nursin with full basement of 1962 and 1977. Building-0204 Sub A no basement of Type Building-0204 Is con- separated by a 2-hou is also connected to that was not surveye from the assisted livi fire barrier. Building-0304 Chape no basement of Type constructed in 2002. What is referred to a purposes, Building-0	I Monitoring Survey, Bethany be not in substantial requirements for participation d at 42 CFR subpart y from Fire, and the related ion Association (NFPA) edition. If was surveyed as four ag Home, is 1-story structure (Type II (000) constructed in cute, is 3-story structure with e II (111) constructed in 2003. nected to Building-0104 and ur Fire Barrier. Building-0204 an assisted living occupancy d because it was separated ng occupancy by a 2-hour el, is a 1-story structure with e IV (Heavy Timber) s Building-0404 for survey 404 is the 1-st floor of the				
	east wing of Building entrance area of Buil	ding-0204 that were both				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution mey 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 clied, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Provious Versions Obsolate

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		MEDICAID SERVICES				OMB N	IO. 0938-039
	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			SUB ACUTE		re Survey Mpleted
		245434	B. WING			0	5/16/2013
NAME OF PI	ROVIDER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP CODE	f	
BETHAN	HOME				LARK STREET IXANDRIA, MN 66308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of deficiencies Y Must be preceded by full LSC (dentifying information)	ið Prefi Tag	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DAYE
K 000	fully renovated in 201 101-2000 Edition effect the major renovation after 2003, it must me Health care as outline Safety Code. All buildings are fully supervised smoke de corridor and spaces of as in all resident room Bethany Home facility 83 beds are dually ce Medicaid. At the time	2. CMS adopted NFPA active March 2003. Due to of this area that took place set the requirements for New ad in Chapter 18 of the Life sprinklered and there are tectors located in the open to the corridors, as well		000			
K 014 \$8=E	NOT MET as evidence NFPA 101 LIFE SAFE Interior finish for corri exposed interior surfa fixed or movable walk	ETY CODE STANDARD dors and exitways, including ces of buildings such as s, partitions, columns, and pread rating of Class A or	ĸ)14			
1	Based on observation failed to provide inten- the flame spread required 2000 edition, Sections 10.2.3. This deficient	ot met as evidenced by: 1 and interview, the facility or finish materials that meet irements of NFPA 101 - 19.3.3.1, 19.3.3.2 and practice could affect 9 of ell as an undetermined					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: TE0821

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Facility ID: 00106

If continuation sheet Page 2 of 4

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TATEMENT	IS FOR MEDICARE & OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:			NISTRUCTION SUB ACUTE	(X3) DATE), 0938-01 Survey Leted
		245484	B. WING_			05/	16/2013
NAME OF PI	Kowder or Supplier I Home			1020	TADORESS, CITY, STATE, 20 COOL LARK STREET XANDRIA, MN 66308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEPICIPACIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Priefix Tag	:	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	Dae	(S) COMPLET DATE
K 014	Continued From page	e 2	KO	114	······································		
	Findings include:					1	
	On 5/16/13 at 4:50 pr in the main lobby are: up to 48 inches on all	m, observation revealed that a th are was wood paneling I walls.			K014 SS=E 1. Oak is rated at 100 by the See Attached: Date com 6/7/2013	plete:	
K 062	Maintenance Coordin Coordinator at the tim	e was confirmed by the later and the Education he of discovery. ETY CODE STANDARD	KO	82	Fire rating and documentation construction will be stored in administrator's office for fire review.	the	
56=E	condition and are insp periodically. 19.7.8	ted in reliable coerating					
	9.7.5				K062 SS=E	•	
	This OTANDADD !				1. Sprinkler head was foreign material and	i paint. Da	te
	Based on observation review, it was determi	uot met as evidenced by: n, interview, and record ined that the facility failed to automatic sprinkler system			Complete: 6/4/2013 Sprinkler heads added to safe	ety commit	ice
	in accordance with NF Sections 19.3.5 and 9 edition, Sections 2.2.1 Table 2-1. This deficis 77 residents and an un	FA 101 - 2000 edition. FA 101 - 2000 edition. 7 and NFPA 25 - 1998 1.1, 2-4.1.4, 9-7, 9-7.1 and 2nt practice could affect all indetermined number of			facility inspection sheet any will be replaced by maintena	foreign mat nce.	erial
	staff and visitors. Findings include:						
Ì	-						
	a sprinkler in the Shori free of foreign material	n, observation revealed that t Term Rehab Spa was not I.					
	This deficient practice	was confirmed by the					

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		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 05/24/201 RM APPROVEI 10. 0938-039
STATEMENT	Of Deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			SUB AQUTE	(X3) DA	TE SURVEY MPLETED
		245434	B. WING		19 17 - 19 1 - 19 1 - 19 1 - 19 1 - 19 1 - 19 1 - 19 1 - 19 1	0	5/16/2013
NAME OF PR	Rovider or supplier / Home			1020	TADDRESS, CITY, STATE, ZIP CODE LARK STREET XANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATSMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Pref Tag		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) Completión Date
K 062	Maintenance Coordin	nator and the Education	к	062			
K 103 SS=E		ETY CODE STANDARD	к	103			
	Interior walls and par or Type II constructio limited-combustible n	titions in buildings of Type I n are noncombustible or naterials. 19.1.6.3					
	Based on observation failed to install all fram non-combustible com- the requirements of M section 19.1.6.3. This affect approximately an undetermined num	not met as evidenced by: in and interview, the facility ming of interior walls of struction in accordance with IFPA 101 2000 edition, s deficient practice could 12 of the 77 residents and nber of staff and visitors.					
	that the building was construction and inter	om, observation revealed a non-combustible type of rior walls in the Director of					
	These deficient practi	f wood framed construction. ices were confirmed by the ator and the Education le of discovery.					
							1

FORM CMS-2567(02-99) Pravious Versions Obsolete

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Event ID: TEO821

Facility ID: 00108

If continuation sheat Page 4 of 4

	RS FOR MEDICARE &	MEDICAID SERVICES					(M APPROVE (0, 0938-039
	of deficiencies F Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION 2 - SUB ACUTE		e surve y Ipleted
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		245434	B. WING			05	5/16/2013
NAME OF P	rovider or supplier <b>Y home</b>			10	EET ADDRESS, CITY, STATE, 21P CODE D20 LARK STREET		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	l	A	LEXANDRIA, MN 56308		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING (NFORMATION)	ID PREFI) TAG	۲	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	36	(X5) COMPLETION DATE
K 062	Continued From page	3	к	162			
		ator and the Education					
k 103 SS=E	NFPA 101 LIFE SAFE	TY CODE STANDARD	К1	03			
	Interior walls and part or Type II construction limited-combustible m	itions in buildings of Type I are noncombustible or laterials. 19.1.6.3					
Ì	Based on observation failed to install all fram non-combustible cons the requirements of NI section 19.1.6.3. This affect approximately 1 an undetermined num	truction in accordance with			<ul> <li>K103 SS=E</li> <li>1. Heinz Construction is general replace wood frame with completed by 7/24/2013</li> <li>Wood frame construction will no the future.</li> </ul>	1 steel to	
	that the building was a construction and interi Nursing office were of	m, observation revealed non-combustible type of or walls in the Director of wood framed construction. was were confirmed by the for and the Education of discovery.					

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Event ID: TEO821

Facility (D; 00108

If continuation sheet Page 4 of 4

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING 07 ·			TE SURVEY MPLETED
		245434	8, WING			5/16/2013
NAME OF PR	OVIDER OR SUPPLIER		102	TADDRESS, CITY, STATE, ZIP CODE 9 LARK STREET EXANDRIA, MN 55308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Prefix TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X8) Completio Date
K 000	INITIAL COMMENTS	3	K 000	r		
	for Medicare & Medic 5/16/13 following a M Public Safety survey Comparative Federal Home was found to & compliance with the in Medicare/Medicald 483.70(a), Life Safety	as conducted by the Centers caid Services (CMS) on linnesota Department of on 4/24/13. At this I Monitoring Survey, Bethany be not in substantial requirements for participation at 42 CFR subpart by from Fire, and the related lon Association (NFPA)	•			
	Bethany Home facilit buildings as follows:	y was surveyed as four				
	Building-0104 Nursin with full basement of 1962 and 1977.	g Home, is 1-story structure Type II (000) constructed in				
	no basement of Type Building-0204 is com separated by a 2-hou is also connected to a that was not surveye	cute, is 3-story structure with II (111) constructed in 2003. nected to Building-0104 and Ir Fire Barrier. Building-0204 an assisted living occupancy d because it was separated ng occupancy by a 2-hour				
	Building-0304 Chape no basement of Type constructed in 2002.	I, is a 1-story structure with IV (Heavy Țimber)				
	purposes, Building-0- east wing of Building-	Building-0404 for survey 404 is the 1-st floor of the -0104 and the South ding-0204 that were both				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is detarmined that other safeguards provide sufficient protection to the patients, (See Instructions.) Except for nursing homes, the indings 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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Facility (D: 00108

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		ID HUMAN SERVICES					
							). 093 <u>8-0391</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 03 - CHAPEL AREA	(X3) DATE COMP	PLETED
		245434	B. WING			05	16/2013
NAME OF PR	OVIDER OR SUPPLIER			នា	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY	HOME				ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	id Pref Tad	٦X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL OROSS-REPERENCED TO THE APPRO DEFICIENCY)	LD 96	(X5) COMPLETION DATE
K 000 K 015 SS=E	101-2000 Edition effi the major renovation after 2003, it must m Health care as outlin Safety Code. All buildings are fully supervised smoke de corridor and spaces as in all resident root Bethany Home facilit 83 beds are dually c Medicaid. At the tim was 77. The requirement at 4 NOT MET as eviden NFPA 101 LIFE SAF Interior finish for root corridors or exitways surfaces of buildings walls, partitions, colu flame spread rating of fully sprinklered build Class A, Class B, or use within rooms set 19.3.6 from the accession	12. CMS adopted NFPA active March 2003. Due to of this area that took place eat the requirements for New ed in Chapter 18 of the Life sprinklered and there are atectors located in the open to the corridors, as well ms. by has 83 certified beds. All ertified for Medicare and e of the survey the census A2 CFR, subpart 483.70(a) is ced by: ETY CODE STANDARD ms and spaces not used for a, including exposed interior a such as fixed or movable umns, and ceilings, has a of Class A or Class B. (In dings, flame spread rating of Class C may be continued in parated in accordance with		( OD			
	Based on observation	not met as evidenced by: on and interview, the facility rior finish materials that meet					

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Event ID; TEO821

Facility ID: 00108

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	of Déficienciés Correction	(X1) FROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	()(2) MULTIPLE C A. BLILDING 03 -			e survey Pleted
		245434	B. WING			16/2013
NAME OF PR	ovider or supplier Home		102	et addrees, gity, staté, zip gode 8 lark stréét Exandiria, mn 85308		
<b>(%4)</b> ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	il) PREPIX TAG	PROVIDER'S PLAN OF GO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	n Should Be Lappropriate	(33) Confletio Date
K 015 K 038 S3≡€	the flame spread req 2000 edition, Section 10.2.3. This deficient the 77 residents and staff and visitors. Findings include: On 5/16/13 at 5:45 p there was 54 inches in the Chapel. The M stated "I have no ide for the wood panelin This deficient practic Maintenance Coordi Coordinator at the te NFPA 101 LIFE SAF	uiraments of NFPA 101 - to 19.3.3.1, 19.3.3.2 and it practice could affect 10 of an undetermined number of an undetermined number of the servation revealed that of wood paneling on all walls taintenance Coordinator ta what the flame spread is g." the was confirmed by the nator and the Education	K 015 K 038	K015 SS=E 1. Oak is rated. See attached 6/7/2013 Fire rating and do construction will administrator's or review.	Date complete: ocumentation on be stored in the	2003
	Based on observati failed to provide mea with the requirement Sections 19.2.1, 7.1 7.2.5.2 (a). This def approximately \$0 of	not met as evidenced by: on and interview, the facility ans of egress in accordance is of NFPA 101 - 2000 edition, .6, 7.2.6, 7.8.1, and Table incient practice could affect the 77 residents and an er of staff and visitors.				

TATEMENT	of deficiencies F correction	MEDICAID SERVICES (X1) PROVIDERSLIPPLENOLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 03 - CHAPEL AREA	(XSI) DAT	<b>C. 0938-0</b> E SURVEY IPLETED
		245434	B. WING			/16/2013
Bethan	rovider or supplier Y hörne			veet address, city, state. Zip code 1929 Lark Street 11 Exandria, MN 58308		<u>197713</u>
(X4) ID PREFIX TAG	( CEACH DEFICIENCY	Venent of Deficiencies Must be preceded by full SC identifying information)	ið PREfix TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO OFFICIENCY)	LI) BE	()(5) COMPLETIX DATE
K 038	1. On 5/16/13 at 5:46	3 am, observation revealed entrance has a 2" step at	К 03В	Gentlewsy		
·]. ].	That the north Chapel e drop at the edge of the the exit door, of a 3 dp has no hand rail or gua 3. On 5/16/13 at 5:50 p	m, observation revealed oors out of the Chapel are ay. When asked if the m an AHJ for the 30 cks. the Maintenance		<ul> <li>K038 SS=E</li> <li>Alexandria Welding bid received and approved a will be installed to level Date complete: 7/24/201</li> <li>Alexandria Welding bid received and approved h be installed along sidewa complete: 7/24/2013</li> <li>Alexandria Electronics to door to current code. Date complete: 7/24/2013</li> </ul>	steel seam sidewalk. 3 has been andrail will ilk. Date o update	
K 073    55=5	Maintenance Coordinat Coordinator at the time NFPA 101 LIFE SAPET No furnishings or decord	of discovery.	·K 073			
fic C N C A F	price to ensure the facili ombustible decorations IFPA 101 - 2000 edition ould affect approximate	nd interview, the tacility ty was free of in accordance with , Section 19.7.5.4. This ly 50 of the 77 residents mber of staff and visitors.		<ul> <li>K073 SS=E</li> <li>Candle wick was clipped Complete: 6/3/13</li> <li>Housekeeping is going to add facility and room inspections candles with wicks are allow wicks, they will be clipped or</li> </ul>	l candles to , no ed with	

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Facility ID: 00108

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUL	TIPLE Ç	ONSTRUCTION		<u>). 0938-036</u> Survey
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG <b>04</b> -	- 2012 RENOVATED AREA		LETED
		245434	9, WING			05	/16/2013
BETHANY	Rovider or Supplier <b>' Home</b>			102	TADDRESS, CITY, STATE, ZIP CODE		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ALI	EXANDRIA, MN 56308		1
PREFIX	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BÉ	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	к	000			
	A Life Safety Code	Comparative Federal					
	Monitoring Survey v	was conducted by the Centers licald Services (CMS) on					
	5/16/13 following a	Minnesota Department of					
	Public Safety surve Comparative Feder	y on 4/24/13. At this a) Monitoring Survey, Bethany					
	Home was found to	be not in substantial					
	compliance with the in Medicare/Medica	erequirements for participation id at 42 CFR subpart					
	483.70(a), Life Safe	ity from Fire, and the related					
	National Fire Protect standard 101 - 2000	tion Association (NFPA) Dedition.					
	Bethany Home facili buildings as follows:	ity was surveyed as four :					
	Building-0104 Nursi with full basement o 1962 and 1977,	ing Home, is 1-story structure If Type II (000) constructed in					
	no basement of Typ	Acute, is 3-story structure with e II (111) constructed in 2003. Inected to Building-0104 and					
	separated by a 2-ho	ur Fire Barrier, Building-0204					
	is also connected to that was not survey	an assisted living occupancy ed because it was separated					
1	from the assisted liv fire barrier.	ing occupancy by a 2-hour					
	Building-0304 Chape no basement of Type constructed in 2002.	el, is a 1-story structure with e IV (Heavy Timber)					
	purposes, Building-O	is Building-0404 for survey 1404 is the 1-st floor of the					
	east wing of Building entrance area of Bui	-0104 and the South Iding-0204 that were both					
ORATORY DI	RECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	 I		TILE		(6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00108

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STATE MENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         STATE MENT OF DEFICIENCIES       IDENTIFICATION NUMBER:       A BUILDING 04 - 2012 RENOVATED AREA       (X3) DATE SURVEY         AND PLAN OF CORRECTION       246434       B. WING       05/16/2013         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       05/16/2013         BETHANY HOME       SLIMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION			ND HUMAN SERVICES					MAPPROVED 0. 0938-0391
NME OF PROVIDER OR BUFFUEA         Enternation           BETMARY HOME         SUMMARY STATEMENT OF DEFICIENCIES         International State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State	TATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				(XS) DAT	e survey
BETMANY HOME         1028 LANK STREET           ALEXANDRAL, BM 56306         ALEXANDRAL, BM 56306           PREFIX TXS         SUMMARY STATEMENT OF DERCENCES RECOUNTRY OR LISC DERCEMENT MISTING INFORMATION         ID PREFIX TXS         ID PREFIX			245434	B. WING			0	5/16/201 <u>3</u>
ALEXANDRU, MR 1930       Priority Tool     Subliview starsument or DEPICIENCIES (EACH ORREST PLAY OF CORRECTION EACH DEPICIENCY AUTORY OR LISE IDEMITIPING INFORMATION)     Priority Tool     Precision (EACH CORRECTION ACTION HOLLD BE CROSS-REFERENCIES to THE APPROPRIATE DEPICIENCY)     Office Office (ROOS REFERENCIES to THE APPROPRIATE DEPICIENCY)       K 000     Continued From page 1 fully renovated in 2012. CMS adopted NFPA 101-2000 Edition effective March 2003. Due to the major renovation of this area that took place after 2003, it must meet the requirements for New Health care as outlined in Chapter 18 of the LIFs Safety Code.     K 000       All buildings are fully sprinklered and there are supervised mixed editactors located in the corridor and spaces open to the corridora, as well as in all resident rooms.     K 011       Bethany Home facility has 83 certified beds. All 83 beds are dually certified for Medicare and Medicati. At the time of the survey the cansus was 77.     K 011       NTME T as avidanced by: NOT MET as avidanced by: SS=E     K 011       If the building has a common well is a free barrier having at least a two-hour fine resistance refing constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-cloaing fine doors. 18.1.1.4.1, 18.1.1.4.2       This STANDARD Is not met as evidenced by: Based on observation and interview, the facility failed to property fine-stop fine barrier penetrations in accordance with LGS Sections 8.2, 16.1.1.4.1, and 18.1.1.4.2 and NFPA 80, 1998 Edition. This deficient practice could affect 40 of the 77					-			
Pairtin Tool         Pairtin RESULTION OR LISC IDENTIFYING INFORMATION)         Pairtin The Security of the construction of the series of cost-references on the APROPRIATE DEFICIENCY         Construction of all cost of the major renovation of this area that core as cullined in Chapter 18 of the Life Safety Code.         K 000           All buildings are fully sprinklered and there are supervised smoke detectors located in the confider and specific provide the survey the census was 77.         K 011         K 011           Select House on the confider and there are supervised smoke detectors located in the confider and specific provide the confiders, as well as in all resident rooms.         K 011           Bethany Home facility has 83 certified beds. All 83 beds are dually certified for Medicare and Medicald. At the time of the survey the census was 77.         K 011           KM011 SS=E House on the conting publicing, the common well with a nonconforming building, the common well with a nonconforming building, the common well with a nonconforming potenties occur only in conting one protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2           This STANDARD Is not met as evidenced by: Based on observation and interview, the facility failed to properly fire-stop fire barcher penetrations in accordance with LSC Sections 8.2, 18.1.1.4.1, and 18.1.1.4.2 and NFPA 80, 1988 Edition. This deficient practice out affect 50 of the 77	BETHANY	HOME			AL	EXANDRIA, MN 56308		
fully renovation 12012. CMS adopted NFPA 101-2000 Edition effective March 2003. Due to the major renovation of this area that took place after 2003, it must meet the requirements for New Health care as outlined in Chepter 18 of the Life Safety Code.         All buildings are fully sprinklered and there are supervised smoke detectors located in the corridor and spaces open to the corridors, as well as in all resident rooms.         Bethany Home facility has 30 certified beds. All S3 beds are dualty certified for Medicare and Medicaid. At the time of the survey the census was 77.         The requirement at 42 CFR, subpart 483.70(a) is NOT MET as avidenced by: K011 SS=E         If the building has a common well with a nonconforming building, the common well is a fire barrier having at least a two-hour fire resistance rating constructed of meterials as required for the addition. Communicating openings occur only in corridors and are protected by sproved self-closing fire doors. 18,1.1.4.1, 18.1.1.4.2         This STANDARD Is not met as evidenced by: Based on observation and interview, the facility failed to properly fire-stop fire barrier preventations in accordance with LSC Sections 8.2, 18,1.1.4.1, and 18.1.1.4.2 and NFPA 80, 1998 Edition. This deficient practice could states 10 of the 77	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETION
wes 77.         The requirement at 42 CFR, subpart 483.70(a) is         NOT MET as avidenced by:         NFPA 101 LIFE SAFETY CODE STANDARD         SS=E         If the building has a common well with a nonconforming building, the common well is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2         This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to properly fire-stop fire barrier penetrations in accordance with LSC Sections 8.2, 18.1.1.4.1, and 18.1.1.4.2 and 18.1.1.4.2 and NFPA 80, 1998 Edition. This deficient practice could affect 50 of the 77	K 000	fully renovated in 20 101-2000 Edition eff the major renovation after 2003, it must m Health care as outlin Safety Code. All buildings are fully supervised smoke d corridor and spaces as in all resident root Bethany Home facili 83 beds are dually of	12. CMS adopted NFPA ective March 2003. Due to n of this area that took place neet the requirements for New ned in Chapter 18 of the Life y sprinklered and there are etactors located in the open to the corridors, as well ons, ity has 83 certified beds. All certified for Medicare and	K	000			
Based on observation and interview, the facility failed to properly fire-stop fire barrier penetrations in accordance with LSC Sections 8.2, 18.1.1.4.1, and 18.1.1.4.2 and NFPA 80, 1998 Edition. This deficient practice could affect 50 of the 77		was 77. The requirement at NOT MET as evider NFPA 101 LIFE SAF If the building has a nonconforming build barrier having at lea rating constructed o addition. Communic corridors and are pr	42 CFR, subpart 483.70(a) is need by: FETY CODE STANDARD common wall with a ling, the common wall is a fire st a two-hour fire resistance f materials as required for the cating openings occur only in otected by approved	ĸ	011			
		Based on observati failed to properly fire in accordance with 1 and 18.1.1.4.2 and deficient practice co	on and interview, the facility a-stop fire barrier penetrations LSC Sections 8.2, 18.1.1.4.1, NFPA 80, 1998 Edition. This uld affect 50 of the 77					

(05) NPLETICIN DATE

PRINTED: 05/24/2013 FORMAPPROVED OMB NO. 0938-0391

### 08/07/2013 14:32 FAX 320 762 5316 BETHANY BUSINESS OFFICE DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (KZ) MULTIPLE CONSTRUCTION (X1) PROMDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING 04 - 2012 RENOVATED AREA 05/16/2013 B. WING 245434 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1020 LARK STREET **BETHANY HOME** ALEXANDRIA, NN 55308 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION D ()(4) 10 PREFIX PREFIX TAG DEFICIENCY K 011 K 011 Continued From page 2 staff and visitors. Findings include: On 5/16/13 at 6:00 pm. observation revealed the two sets of double doors leading into the Chapel KOII SS-E 1. Door coordinator installed on would not close and latch because they did not doors. Date complete: 7/7/13 have a coordinator. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery. K 014 NFPA 101 LIFE SAFETY CODE STANDARD K 014 SS=E Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, pertitions, columns, and cellings, has a flame spread rating of Class A or Class B. Lower portions of corridor walls can be Class C. 18.3.3.1, 18.3.3.2 This STANDARD is not met as evidenced by: K014 SS=E Based on observation and interview, the facility failed to provide interior finish materials that meet 1. Oak is rated at 100 by the ASTM. the flame spread requirements of NFPA 101 -See Attached: Date complete: 6/7/2013 2000 edition, Sections 18.3.3.1, 19.3.3.2 and 10.2.3. This deficient practice could affect 9 of Fire rating and documentation on 2003 the 77 residents, as well as an undetermined construction will be stored in the number of staff and visitors. administrator's office for fire marshal to review. Findings include: On 5/16/13 at 4:50 pm, observation revealed that at the main lobby area there was wood paneling

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up to 48 inches on all walls.

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Fund ID: TEOB21

Fedility (D: 00108

if continuation sheet Page 3 of 7

PRINTED: 05/24/2013 FORM APPROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES A. BUILDING 64 - 2012 RENOVATED AREA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: e. Wing 05/16/2013 245434 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1020 LARK STREET BETHANY HOME ALEXANDRIA, MN 66309 (75) IPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIE Ð (X4)10 PREPX EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC (DENTIFYING INPORMATION) TAG DEFICIENCY) K 014 K 014 **Continued From page 3** This deficient practice was confirmed by the Maintenance Coordingtor and the Education Coordinator at the time of discovery. K 038 K 038 NFPA 101 LIFE SAFETY CODE STANDARD 88×E Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: K38 SS=E Based on observation and Interview, the facility 1. Light bulb replaced and exit sign failed to provide means of egress in accordance visible. Date complete 6/7/2013 with the requirements of NFPA 101 - 2000 edition, Sign stating delayed egress 2. Sections 18.2.1, 7.1.6, 7.2.5 and Table 7.2.5.2 installed. Date complete 6/7/2013 (a). This deficient practice could affect 3. Alexandria electronics bid received approximately 8 of the 77 residents and an and door alarm going to be undetermined number of staff and visitors. installed and gate removed. Complete by 7/24/2013 Findings include: 4. Alexandria electronics bid received 1. On 5/16/13 at 3:35 pm, observation revealed and door alarm going to be that Stair 13 discharge was not obvious because installed and gate removed. there was no exit sign above the door. Complete by 7/24/2013 2. On 5/16/13 at 5:20 pm, observation revealed that on the 2nd floor the Main Exit door had a delayed-egress lock but there was no sign indicating this condition. 3. On 5/16/13 at 5:32 pm, observation revealed that on the 2nd floor the Exit Stair by Room A-27 had a gate at the top of the stair that swung against the direction of egress. Papility ID: 00108 If continuation sheet Page 4 of 7 -ORM CMS-2967(02-99) Previous Ventiens Obselete Event ID: TEO821

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		D HUMAN SERVICES					APPROVEC 0938-0391
STATEMENT O	FOR MEDICARE &	MEDICAID SERVICES (X1) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER;			INSTRUCTION 2012 RENOVATED AREA	(X3) DATE : COMPI	SURVEY
		245434	B. WING_	05/16/2013			
NAME OF PR	DWDER OR SUPPLIER				TADDRESS, CITY, STATE, ZIP CODE		
BETHANY	Home				LARK STREET XANDRIA, MN 56308		
(X4) ID PREFIX TAG	Summary Bi (BACH DEFICIENC REGULATORY CR	10 PREFIL TAG	×	PROVIDER'S PLAN OF CORRECTION (BACH CORRECTIVE ADTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	non should be		
K ()38	that the door to the 2 E-Dining Room requi the frame at approximation the lever handle to op required two actions These deficient practices	) pm, observation revealed nd floor east stair by the ired holding a button in on nately 5' high while turning pen the door. This door to open the door. lices were confirmed by the nator and the Education	K	38			
K 045 56∞E	NFPA 101 LIFE SAF lilumination of means discharge, is amange lighting fixture (bulb) darkness. (This doe	ETY CODE STANDARD s of egress, including exit ed so that feilure of any single will not leave the area in s not refer to emergency se with section 7.8.) 18.2.8	K	045	K045 SS=E		
	This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide reliable lighting for all components of the means of egress as required by NFPA 101 - 2000 edition, Sections 19.2.8, 7.8.1.3 and 7.8.1.4. This deficient practice could affect approximately 15 of the 77 residents and an undetermined number of staff and visitors.				<ol> <li>South exit light was rep complete: 6/3/2013</li> <li>Exit light near chapel was inspen placed on routine maintenance li testing. Other exit lights checke and tested.</li> </ol>	oted and ist for	
	the exterior light fixtu	nn, observation revealed that Ine outside of the South Edit Exture and had only one light					
		e was confirmed by the Maintenance at the time of					

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Event ID; TEO821

Facility in: 00108

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DEPARTA	NENT OF HEALTH AN	ID HUMAN SERVICES				OMB NO	0938-0391
	FOR MEDICARE &	MEDICAID SERVICES			CONSTRUCTION	(PC3) DATE S	SURVEY
AND PLAN OF	CORRECTION	JDENTIFICATION NUMBER;	, A, BUILDI	NG O	4 - 2012 RENOVATED AREA		
		245434	B. WING			05/	16/2013
NANE OF PR	ovider or supplier				EET ADDRESS, CITY, STATE, ZIP CODE		
BETHANY	HOME				020 lark street Llexandria, NN 56308		
		FATEMENT OF DEFICIENCIES	I IP		PROVIDER'S PLAN OF CORRECTION		(AD) COMPLETION
(X4) ID Prefix Tag	EACH DEFICIENC REGULATORY OR	PREF		(BACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED YO THE APPROPR DEFICIENCY)	A ACTION SHOULD BE		
K 045	Continued From pag	¢5	ĸ	046			
	discovery.	ETY CODE STANDARD	к	051			
K 051 SS≃F							
•	A fine alarm system v	with approved compohents, nt is installed according to					
	NFPA 72, to provide	effective warning of fire in					1
	any part of the build	ing. Activation of the system is by manual fire					
	alarm initiation, auto	matic detection, or					
	extinguishing system	n operation. Pull stations are of egness, Electronic or	-				l
	written records of te	ats are available. A reliable			K051 SS=E 1. Fire Fighter & Detecti	on is	
ł	i second source of po systems are maintai	ower is provided. Fire alarm Ined in accordance with NFPA			contacted and will mo	ve smoke	
1	72. National Fire Ala	arm Code, and records of			detectors. To be com	pleted by	
	maintenance are ke remote annunciation	pt readily available. There is n of the fire alarm system to			7/24/2103.		•
	an approved central	l station. 18,3.4, 9.6					
			-				
	The STANDARD is	s not met as evidenced by:					
1	Based on observat	tion and interview, the facility					
	accordance with the	e requirements of NFPA 101 -					
		ons 18.3.4 and 9.6 and NFPA lections 2-1.3 and 2-1.3.2.					
1	This deficient pract	ce could affect approximately					
1	all of the 77 resident	nts and an undetarmined					
		2 4 mainte 19 a .	·	•			
1	Findings include:						
	On 5/16/13 at 5:57	pm, observation revealed that					
	two amake detector ceiling diffuser.	rs were within the airflow of the					
1					16.		Bane And

FORM CM5-2507 (02-09) Previous Versions Obsolate

Event ID: TEO821

Facility IC: 00108

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV								
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 4 - 2012 RENOVATED AREA	(X3) DATE SURVEY COMPLETED		
		245434	8. WING			05/	16/2013	
NAME OF PR	OVIDER OR SUPPLIER			•	EET ADDRESS, CITY, STATE, ZIP CODE			
BETHANY HOME					020 LARK STREET LEXANDRIA, MN 66308			
(X4) ID SUMMARY SYATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			id Pref Tag		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) Completion Date	
K 051		e 6 e was confirmed by the	к	051				
		ator and the Education						

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Event ID; TEO621

Facility ID: 00108

If continuation sheet Page 7 of 7

Flame spread rating for oak

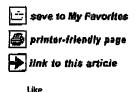
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Knowledge Base

Article



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Flame spread rating for oak

## Oak is rated at 100 by the ASTM. 1998.

by Professor Gene Wengert

#### Q.

What is the FlameSpread rating for Red Oak Lumber?

#### **A**.

The flame spread is a measure of the speed with which a fire will spread on the wood's surface in a specific test set-up. The test set-up is covered in ASTM (Amer. Soc. of Testing and Materials) E84. Red oak is the standard and given a rating of 100. For more information, you can contact the US Forest Products Lab, One Gifford Pinchot Drive, Madison, WI 53705. The topic is discussed briefly in the WOOD HANDBOOK (US Dept of Agr Handbook No. 72—in most libraries).

Professor Gene Wengert is Extension Specialist in Wood Processing at the Department of Forestry, University of Wisconsin-Madison.

Click on Wood Doctor Archives to peruse past answers.

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If you would like to obtain a copy of <u>"The Wood Doctor's Rx"</u>, visit the <u>Wood Education and Resource Center</u> Web site for more information.

Would you like to <u>add information to this article?</u> Interested in <u>writing or submitting an article?</u> <u>Have a question</u> about this article?

Have you reviewed the related Knowledge Base areas below?

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#### SAFETY TO LIFE FROM FIRE IN BUILDINGS AND STRUCTURES

(b) Class II Interior Floor Finish. Critical radiant flux not less than 0.22 W/cm² but less than 0.45 W/cm² as determined by the test described in 10.2.7.1.

10.2.7.3 Wherever the use of Class II interior floor finish is required, Class I interior floor finish shall be permitted.

#### 10.2.8 Automatic Sprinklers.

10.2.8.1 Unless specifically prohibited elsewhere in this Code, where an approved automatic sprinkler system is in accordance with Section 9.7. Class C interior wall and ceiling finish materials shall be permitted in any location where Class B is required, and Class B interior wall and ceiling finish materials shall be permitted in any location where Class A is required.

10.2.8.2 Unless specifically prohibited elsewhere in this Code, where an approved automatic sprinkler system is in accordance with Section 9.7, Class II interior floor finish shall be permitted in any location where Class I interior floor finish is required, and where Class II is required, no critical radiant flux rating shall be required.

#### SECTION 10.3 CONTENTS AND FURNISHINGS

10.3.1* Where required by the applicable provisions of this Code, draperies, curtains, and other similar loosely hanging furnishings and decorations shall be flame resistant as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films.

10.3.2* Where required by the applicable provisions of this *Code*, upholstered furniture and mattresses shall be resistant to a cigarette ignition (that is, smoldering) in accordance with the following:

- (1) Where required by the applicable provisions of this Code, the components of the upholstered furniture, unless located in rooms or spaces protected by an approved automatic sprinkler system, shall meet the requirements for Class I when tested in accordance with NFPA 260, Standard Matheds of Tests and Classification System for Cigaretic Ignition Resistance of Components of Upholstered Furniture.
- (2) Where required by the applicable provisions of this Code, mocked-up composites of the upholstered funciture, unless located in rooms or spaces protected by an approved automatic sprinkler system, shall have a char length not exceeding 1.5 in. (3.8 cm) when tested in accordance with NFPA 261, Standard Method of Test for Determining Resistance of Mock-Up Upholstered Furniture Material Assemblies to Ignition by Smoldaring Cigarettes.

(3) *Where required by the applicable provisions of this Code, mattresses, unless located in rooms or spaces protected by an approved automatic sprinkler system, shall have a char length not exceeding 2 in. (5.1 cm) when tested in accordance with Part 1632 of the Code of Federal Regulations 16.

10.3.8* Where required by the applicable provisions of this Code, upholstered furniture, unless the furniture is located in a room or space protected by an approved automatic sprinkler system, shall have limited rates of heat release when tested in accordance with NFPA 266, Standard Method of Test for Fire Characteristics of Upholstered Furniture Exposed to Flaming Ignitian Source, or with ASIM E 1537, Standard Method for Fire Testing of Real Scale Upholstered Furniture Items, as follows:

- The peak rate of heat release for the single upholstered furniture item shall not exceed 250 kW.
- (2) The total energy released by the single upholstered furniture item during the first 5 minutes of the test shall not exceed 40 MJ.

10.3.4^{*} Where required by the applicable provisions of this Code, matresses, unless the mattress is located in a room or space protected by an approved automatic sprinkler system, shall have limited rates of heat release when tested in accordance with NFPA 267, Standard Method of Test for Five Characteristics of Mattresses and Bedding Assemblies Exposed to Flaming Ignition Source, or ASTM E 1590, Standard Method for Five Testing of Real Scale Mattresses, as follows:

- The peak rate of heat release for the mattress shall not exceed 250 kW.
- (2) The total energy released by the mattress during the first 5 minutes of the test shall not exceed 40 MJ.

10.3.5* Furnishings or decorations of an explosive or highly flammable character shall not be used.

10.3.6 Fire-retardant coatings shall be maintained to regain the effectiveness of the treatment under service conditions encountered in actual use.

10.3.7* Where required by the applicable provisions of this Code furnishings and contents made with foamed plastic materials that are unprotected from ignition shall have a heat release rate not exceeding 100 kW when tested in accordance with UL 1975, Standard for Fire Tests for Foamed Plastics Used for Decorative Purposes.

2000 Edition

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## SAFETY TO LIFE FROM FIRE IN BUILDINGS AND STRUCTURES

### Chapter 10 INTERIOR FINISH, CONTENTS, AND FURNISHINGS

## SECTION 10.1 GENERAL

10.1.1 Application. The interior finish, contents, and furnishings provisions set forth in this chapter shall apply to new construction and existing buildings.

10.1.2 Special Definitions.

**Contents and Furnishings.** See 3.3.83.

Flashover. See 3.3.79.

Interior Finish. See 3.3.112.

Interior Ceiling Finish. See 3.3.112.1.

Interior Floor Finish. Sec 3.3.112.2.

Interior Wall Finish. See 3.3.112.3.

## SECTION 10.2* INTERIOR FINISH

10.2.1 General. Classification of interior finish materials shall be in accordance with tests made under conditions simulating actual installations, provided that the authority having jurisdiction shall be permitted to establish the classification of any material on which a rating by standard test is not available.

Exception: Materials applied, in total thickness of less than 1/28 in. (0.09 cm), directly to the surface of walls and ceilings shall be exempt from tests simulating actual installation if they meet the requirements of Class A interior wall or ceiling finish when tested in accordance with 10.2.3.1 using inorganic reinforced cament board as the substrate material.

#### 10.2.2* Use of Interior Finishes.

10.2.2.1 Requirements for interior wall and ceiling finish shall apply as follows:

- Where specified elsewhere in this Code for specific occupancies (See Chapter 7 and Chapters 11 through 42.)
- (2) As specified in 10.2.4

10.2.2.2* Requirements for interior floor finish shall apply only under either or both of the following conditions:

- (1) Where floor finish requirements are specified elsewhere
- in this Code for specific occupancies 2) Where there is a floor finish of unusual hazard

10.2.3 Interior Wall or Ceiling Finish Testing and Classification.

10.2.3.1* Interior wall or ceiling finish that is required elsewhere in this Gode to be Class A, Class B, or Class C, shall be classified based on test results from NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials.

Exception No. 1: Exposed portions of structural members complying with the requirements for Type IV(2HH) construction in accordance with NFPA 220, Standard on Types of Building Construction, shall be exempt from NFPA 255 testing and classification.

Exception No. 2: Interior wall and ceiling finish tested in accordance with NRPA 286, Standard Methods of Fire Tests for Evaluating Contribution of Wall and Ceiling Interior Finish to Room Fire Growth, shall be exempt from NFPA 255 testing and classification.

10.2.3.2* Products required to be tested in accordance with NFPA 255, Standard Method of Test of Surface Burning Characteristics of Building Materials, shall be grouped in the following

2000 Edition

classes in accordance with their flame spread and smoke development.

(a) <u>Class A Interior Wall and Ceiling Finish</u>. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire.

(b) Class B Interior Wall and Cailing Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale.

(c) <u>Class C</u> Interior Wall and Ceiling Finish Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale.

Exception: Existing interior finish shall be exempt from the smoke development criteria.

10.2.9.3 The classification of interior finish specified in 10.2.5.2 shall be that of the basic material used by itself or in combination with other materials.

10.2.3.4 Wherever the use of Class C interior wall and ceiling finish is required, Class A or Class B shall be permitted. Where Class B interior wall and ceiling finish is required, Class A shall be permitted.

10.2.3.5 Products tested in accordance with NFPA 265, Standard Methods of Fire Tests for Evaluating Room Fire Crowth Contribution of Testile Wall Conterings, shall comply with the criteria of 10.2.3.5.1 or 10.2.3.5.9. Products tested in accordance with NFPA 286, Standard Methods of Fire Tests for Evaluating Contribution of Wall and Ceiling Interior Finish to Room Fire Growth, shall comply with the criteria of 10.2.3.5.3.

10.2.3.5.1* The following criteria shall be met when using method A of the NFPA 265, Standard Methods of Fire Tests for Evaluating Rodm Fire Growth Contribution of Textile Wall Coverings, test protocol:

- (1) Flame shall not spread to the ceiling during the 40-kW exposure.
- (2) During the 150-kW exposure, the following criteria shall be met:
  - a. Flame shall not spread to the outer extremity of the sample on the 8 ft × 12 ft (2.4 m × 3.7 m) wall.
  - b. The specimen shall not burn to the outer extremity of the 2-ft (0.6-m) wide samples mounted vertically in the corner of the room.
  - c. Burning droplets that are judged to be capable of igniting the textile wall covering or that persist in burning for 30 seconds or more shall not be formed and dropped to the floor.
  - d. Flashover shall not occur.
  - e. The maximum instantaneous net peak rate of heat release shall not exceed \$00 kW.

10.2.3.5.2* The following conditions shall be met when using method. B of the NFPA 265, Standard Methods of Fire Tests for Evaluating Roam Fire Growth Contribution of Textile Wall Coverings, test protocol:

- (1) Flame shall not spread to the ceiling during the 40-kW exposure.
- (2) During the 150-kW exposure, the following criteria shall be met



#### **Consent For Services**

□ I acknowledge that dentistry is not an exact science and that no guarantee or assurance has been given by anyone as to the results that may be obtained by my consent to treatment. I hereby authorize Joseph Gendler DDS and his associates to perform or participate in the proposed treatment. I further authorize Joseph Gendler DDS and his associates to perform such procedures as necessary, in the exercise of his/her professional judgment, to remedy unforeseen acute conditions which may be revealed during the course of the original treatment.

I authorize the Doctor to take x-rays, study models, photographs, videos, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs, which will be used as records of my care and treatment. I understand that the records may be used for educational and marketing purposes, for future lectures, or demonstrations to help other patients or professionals understand the benefits of the services rendered by this office. I further understand that I will receive no financial compensation for this use at any time or in the future use of my testimonials or records.

□ I understand that responsibility for payment for Dental Services provided in this office for myself or my dependants is mine, due and payable at the time services are rendered unless other financial arrangements have been made prior.

L further understand that a finance, re-billing, collection charge, or attorney fees will be added to any overdue balances. A service charge of 1.5% per month (18% per year) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written arrangements are satisfied.

□ I understand that if I have insurance, I assign directly to TCDC all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I grant my permission to you or your assignee, to telephone me at provided phone numbers to discuss matters related to my treatment.

Liscknowledge receipt of a copy of Twin Cities Dental Center's notice of privacy practice with an effective date of 04/14/2003.

Should any disputes arise regarding fees, treatment, its outcome, or other matters with TCDC, I agree to seek resolution through arbitration (peer review process) in lieu of court in order to seek a speedy and fair resolution of such issues. By signing this consent form I am agreeing to handle any dispute that might arise as a result of treatment through a dental peer review process (arbitration).

l have read the conditions of treatment and payment and agree to their content.

Patient's Name: __

Signature will be recorded later

Signature

11/6/2013

Submit

https://opendentalsoft.com/WebForms/Sheets.aspx?DentalOfficeID=...

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(Y1) Provider / Supplier / CLIA / Identification Number 245434	(Y2) Multiple Construction A. Building B. Wing 01 - NUF	RSING HOME	(Y3) Date of Revisit 8/19/2013
Name of Facility		Street Address, City, State, Zip Code	
BETHANY HOME		1020 LARK STREET ALEXANDRIA, MN 56308	

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix			Correction Completed 07/24/2013	ID Prefix			Correction Completed 06/24/2013		ID Prefix			Correction Completed 07/24/2013
	NFPA 101				NFPA 101				-	NFPA 101		
LSC	K0018			LSC	K0025				LSC	K0038		
			Correction				Correction					Correction
ID Prefix			Completed 07/24/2013	ID Prefix			Completed 06/04/2013		ID Prefix			Completed 06/07/2013
-	NFPA 101			-	NFPA 101				-	NFPA 101		
LSC	K0051			LSC	K0062				LSC	K0069		
			Correction				Correction					Correction
ID Prefix			Completed 06/03/2013	ID Prefix			Completed 06/05/2013		ID Prefix			Completed 06/07/2013
	NFPA 101			Reg. #	NFPA 101					NFPA 101		
LSC	K0073			LSC	K0074				LSC	K0147		
ID Prefix			Correction Completed	ID Prefix			Correction Completed		ID Prefix			Correction Completed
Reg. # LSC				Reg. # LSC								
ID Prefix Reg. # LSC				Reg. #			Correction Completed		<b>Б</b> "			
Reviewed	Ву	Reviewed	Ву	Date:	Signatur	e of Sur	veyor:				Date:	
State Agen	су	PS/	sd	09/27/1	3	2720	00					08/19/13
Reviewed CMS RO	Ву	Reviewed	Ву	Date:	Signatur	e of Sur	veyor:				Date:	
Followup	to Survey Co 5/16	mpleted on 2013	1:							Summary of the Facility?	YES	NO

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(Y1) Provider / Supplier / CLIA / Identification Number 245434	(Y2) Multiple Construction A. Building B. Wing 02 - SUB ACUTE	(Y3) Date of Revisit 8/19/2013
Name of Facility	Street Address, City, State,	Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 5	

Correction     Correction       ID Prefix     06/07/2013     ID Prefix     Completed       Reg. #     NFPA 101     Reg. #     NFPA 101     Reg. #       LSC     K0014     LSC     K0062     LSC       ID Prefix     Correction     Correction     Correction       Correction     Correction     Correction     Correction       Correction     Correction     Correction     Correction       ID Prefix	Ca	•
ID Prefix         06/07/2013         ID Prefix         06/04/2013         ID Prefix           Reg. #         NFPA 101         Reg. #         NFPA 101         Reg. #         NFPA 1           LSC         K0014         LSC         NFPA 101         Reg. #         NFPA 1           LSC         K0014         LSC         NFPA 101         Reg. #         NFPA 1           LSC         K0014         LSC         NFPA 101         LSC         NFPA 1           ID Prefix         Correction         Correction         Completed         ID Prefix         ID Prefix           Reg. #         SC         SC         SC         SC         SC         SC           ID Prefix         Correction         Correction         Correction         Completed         ID Prefix         SC         SC <t< td=""><td>00</td><td>rrection</td></t<>	00	rrection
LSC       K0014       LSC       K0062       LSC       K0103         ID Prefix       Correction       Correction       Correction       ID Prefix       ID Prefix <t< td=""><td></td><td>mpleted /<b>24/2013</b></td></t<>		mpleted / <b>24/2013</b>
ID Prefix       Correction       Correction         Reg. #       ID Prefix       ID Prefix         LSC       Reg. #       Reg. #         ID Prefix       Reg. #       Reg. #         LSC       Correction       Correction         Correction       Correction       Correction         Correction       Correction       Correction         Correction       Correction       Completed         ID Prefix       ID Prefix       ID Prefix         Reg. #       ID Prefix       Reg. #         ID Prefix       ID Prefix       ID Prefix         Reg. #       ID Prefix       ID Prefix         Reg. #       LSC       ID Prefix         ID SC       ID Prefix       ID Prefix	01	
ID Prefix       Completed       ID Prefix       Completed       ID Prefix       ID Prefix       Reg. #       ID Prefix       Reg. #       Reg. #       ID Prefix       ID Prefix <t< td=""><td></td><td></td></t<>		
ID Prefix       ID Prefix       ID Prefix       ID Prefix       ID Prefix       Reg. #       Reg. #       ID Prefix       Reg. #       ID Prefix       ID Prefix       Reg. #       ID Prefix       ID Prefix       Reg. #       ID Prefix       ID Pr	Co	rrection
Reg. #		ompleted
Correction     Correction       ID Prefix     Completed       Reg. #     Reg. #       LSC     LSC		
ID Prefix         Completed         ID Prefix         Completed         ID Prefix         ID Prefix <t< td=""><td></td><td></td></t<>		
ID Prefix       ID Prefix       ID Prefix         Reg. #       Reg. #       Reg. #         LSC       LSC       LSC	Co	rrection
Reg. #         Reg. #         Reg. #           LSC	Co	mpleted
LSC LSC		
Correction Correction		
		rrection
Completed     Completed       ID Prefix     ID Prefix	Co	ompleted
Reg. # Reg. # Reg. #		
LSC LSC LSC		
Correction Correction	Co	orrection
Completed     Completed       ID Prefix     ID Prefix		ompleted
LSC LSC LSC		
Reviewed By         Reviewed By         Date:         Signature of Surveyor:	Date:	
State Agency         PS/sd         09/27/13         27200	08/19/1	3
Reviewed By     Reviewed By     Date:     Signature of Surveyor:       CMS RO	Date:	
Followup to Survey Completed on:       Check for any Uncorrected Deficiencies. Was a Summa Uncorrected Deficiencies (CMS-2567) Sent to the Fac         5/16/2013       Uncorrected Deficiencies (CMS-2567) Sent to the Fac		

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(Y1) Provider / Supplier / CLIA / Identification Number 245434	(Y2) Multiple Construction A. Building B. Wing 03 - CHAPEL AREA	(Y3) Date of Revisit 8/19/2013
Name of Facility	Street Address,	City, State, Zip Code
BETHANY HOME	1020 LARK ALEXANDF	STREET RIA, MN 56308

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y	′5) I	Date
		Correction			Correction				Correction
ID Prefix		Completed 06/07/2013	ID Prefix		Completed 07/24/2013	ID Prefix			Completed 06/03/2013
-	NFPA 101		-	NFPA 101		•	NFPA 101		_
LSC	K0015		LSC	K0038		LSC	K0073		_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix			ID Prefix						_
Reg. #			Reg. #			Reg. #			_
			LSC			LSC			_
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix									_
Reg. #			Reg. #			Reg. #			_
			LSC						_
		Correction			Correction				Correction
		Completed			Completed				Completed
Reg. #			Reg. #			Reg. #			_
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		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix									_
Reg. #			Reg. #			Reg. #			_
Reviewed B	By Rev	viewed By	Date:	Signature o	of Surveyor:		1	Date:	
State Agen		S/sd	09/27/1	3	27200			08/1	9/13
Reviewed E CMS RO	By Rev	riewed By	Date:	Signature o	of Surveyor:		1	Date:	
Followup t	o Survey Comple	ted on:			Uncorrected Defic				
	5/16/201	3		Uncorrected	Deficiencies (CM	S-2567) Sent to	the Facility?	YES	NO

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245434	(Y2) Multiple Construction A. Building B. Wing 04 - 2012	2 RENOVATED AREA	(Y3) Date of Revisit 8/19/2013
Name of Facility		Street Address, City, State, Zip Code	
BETHANY HOME		1020 LARK STREET ALEXANDRIA, MN 56308	

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4	l) Item		(Y5)	Date
		Correction			Correctio	n				Correction
ID Prefix		Completed 07/07/2013	ID Prefix		Complete 06/07/201		ID Prefix			Completed 07/24/2013
0	NFPA 101		0	NFPA 101			0	NFPA 101		
LSC	K0011		LSC	K0014			LSC	K0038		
		Correction			Correctio	n				Correction
ID Drefit		Completed	ID Drefu		Complete		ID Drofin			Completed
ID Prefix		06/03/2013			07/24/201	3				
	NFPA 101 K0045			NFPA 101 K0051			Reg. # LSC			
		Correction			Correctio	n				Correction
ID Prefix		Completed	ID Profix		Complete	ed	ID Profix			Completed
Reg. # LSC			Reg. # LSC				LSC			
		Correction			Correctio					Correction
ID Prefix		Completed	ID Prefix		Complete	d	ID Prefix			Completed
Reg. #							Б <i>и</i>			
			LSC				LSC			
		Correction			Correctio	n				Correction
		Completed			Complete	ed				Completed
Reg. #			Reg. #				Reg. #			
Reviewed I	By Boyi	ewed By	Date:	Cignoturo	of Cumovon				Deter	
		-		-	of Surveyor:				Date:	/10/12
State Agen	10	/SCI ewed By	09/27/1 Date:		27200 of Surveyor:				Date:	8/19/13
CMS RO		circu Dy	Date.	Signature	or our veyor.				Dale.	
Followup t	o Survey Complet	ed on:			Uncorrected De					
	5/16/2013	3		Uncorrected	Deficiencies (	CMS-2	567) Sent to	the Facility?	YES	NO

DEPARTMENT OF HEALTH A	ND HUMAN	SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: JMFW		
	PART I	- TO BE COMP	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00108		
1. MEDICARE/MEDICAID PROVIDER NO (L1) <b>245434</b>	Ι.	3. NAME AND AU (L3) BETHANY		LITY		<ol> <li>TYPE OF ACTION: <u>2</u>(L8)</li> <li>Initial 2. Recertification</li> </ol>		
2.STATE VENDOR OR MEDICAID NO.		(L4) 1020 LARK	STREET			3. Termination 4. CHOW		
(L2) <b>568340800</b>		(L5) ALEXANDE	RIA, MN		(L6) <b>56308</b>	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
<ol> <li>EFFECTIVE DATE CHANGE OF OWNE (L9)</li> </ol>	RSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	RY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 04/25/20	013 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/III	0 15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited1 TJC2 AOA3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY						
From (a):		A. In Complia			And/Or Approved Waivers Of Th			
To (b):			Requirements ace Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director		
12.Total Facility Beds	<b>83</b> (L18)	1	Acceptable POC		4. 7-Day RN (Rural SNF 5. Life Safety Code			
13.Total Certified Beds	<b>83</b> (L17)		mpliance with Prog ents and/or Applied		* Code: <b>B</b> *	(L12)		
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
83								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS	(IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:		
Angela Hofmann, HFE NEI	I		06/03/2013	(L19)	Colleen B. Leach, Program Specialist 06/13/2013			
PAR	T II - TO BE	COMPLETED	BY HCFA RE	EGIONA	L OFFICE OR SINGLE ST.	ATE AGENCY		
19. DETERMINATION OF ELIGIBILITY		20. COM	MPLIANCE WITH	CIVIL	21. 1. Statement of Finan	cial Solvency (HCFA-2572)		
1. Facility is Eligible to Partic	nate	RI	GHTS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)		
2. Facility is not Eligible	-							
	(L21)							
22. ORIGINAL DATE 2.	3. LTC AGREEM	IENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION	BEGINNING	DATE	ENDING DAT	Е	<u>VOLUNTARY</u> <u>00</u>	INVOLUNTARY		
02/01/1987					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	6		
25. LTC EXTENSION DATE: 27		VE SANCTIONS			04-Other Reason for Withdrawal	OTHER		
	A. Suspensior	n of Admissions:	(L44)			07-Provider Status Change 00-Active		
(L27)	B. Rescind Sus	pension Date:	(L44)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001			Destad of /oo			
	(L28)			(L31)	Posted 06/20/	2013 CO.		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D.	ATE	JMFW			
	(L32)			(L33)	DETERMINATION APPR	OVAL		

DEPARTMENT OF HEALTH AND HUMAN SERVICES	<b>CENTERS FOR MEDICARE &amp; MED</b>	ICAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AND T	RANSMITTAL	ID: JMFW
PART I - TO BE COMPLETED BY THE STATE SU	RVEY AGENCY	Facility ID: 00108

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5434 Page#2

Standard survey completed on April 25, 2013 to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 3545

May 9, 2013

Mr. Patrick McDonald, Administrator Bethany Home 1020 Lark Street Alexandria, Minnesota 56308

RE: Project Number S5434022

Dear Mr. McDonald:

On April 25, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

## DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor Minnesota Department of Health 1505 Pebble Lake Road #300 Fergus Falls, Minnesota 56537

Telephone: (218)332-5158 Fax: (218)332-5196

# **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 4, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 4, 2013 the following remedy will be imposed:

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

# PLAN OF CORRECTION (PoC)

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

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

Bethany Home May 9, 2013 Page 3

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

# PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

# VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

Bethany Home May 9, 2013 Page 4 in your plan of correction.

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

## Original deficiencies not corrected

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

## Original deficiencies not corrected and new deficiencies found during the revisit

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

## Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 25, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 25, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is

Bethany Home May 9, 2013 Page 5

mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## **INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Bethany Home May 9, 2013 Page 6 Feel free to contact me if you have questions.

Sincerely,

Colleen Feach

Colleen Leach, Program Specialist Licensing and Certification Program Division of Compliance Monitoring PO Box 64900 Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

		I AND HUMAN SERVICES		C		APPROVE . 0938-039
STATEMEN AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION		E SURVEY
		245434	B. WING _		04/	25/2013
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	YHOME			1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 SS=D	as your allegation of Department's accept bottom of the first pro- be used as verification Upon receipt of an a revisit of your facility validate that substan- regulations has been your verification. 483.20(k)(3)(ii) SER PERSONS/PER CA The services provide must be provided by accordance with eac care. This REQUIREMEN by: Based on observation review, the facility fa for 1 of 2 residents of prevention, and for 1 required assistance of Findings include: R17's care plan date problem of falls, and which included: "wea worn at all times duri foot rest on recliner of	f correction (POC) will serve f compliance upon the otance. Your signature at the age of the CMS-2567 form will ion of compliance. Acceptable POC, an on-site may be conducted to ntial compliance with the n attained in accordance with VICES BY QUALIFIED RE PLAN ed or arranged by the facility qualified persons in ch resident's written plan of T is not met as evidenced on, interview and document iled to follow the plan of care (R17) related to fall of 1 residents (R40) who	F 00	F 282 Policy: The care planning process b during pre-admission/intake and cor on a regular and periodic basis throu the resident/patient stay. The reside and/or their representative, along wi entire care team is involved in the ca planning process. Care is planned to attain or maintain the resident's/patien highest practicable physical, mental psychosocial well-being. Purpose: To assure continuity of care	at at can be stem and at can be stem and with y team e are, racker ry and care to ii lso care at can be	0/3/ andu
ORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGN/	ATURE	TITLE	``[	K6) DATE
Tato	Mark			Concentra Diret	Slo	12013

In the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ollowing 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 lays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued irogram participation.

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: JMFW11

Facility ID: 00108

MAY 2 0 2013 MN Dept of Health Fergus Falls

		AND HUMAN SERVICES				FORM	D: 05/09/2013 MAPPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		TE SURVEY MPLETED
		245434	B. WING	;		04	/25/2013
	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	ALEXANDRIA, MN 56308 PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	On 4/25/2013 at 7:3 alone in her room, s bed farthest from th R17's room was dar of sunlight coming in R17 remained alone bed, bare feet restin when nursing assist During an interview that R17 had not be when she entered th of R17's feet were b On 4/25/2013 at 8:4 into the reclining cha extended the foot re both legs resting on NA-B adjusted the t exited R17's room. F in a recliner with bott of the recliner. On 4/25/2013 at 8:52 NA-B confirmed that history of falls, liked recalled she did so y she routinely extend in the recliner chair in During an interview of RN-B confirmed that impaired, had freque for further falls. RN- included the interven all times during the n	44 a.m. R17 was observed witting up on the side of the e door with both feet bare. The eccept for a small amount in through the drawn shades. A, seated on the side of the ig on the floor, until 7:47 a.m., ant (NA)-A entered the room. at 8:03 a.m., NA-A confirmed en wearing gripper socks the room and confirmed both are. 1 a.m., NA-B assisted R17 air in R17's room, and st of the recliner with R17's the foot rest. At 8:45 a.m. elevision, then immediately R40 remained alone, seated h feet resting on the foot rest 2 a.m., an interview with R17 was a fall risk, had a to "self transfer," and esterday. NA-B confirmed ed the foot rest when R17 sat n R17's room. on 4/25/2013 at 1:21 p.m.,	F2	282	regarding the plan of care for gripper and not raising the foot rest on her chi- Staff were also provided education as importance of these interventions for resident safety, fall prevention and to reduce the possibility of injuries. This education was also provided by a post the nurses' station and will be provided shift report. 4-30-13 Staff education was provided staff on how to identify residents who require encouragement and assistance meals as directed by the plan of care w tracker message. On 4-30-13 R40 wa moved to a table that more assistance supervision is provided. All residents observed in the dining room to assure are at appropriate tables to receive ass or supervision as required. Education provided to staff of notifying Nurse Managers or Dietary manager of any of that may need to be made to assure rea are getting the assistance they require. 13 and 5-21-13 Education regarding th plans, group lists, safety interventions dietary cards was provided at staff me Any resident in the facility with safety interventions in place has the potentia affected. There for audits to assure that safety interventions are being followed as pe plan of care will be completed on ran- basis on all resident with safety interventions weekly x2 weeks then monthly x2. All residents that require assistance or supervision has the potential to be affer	air. to the help ing at ed at to with via care s and were they istance sidents 5-20- ne care and eting. I to be r the dom	

		AND HUMAN SERVICES				FORM	): 05/09/2013 / APPROVED ). 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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NAME OF F	ROVIDER OR SUPPLIER		•		REET ADDRESS, CITY, STATE, ZIP CODE	L	
BETHAN	IY HOME				1020 LARK STREET ALEXANDRIA, MN 56308		
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F 282	extended. RN-B ver that gripper socks w positioning in the re RN-B stated she wo	ified it was not acceptable vere not utilized, and incorrect cliner was done for R17. buld expect R17's fall ions as in the care plan to be	F 2	282	Therefor audits on assisting and super of residents requiring assistance while will be done weekly x 4 weeks. Further audits will be completed if indicated. Audits will be conducted and results reported to the CQI team. Clinical Director or designee responsi Completion date 5-24-13	e eating	
	meal as directed by R40's plan of care d R40 required assist Interventions directe eating, encourage in and resident require completing her meal During observation of registered nurse (RN two pancakes, one r cup of syrup, and a t food items next to a of coffee. RN-A hand the resident started t RN-A immediately w R40 continued to has	ated March 2013, identified at meals due to dementia. d staff to assist at meals with take, assist with meal set-up, d assist of one to finish					

245434     B. WING     04/2       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     04/2       BETHANY HOME     ALEXANDRIA, MN 56308	05/09/2013 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       BETHANY HOME       STREET ADDRESS, CITY, STATE, ZIP CODE       1020 LARK STREET       ALEXANDRIA, MN 56308       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID     PROVIDER'S PLAN OF CORRECTION SHOULD BE       F 282     Continued From page 3     (EACH CORRECTIVE ACTION SHOULD BE     DEFICIENCY)       F 282     Continued From page 3     F 282       picked up the souffle cup of syrup and began to drink the syrup. R40 placed the souffle cup back on her plate and yelled out to a nearby staff member , who replied, "In a minute Elaine" while continuing to walk away from R40's area of the dining room. R40 was again observed to pick up     F 282	SURVEY PLETED
BETHANY HOME         International control of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider strength of the provider streng	5/2013
BETHANY HOME       ALEXANDRIA, MN 56308         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 282       Continued From page 3 picked up the souffle cup of syrup and began to drink the syrup. R40 placed the souffle cup back on her plate and yelled out to a nearby staff member , who replied, "In a minute Elaine" while continuing to walk away from R40's area of the dining room. R40 was again observed to pick up       F 282	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 282       Continued From page 3 picked up the souffle cup of syrup and began to drink the syrup. R40 placed the souffle cup back on her plate and yelied out to a nearby staff member , who replied, "In a minute Elaine" while continuing to walk away from R40's area of the dining room. R40 was again observed to pick up       F 282	
picked up the souffle cup of syrup and began to drink the syrup. R40 placed the souffle cup back on her plate and yelled out to a nearby staff member , who replied, "In a minute Elaine" while continuing to walk away from R40's area of the dining room. R40 was again observed to pick up	(X6) COMPLETION DATE
the syrup, then ploked up the sausage patty with her fingers and rolled it up in her hand like a taco. R 40 did not receive assistance and encouragement from staff for the entire meal observation from 5:36 p.m. to 6:00 p.m. when R40 wheeled herself out of dining room. R40 had consumed approximately 15 cc of syrup and 75% banana. Two pancakes, a sausage patty, coffee cup, juice glass, and water glass were left untouched at the table. On 4/25/13 at 1:26 p.m., RN-A stated she recalled offering to assist R40 with her meal the evening of observation, by peeling her banana. RN-A stated R40 had indicated she only wanted the banana so RN-A did not assist in cutting the pancakes or sausage patty on her plate. She indicated she was unaware if R40 received assistance to complete her evening meal. On 4/25/13 at 8:32 a.m., licensed practical nurse (LPN)-A stated R40 required set-up and encouragement from staff with all meals because she is very confused, becomes angry, and sometimes would throw her food. On 4/25/13 at 1:15 p.m., the director of nursing (DON) confirmed R40's current plan of care and confirmed she would expect staff to assist R40 with all meals. The facility policy titled Care Planning IDT,	

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	KANNER AND SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	1 · ·	PLE CONSTRUCTION G		) DATE SURVEY COMPLETED	
		245434	B. WING		04/	25/2013	
NAME OF I	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·	·	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/20/10	
BETHAN	IY HOME			1020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X6) COMPLETIO DATE	
F 282	revised 5/2011, ind	ge 4 lcated care plan interventions ted to meet the individual	F 28	2 F311			
F 311 SS=D	11 483.25(a)(2) TREATMENT/SERVICES TO		F 31 ⁻	Policy: The care planning process begin during pre-admission/intake and continu on a regular and periodic basis through the resident/patient stay. The resident and/or their representative, along with t	ues out		
	specified in paragra This REQUIREMEN by: Based on observati review the facility fa	ph (a)(1) of this section. IT is not met as evidenced ion, interview and document iled to provide the necessary ng for 1 of 1 resident (R40)		entire care team is involved in the care planning process. Care is planned to he attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well-being. On 4-30-13 R40 was moved to a table to more assistance and supervision is prov 4-30-13 Staff education was provided to	hat ided.		
	findings include:			staff on how to identify residents who require encouragement and or assistance with meals as directed by the plan of ca via care tracker message. 5-20-13 and 5	e re		
	2/20/13, identified R	um Data Set (MDS), dated 40 had severe cognitive Jired assistance of one for		<ul><li>13 Education regarding the care plans, glists, safety interventions and dietary car was provided at staff meeting.</li><li>All resident in the facility requiring assistance and or supervision have the</li></ul>			
	R40 required assist Interventions directe eating, encourage in	ated March 2013, identified at meals due to dementia. d staff to assist at meals with take, assist with meal set-up, d assist of one to finish		potential to be affected. Therefore on 4- 13 all residents were observed in the dir room to assure they are at appropriate ta to receive assistance or supervision as required, table changes were provided a needed. Education provided to staff of notifying Nurse Managers or Dietary	ing bles		
	was sitting at a table looking at other resid down the silverware R40 turned her whee	on 4/23/13 at 5:29 p.m., R40 alone in the dining room, lents and picking up/putting on her table. At 5:32 p.m., elchair away from the table out of the dining room,		manager of any moves that may need to made to assure residents are getting the assistance they require. Audits on assisting and supervision of residents requiring assistance while eatin will be done weekly x 4 weeks.			

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		AND HUMAN SERVICES				FOR	D: 05/09/2013 M APPROVED D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	0.01101	
		245434	B. WING	)	······	04	/25/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	-	
BETHAN	IY HOME				020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	5:36 p.m., registere from the hallway ba room. She brought I one round sausage and a banana and s to a glass of water, J handed the banana started to peel the b immediately walked continued to handle took a bite. R40 put plcked up the souffle drink the syrup. R40 on her plate and yell member , who replie continuing to walk as dining room. R40 wat the souffle cup from the syrup, then picke her fingers and roller R40 did not take a b patty, but continued pancake with her fin any food item. At 5:: from table out of the adjacent hallway. At observed wheeling F dining room and stat immediately walked member did not cut to provide any other as for R40. R40 then pi the spoon repeatedly sausage patty. R40 p	djacent to the dining room. At d nurse (RN)-A assisted R40 ck to her table in the dining R40 a plate of two pancakes, patty, a souffle cup of syrup, et the plate of food items next juice and cup of coffee. RN-A to R40, and the resident anana, then RN-A away from the table. R40 the banana and peeling and the banana on the plate, e cup of syrup and began to D placed the souffle cup back led out to a nearby staff ed, "In a minute Elaine" while way from R40's area of the as again observed to pick up her plate and take a drink of ed up the sausage patty with d it up in her hand like a taco. ite of pancake or sausage to handle the sausage patty, gers, but did not take a bit of 38 p.m., R40 wheeled away dining room, toward an	F3	311	Further audits will be completed if indicated. Audits will be conducted and results reported to the CQI team. Clinical Director or designee respon Completion date 5-24-13	ł	

		I AND HUMAN SERVICES		0.799803		FORM	): 05/09/2013 1 APPROVED ): 0938-0391
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X6) COMPLETION DATE
	cup, and had not co or sausage. No sta R40 or provide enco 5:52 p.m., R40 whe room into the hallwa intervene. At 6:00 p observed to assist F to her table, then tur providing assistance R40 immediately wh dining room again fo consuming approxim banana. Two pance cup, juice glass, and untouched at the tak On 4/25/13 at 1:26 p recalled offering to a evening of observati RN-A stated R40 ha the banana so RN-A pancakes or sausag indicated she was un assistance to comple On 4/25/13 at 8:32 at (LPN)-A stated R40 encouragement from she is very confused sometimes would the On 4/25/13 at 1:15 p (DON) confirmed R4 confirmed she would with all meals.	e glass, water glass, or coffee onsumed any of the pancakes iff were observed to assist ouragement to eat. Again at eled herself out of the dining ay, no staff were observed to .m., a staff member was R40 back into the dining room med and walked away without or encouragement. Then heeled herself out of the or the last time, after nately 15 cc of syrup and 75% akes, a sausage patty, coffee d water glass were left ole. .o.m., RN-A stated she assist R40 with her meal the ion, by peeling her banana. Id indicated she only wanted a did not assist in cutting the ise patty on her plate. She naware if R40 received ete her evening meal. , licensed practical nurse required set-up and n staff with all meals because becomes angry, and	F3	311			

ATEMEN	T OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	. 0938-039 E SURVEY IPLETED
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	PROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 311	Continued From pa would be implement	age 7 nted to meet the individual	F3	311			
F 323 SS=D	environment remain as is possible; and	F ACCIDENT VISION/DEVICES sure that the resident ns as free of accident hazards each resident receives on and assistance devices to	F 3	323	F323 Policy: To identify residents who are at for falls and develop individual fall precautions for those residents. To main a comfortable, safe, and secure environ for residents while providing the least restrictive level of care. To provide an ongoing system for monitoring and analyzing incidents of falls in order to	ntain ment	
<b>-</b>	by: Based on observat review, the facility fa interventions to min	imize the risk of falls for 1 of 2			determine causal factors and implement appropriate interventions. Purpose: To provide a systematic way f the interdisciplinary team to prevent, monitor and assess resident falls occurr in the facility. On 4-25-13 the cord was immediately removed from resident R17 chair so tha staff are no longer able to raise the foot the chair. Any resident who is assessed	for ing t of	
	R17's diagnoses incosteoporosis, Parkir degeneration. The a (MDS) assessment R17 had severe cog Area Assessment (C ndicated R17 requir grooming, toileting, f ransfer and ambula	s (R17) in the sample who had a history include: agnoses included dementia, osis, Parkinson's disease and macular ation. The annual Minimum Data Set essessment dated 4/10/2013 indicated severe cognition impairment. The Care ressment (CAA) dated 4/10/2103, R17 required assistance with dressing, by toileting, transferring and ambulating; and ambulation required the assist of one of a gait belt. The CAA also indicated		considered unsafe to operate a lift chair have the cord removed or zip tied and notification attached that states do not u On 4-29-13 staff education was provide all staff working with Resident R17 regarding the plan of care for gripper so and not raising the foot rest on her chair	will se. d for cks,		
		nent form dated 4/10/2013 high risk for falls, had					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		245434	B. WING		04	/25/2013
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1020 LARK STREET ALEXANDRIA, MN 56308		
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	several falls this qu walker and an assis R17's care plan dat problem of falls, an which included: "we worn at all times du foot rest on recliner know how to lower foot rest up." Review of the Resid indicated between 1 had experienced thi Interdisciplinary Pro R17 had experience 3/23/2013, 3/28/201 dated 3/23/2013 at 1 found sitting on floo assessments and n documented at that 3/28/2013 revealed sitting on her bottom Gripper socks were added that "gripper all times during noc resident's risk of fall IPN dated 4/13/2013 was found on floor in indicated "will monif documentation of a new interventions pu On 4/25/2013 at 7:3 alone in her room, s bed farthest from the R17's room was dar	arter, and ambulated with a	F3	23 Staff were also provided educatimportance of these intervention resident safety, fall prevention reduce the possibility of injurie education was also provided by the nurses' station and will be shift report. Resident R17 falls reviewed with a new fall assest completed on 5-16-13 intervent implemented, care plan, care sl and staff informed of intervent Licensed staff were provided w that "will monitor" is not an act intervention via care tracker m Guidelines for investigating a find an appropriate intervention provided. Any resident in the facility wit interventions in place has the p affected. Audits to assure that safety into being followed as per the plan be completed on random basis residents with safety interventi x2 weeks then monthly x2. Further audits will be completed indicated. Audits will be conducted and r reported to the CQI team. Clinical Director or designee recompletion date 5-24-13	ons for and to help es. This y a posting at provided at were sment tions neets updated ions. with education ceptable essage. fall to help in was also h safety otential to be erventions are of care will on all ons. Weekly ed if esults	

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NAME OF F	PROVIDER OR SUPPLIER			E	STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	IY HOME				1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	R7 remained alone, bed, bare feet restin when nursing assist During an interview that R17 had not be when she entered th of R17's feet were b On 4/25/2013 at 8:4 into the reclining cha extended the foot re both legs resting on NA-B turned on, adju immediately exited F alone, seated in a re on the foot rest of th On 4/25/2013 at 8:52 NA-B confirmed that history of falls, liked recalled she did so y she routinely extended in the recliner chair in During an interview of RN-B confirmed R17 up, walk, when toiletit transfer. NA-C stated fallen in the recent pa During an interview of RN-B confirmed R17 was of frequent falls and wa RN-B verified R17's of interventions of gripp	seated on the side of the g on the floor, until 7:47 a.m., ant (NA)-A entered the room. at 8:03 a.m., NA-A confirmed en wearing gripper socks the room and confirmed both are. 1 a.m., NA-B assisted R17 air in R17's room, and st of the recliner with R17's the foot rest. At 8:45 a.m. usted the television, then R17's room. R40 remained cliner with both feet resting e recliner. 2 a.m., an interview with R17 was a fall risk, had a to "self transfer," and esterday. NA-B confirmed ed the foot rest when R17 sat in R17's room. and the foot rest when R17 sat in R17's room. an 4/25/13 at 9:52 a.m., ineeded assistance to stand ng and when attempting to the was aware R17 had	F3	323	3		

PRINTED: 05/09/2013

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
245434		B. WING			04/25/2013		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	IY HOME				020 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=F	recliner, the leg rest RN-B verified it was socks were not utiliz in the recliner was d would expect R17's as in the care plan to The facility policy titl 9/2010 indicated ind interventions would implemented for all in 483.35(i) FOOD PRO STORE/PREPARE/S The facility must - (1) Procure food fror considered satisfacto authorities; and	was not to be extended. not acceptable that gripper ted, and incorrect positioning one for R17. RN-B stated she fall prevention interventions to be followed at all times. ed, "Fall Prevention," revised ividualized fall precaution be developed and residents at risk for falls. OCURE, SERVE - SANITARY In sources approved or bry by Federal, State or local istribute and serve food	F 3		F 371 Dietary Plan of Correction: A. A citation was received from State Inspection Review noting a dirty located in the dishwashing area. Correction: The Maintenance Dept. h been responsible for cleaning the fans Dietary Dept. The revision will be that cleaning of the fans will be added to the monthly dietary cleaning list and will cleaned by the dietary staff. The dietar has been educated on the new process will be instructed by maintenance how correctly do the cleaning on May 30, 2 A long term goal of Bethany is to redo air exchange system in the kitchen to eliminate use of the fans. The fan clea will also be added to the monthly Sam Assessment that is completed by the Production Supervisor or her assistant	fan as in the t be ty staff and v to 2013. o the nliness itation	
	by: Based on observation review, the facility fait sanitation procedures food safety in the math kitchenettes having the residents residing in was unsafe storage at the main kitchen and	T is not met as evidenced on, interview and document led to follow equipment s to promote sanitation and in kitchen and 1 of 2 he potential to affect 76 of 79 the facility. In addition, there and undated food items in in 1 of 2 kitchenettes having 76 of 79 residents residing			<ul> <li>B. Citation of cupboard doors at drawer fronts soiled and buildup arout handles.</li> <li>Correction: Cupboard doors and draw fronts will be sanded and repainted. T dining door will also be sanded and refinished. Daily wiping down of cup doors and drawer fronts will be added daily cleaning list of the serving kitch both day and evening shifts. It will also added to the monthly Sanitation Check</li> <li>C. Citation of frozen food items were not sealed, labeled and dated in kitchen freezer.</li> </ul>	rer The board I to the en of so be klist. s that	

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PRINTED: 05/09/2013

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				RINTED: 05/09/201 FORM APPROVEI MB NO. 0938-039	Ď
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
245434				04/25/2013	
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
BETHANY HOME		1	1020 LARK STREET ALEXANDRIA, MN 56308		
PREFIX (EACH DEFICIENCY MU	ST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
<ul> <li>Findings include:</li> <li>During the kitchen and 1:20 p.m., the following confirmed by the produ (DM)-C.</li> <li>- a dish room fan approdiameter had a heavy b dust buildup hanging do fan. The fan was locate dish area, and at the tim blowing on three trays of the dishroom belt.</li> <li>- outer cabinet and draw dining room kitchenette second floor were soiled and had a buildup of a k cabinet and drawer han above the serving area dirty with a brown mater handles and had food sig cabinets. Eighteen draw counter had a brown dir handles and sixteen cat were soiled with brown so one cabinet was soiled were not labeled no contained an opened on Creek 2% milk that was foods were not labeled ro nearly empty one and or free ice cream carton, the contained an opened on the cabinet of the cabinet and contained an opened on contained an opened on contained an opened on contained an opened on creek 2% milk that was foods were not labeled ro nearly empty one and or free ice cream carton, the contained carton carton contained carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton carton c</li></ul>	PROVIDER OR SUPPLIER NY HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 11 Findings include: During the kitchen and facility tour on 4/23/13 at 1:20 p.m., the following was observed and confirmed by the production dietary manager (DM)-C a dish room fan approximately 24 inches in diameter had a heavy buildup of dust with the dust buildup hanging down from the grill of the fan. The fan was located directly above the clean dish area, and at the time of the kitchen tour was blowing on three trays of clean dishes drying on		Correction: All food items will be sealed labeled and dated when placing in servit kitchen freezer. For assurance the proced being followed, it will be added to the stocking list as the freezer is checked di The freezer will also be monitored biwe and documented by diet aide for correct follow through for a period of 6 monthet added as a CQI goal. D. Citation of 13 expired yogurt observed in the walk in cooler. Correction: All manufactured dated products will be checked daily by the co- on duty for expiration dates and dispose accordingly as appropriate. This proce- be added to the cooks daily checklist of duties that are signed off for follow through. This will be done, in addition following the current policy of checkin expiration dates upon delivery and foll FIFO out procedure. The Dietary Manager has held an in-se- with the dietary staff on May 1st to re- citations and provide training on how follow correct procedures. She will all follow through with monitoring of the correction follow through procedures next CQI project for the coming quart Respectfully Submitted, Val Jerzak, CDM, CFPP Director Director of Dining	ing ess is daily aily. eekly eekly eekly eekly et s and s and s and f f to ng lowing ervice view to lso e at the ter.	

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		I AND HUMAN SERVICES				FORM	): 05/09/2013 1 APPROVED ). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245434		B. WING	3_		04/25/2013		
NAME OF PROVIDER OR SUPPLIER				s	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET		
BETHAN					ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG	'IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	top), ready to heat of 7 pancakes, 3 frend labeled nor dated. The facility's Cleaning fans policy dated 5/ the kitchen will be c as needed and reque Maintenance depart During an interview DM-C and the main DM -C verified the fa stated she had com order on 4/19/13 for MC confirmed the fil specific date when t of work orders." The facility's Cleaning policy dated 4/08, st will be free of food p be cleaned at least to Review of the Dining section of the facility Inspection Check-lis 19th, 2013 did not lis and drawers in the k policy did indicate "c consistently" for the cleaning schedule for did not list the cleaning Furthermore, the san kitchenette "refrigeration"	VIDER OR SUPPLIER HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ontinued From page 12 p), ready to heat opened packages of 4 waffles, pancakes, 3 french toast were not sealed, beled nor dated. he facility's Cleaning/Maintenance of kitchen ns policy dated 5/10/10, stated "fans located in e kitchen will be cleaned every other month or s needed and requested of dietary by the aintenance department." uring an interview on 4/23/13 at 1:20 p.m. with M-C and the maintenance coordinator (MC), M -C verified the fan was dusty and dirty, but ated she had completed a maintenance work der on 4/19/13 for the dirty vents to be cleaned. C confirmed the findings and stated he had no pecific date when to clean them, "We have a lot		37	'1         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         .         . <t< td=""><td></td><td></td></t<>		

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Facility ID: 00108

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		HAND HUMAN SERVICES					RINTED: 0 FORM AI	PROVE
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		MB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
		245434	B. WING	۱ <u></u>			04/25	/2013
	PROVIDER OR SUPPLIER		<u> </u>	102	ET ADDRESS, CITY, STATE, ZIP 0 LARK STREET EXANDRIA, MN 56308	CODE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD	BE C	(X5) OMPLETION DATE
1	<ul> <li>2:35 p.m. with the c -B, the following wa</li> <li>the walk in cooler yogurt cups with an</li> <li>The facility's Food E</li> <li>6/10 indicated "all p</li> <li>will be utilized in a n manufactures (sic) ' not used by this data policy further indicat upon delivery, check items already on sho</li> <li>When interviewed o</li> </ul>	o kitchen tour on 4/25/13 at linical dietary manager (DM) s observed: contained thirteen Yoplait 4oz expiration date of 4/22/13. Expiration Dating policy dated urchased, sealed food items nanner that follows the use by' date and that foods e will be disposed of." The red "when shelving new items c expiration dates of stored elf." n 4/25/13 at 2:35 p.m., DM-B e findings and stated, "They	F	371				
ORM CMS-256	7(02-99) Previous Versions C	bsolete Event ID: JMFW1		Facility I	D: 00108	f continuation	sheet Page	14 of 14

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	(X3) DATE SURVE COMPLETED	
		245434	B. WING		04/24/201
AME OF PRON	/IDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLE
DC: 00.04.2013	LEGATION OF C EPARTMENTS A GNATURE AT TH AGE OF THE CM SED AS VERIFIC PON RECEIPT O N ONSITE REVIS E CONDUCTED T JBSTANTIAL CO EGULATIONS HA CCORDANCE WI	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR TE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, IT OF YOUR FACILITY MAY TO VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.	K 000	POC OK POC OK PS 5-28-13	Selvery
ELC. T. M. 25.2013	innesota Departm ne of this survey, substantial compl participation in M ubpart 483.70(a), 100 edition of Natio sociation (NFPA) ode (LSC), Chapte EASE RETURN DRRECTION FOR EFICIENCIES TO	ent of Public Safety. At the Bethany Home was found not lance with the requirements ledicare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 19 Existing Health Care. THE PLAN OF R THE FIRE SAFETY E INSPECTIONS SHAL DIVISION ET, SUITE 145			

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/09/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUI A. BUILD		DATE SURVEY COMPLETED		
		245434	B. WING			04/2	24/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET		
BETHAN	YHOME				ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFC 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre The facility was sur Home was construct original building (01 constructed in 1964 and was determine construction. In 197 basement was const building that was de construction. In 197 constructed to the s the south wings, be buildings and was construction building was constribuilding is 3 stories Type II (111) constru- addition was constribuilding, is 1-story a	estate.mn.us tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE ORMATION: what has been, or will be, done ency.	K	000	Per MW - The facilit surveyed as 2 buildin initial comments) CMS surveyed as 4 bui	.gs (s	see

		AND HUMAN SERVICES				FORM	05/09/2013 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′		CLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245434	B. WING	-		04/2	24/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET		
BETHAN	IY HOME				ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 046 SS=F	fire barriers. The 0 5 smoke zones on the Acute building is diversed floor by fire bar and 2-hours. The facility is protect automatic fire sprint accordance with NF Installation of Sprint The facility has a fire smoke detection with common areas and installed in accordat National Fire Alarm monitored for fire de Hazardous areas has that is on the fire ala with the Minnesotate edition). The facility has a lice and had a census of The requirement at NOT MET as evided NFPA 101 LIFE SA Emergency lighting provided in accordate This STANDARD is Based on an intervi- failed to ensure that	1 Main building is divided into the each floor and the 02 Sub vided into 2 smoke zones on arriers of 30-minutes, 1-hour eted throughout be an kler system installed in TPA 13 Standard for the kler Systems 1999 edition. e alarm system with corridor th smoke detectors in all spaces open to the corridor nce with NFPA 72 "The Code" 1999 edition and is epartment notification. ave automatic fire detection arm system in accordance State Fire Code (2007 ensed capacity of 83 beds f 79 at the time of the survey. 42 CFR Subpart 483.70(a) is need by: FETY CODE STANDARD of at least 1½ hour duration is		000		1	

Event ID: JMFW21

Facility ID: 00108

If continuation sheet Page 3 of 7

	OF DEFICIENCIES	& MEDICAID SERVICES		LTIPLE CONSTRUCTION DING 01 - NURSING HOME		E SURVEY
515.110						
		245434	B. WING	the second second second second second second second second second second second second second second second se	04/	24/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE	IOULD BE	(X5) COMPLETIO DATE
K 046	affect all residents, of an emergency e outage. Findings include:	.1. This deficient practice could staff and visitors in the event vacuation during a power	ĸ	046		
	04/24/2013, during emergency battery maintenance docu the Maintenance C following deficient 1. that the facility f monthly 30 second	ween 10:30 AM to 2:30 PM on the review of available back up exit lighting mentation and interview with oordinator (DL) revealed the practices, ailed to document the 12 maintenance tests for 3 of 4 back up exit lights, and				
		ailed to document the annual 3 of 4 emergency battery back				
K 054 SS=F	Maintenance Coord NFPA 101 LIFE SA All required smoke activating door hold maintained, inspec	nditions were confirmed by the dinator (DL). AFETY CODE STANDARD detectors, including those d-open devices, are approved, ted and tested in accordance rer's specifications. 9.6.1.3	ĸ	<ul> <li>K-54 SS=F</li> <li>Facility did conduct test, records have been life safety log book.</li> <li>4.27.2013</li> <li>Informed Fire Fighter that we need more accord keeping.</li> </ul>	en added to r Detect ccurate	
	Based on interview documentation, the	is not met as evidenced by: v and review of available facility has not been vity testing of the smoke		4. Maintenance will rev ensure proper forms supplied.		

Facility ID: 00108

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/09/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - NURSING HOME		E SURVEY PLETED
		245434	B. WING	<u></u>		04/2	24/2013
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	YHOME				LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 054 K 056 SS=F	Continued From particle could affect with NFPA 72 (99), practice could affect staff. Findings include: On facility tour betwood/24/2013, during available fire alarm interview with the M it was revealed that provide any current test documentation The most current test documentation The most current test documentation The most current test documentation The most current test documentation The most current test documentation The most current test documentation The most current test documentation for the Installed in accordation of the Installation of provide complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete complete	ge 4 e alarm system in accordance Sec. 7-3.2.1. This deficient at all residents, visitors, and veen 10:30 AM to 2:30 PM on a documentation review of the testing documentation and an Maintenance Coordinator (DL), the facility was unable to smoke detector sensitivity at the time of the inspection. esting documentation that was spection was from 2010.		054	K-56 SS=F 1. Escutcheon rings were rep 2. 4.25.13 3. Inspection of escutcheon inspection has been addeed routine monthly maintena	ring 1 to our	
	Water-Based Fire I supervised. There supply for the syste systems are equipt	, and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler bed with water flow and tamper e electrically connected to the system. 19.3.5			task list.		

		AND HUMAN SERVICES				FORM	05/09/2013 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 01 - NURSING HOME		E SURVEY
		245434	B. WING	3		04/	24/2013
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BETHAN	YHOME		_		020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 056	Continued From pa	ge 5	ĸ	056			5
	Based on observat system is not install accordance with NF Standard for the Ins (99). The failure to in compliance with I sprinkler head activ penetration in the ve of combustion to magnetic states of the second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second	s not met as evidenced by: ions, the automatic sprinkler led and maintained in FPA 13 section 3-2.7.2 the stallation of Sprinkler Systems maintain the sprinkler system NFPA 13 (99) could delay the ation and may also cause a ertical lid allowing the products igrate to other locations of the Il residents, visitors and staff					
K 147 SS=D	On facility tour betw 04/24/2013, observe numerous sprinkler from the sprinkler h facility. This deficient condit Maintenance Coord NFPA 101 LIFE SA Electrical wiring and with NFPA 70, Nati This STANDARD is Based on observati the facility had seve not in accordance w Electrical Code. Th	veen 10:30 AM to 2:30 PM on ations reveled that there escutcheon rings missing eads located throughout the tion was confirmed by the inator (DL). FETY CODE STANDARD I equipment is in accordance onal Electrical Code. 9.1.2 s not met as evidenced by: ion and interview with the staff ral electrical appliances found vith NFPA 70 (99), National is deficient practice could of 83 residents, staff and	K 1	147	<ul> <li>K-147 SS=C</li> <li>Missing electrical plates winstalled.</li> <li>4.25.13</li> <li>Painting contractors will binstructed that covers must replaced before leaving.</li> <li>Maintenance will inspect a painting project to ensure oproperly and safely.</li> </ul>	e t be any	

Facility ID: 00108

If continuation sheet Page 6 of 7

		AND HUMAN SERVICES			FOR	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		245434	B. WING		0	4/24/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
BETHAN	Y HOME			1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 147	04/24/2013, it was of light switches locate room that were not protective covers th energized electrical the switches.	veen 10:30 AM to 2:30 PM on observed that there were 3 ed in the dietary dry storage equipped with the required hus allowing access to the I wires that are connected to	K	147		
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: JMFW2	21	Facility ID: 00108	If continuation sl	neet Page 7 of 7

		AND HUMAN SERVICES				FORM	05/09/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION 02 - SUB ACUTE		E SURVEY PLETED
		245434	B. WING	·		04/	24/2013
NAME OF P	ROVIDER OR SUPPLIER Y HOME			10	EET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000		٢S	ĸ	000			
×	FIRE SAFETY				SERENE		
	ALLEGATION OF O DEPARTMENTS A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.			MAY 2 2 2013		
	AN ONSITE REVIS BE CONDUCTED T SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, IT OF YOUR FACILITY MAY TO VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.			POCOK 8 5-28-13	8	
	Minnesota Departm time of this survey, in substantial comp for participation in M Subpart 483.70(a), 2000 edition of Nati Association (NFPA)	Survey was conducted by the pent of Public Safety. At the Bethany Home was found not liance with the requirements Medicare/Medicaid at 42 CFR, Life Safety from Fire, and the onal Fire Protection Standard 101, Life Safety er 19 Existing Health Care.			121		
	PLEASE RETURN CORRECTION FOR DEFICIENCIES TO	R THE FIRE SAFETY					
	HEALTH CARE FIR STATE FIRE MARS 444 CEDAR STREE ST. PAUL, MN 5510	SHAL DIVISION ET, SUITE 145					
	By e-mail to:	9					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
CTal	two Monds				Execution Christin	5/17	113

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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/09/2013 APPROVED 0938-0391	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION G 02 - SUB ACUTE		E SURVEY PLETED	
		245434	B. WING	<u>}</u>		04/24/2013		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET					
BETHAN	IY HOME				ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
K 000	Barbara.lundberg@ and Marian.Whitney@s THE PLAN OF COI DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pro 3. The name and/or responsible for corr prevent a reoccurre The facility was sur the Sub Acute build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964 build north of the 1964	estate.mn.us tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: what has been, or will be, done ency.	K	000				

Facility ID: 00108

If continuation sheet Page 2 of 9

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 02 - SUB ACUTE	(X3) DATI	E SURVEY PLETED
		245434	B. WING	3		04/:	24/2013
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 1 <b>020 LARK STREET</b>		
BETHAN	IY HOME			I	ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	٦X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000 K 011 SS=D	National Fire Alarm monitored for fire de Hazardous areas ha that is on the fire ala with the Minnesota edition). The facility has a lice and had a census of The requirement at NOT MET as evide NFPA 101 LIFE SA If the building has a nonconforming build barrier having at lea rating constructed of addition. Communi- corridors and are priself-closing fire door This STANDARD is Observations revea penetration in a fire did not meet the rate fire separation and a NFPA 101 "The Life (LSC) section 19.1." practices could allow to travel from one build	Code" 1999 edition and is epartment notification. ave automatic fire detection arm system in accordance State Fire Code (2007 ensed capacity of 83 beds of 79 at the time of the survey. 42 CFR Subpart 483.70(a) is need by: FETY CODE STANDARD common wall with a ding, the common wall is a fire ist a two-hour fire resistance of materials as required for the cating openings occur only in otected by approved rs. 19.1.1.4.1, 19.1.1.4.2 a not met as evidenced by: Need that there was barriers within the facility that ed requirements for two hour are not in accordance with Safety Code" 2000 edition 1.4.3,. These deficient v the products of combustion uilding to another, which could the residents, staff and		000	<ul> <li>K-11 SS=D</li> <li>Penetration around electric conduit was sealed.</li> <li>5.17.2013</li> <li>Contractors are informed to construction that fire bar must be sealed upon completion.</li> <li>Maintenance staff will ins contractors work to ensure are sealed before contractor paid.</li> </ul>	prior arrier pect holes	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G <b>02 - SUB ACUTE</b>		E SURVEY
		245434	B. WING		04/	24/2013
	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
K 011 K 038 SS=D	Findings include: On facility tour betw 04/24/2013, observ fire separation wall wing from the senic have a penetration. around the electricat that is located over penetration is passi separation wall and approved through p intumescent fire car This deficient condi Maintenance Cooro NFPA 101 LIFE SA Exit access is arran accessible at all tim 7.1. 19.2.1 This STANDARD is Based on observat facility failed to prov of several means of the following require Section 19.2.1 and (1) and the 2007 MI	veen 10:30 AM to 2:30 PM on ation revealed, that the 2 hour separating the memory care or apartments was found to The penetration was found al conduit above the ceiling tile the china hutch. The ing through the 2 hours is not sealed with an benetration fire rated ulking.	К 01		our facility	

	and a second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second second sec	AND HUMAN SERVICES				FORM	05/09/2013 APPROVED 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G 02 - SUB ACUTE		E SURVEY PLETED		
		245434	B. WING	3		04/2	24/2013		
NAME OF P	ROVIDER OR SUPPLIER		21		TREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET				
	SUMMADY STA	TEMENT OF DEFICIENCIES	ID	ALEXANDRIA, MN 56308					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
K 038	On facility tour betw 04/24/2013, observ failed to maintain th snow. The snow w on the egress disch was banking toward condition made the	veen 10:30 AM to 2:30 PM on ration revealed that the facility he rehab south exit clear of as approximately 2 feet deep harge to the public way and ds the facility. This deficient rehab south exit discharge	K	03	8				
K 046	emergency. The si south exit door limit approximately 18 in limiting the access These deficient pra Maintenance Coord	ress in the event of an now was also blocking rehab ting the door swing down to an oches of clear width also to the exit discharge. ctices were confirmed by the dinator (DL). JFETY CODE STANDARD	K	040	6				
SS=F		of at least 1½ hour duration is ance with 7.9. 19.2.9.1.			K-46 SS=F 1. The 3 lights were tested 2. 4.25.2013 3. The lights were added to				
	Based on an interv failed to ensure tha been tested in acco Section 7.9, 19.2.9. affect all residents,	s not met as evidenced by: iew with staff, the facility has t 3 of 4 emergency lights have ordance with NFPA LSC (00) 1. This deficient practice could staff and visitors in the event vacuation during a power			monthly check list				
	04/24/2013, during emergency battery	veen 10:30 AM to 2:30 PM on the review of available back up exit lighting nentation and interview with							
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: JMFW2	21	F	acility ID: 00108 If continue	ation shee	et Page 5 of 9		

TATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D2 - SUB ACUTE		E SURVEY PLETED
		245434	B. WING			04/	24/2013
	PROVIDER OR SUPPLIER			10	EET ADDRESS, CITY, STATE, ZIP CODE D20 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 046 K 054 SS=F	following deficient p 1. that the facility fa monthly 30 second emergency battery 2. that the facility fa 90 minute test for 3 up exit lights. These deficient com Maintenance Coord NFPA 101 LIFE SA All required smoke activating door hold maintained, inspect with the manufactur This STANDARD is Based on interview documentation, the conducting sensitivid detectors on the fire with NFPA 72 (99), practice could affect staff. Findings include: On facility tour betw 04/24/2013, during available fire alarm	bordinator (DL) revealed the bractices, ailed to document the 12 maintenance tests for 3 of 4 back up exit lights, and ailed to document the annual 3 of 4 emergency battery back ditions were confirmed by the linator (DL). FETY CODE STANDARD detectors, including those -open devices, are approved, ed and tested in accordance	KO		<ul> <li>K-54 SS=F</li> <li>1. Facility did conduct sensitive test, records have been adder life safety log book.</li> <li>2. 4.27.2013</li> <li>3. Informed Fire Fighter Deter that we need more accurate record keeping.</li> <li>4. Maintenance will review to ensure proper forms are supplied.</li> </ul>	ed to	

Facility ID: 00108

If continuation sheet Page 6 of 9

Shart March of DEFIDIENCIAL Not PLAN OF CORRECTION     (x1) PROVIDERSUPPLIENCIAL DENTIFICATION NUMBER     (x2) MULTIFIE CONSTRUCTION A BULINING 02 - SUB ACUTE     (x3) DATE SURVEY COMPLETED       NAME OF PROVIDER OR SUPPLIER BETHANY HOME     245434     Image: Street F ADORESS, CITY, STATE, 2P CODE 1020 LARK STREET ALEXANDRIA, MN 55306     04/24/2013       NAME OF PROVIDER OR SUPPLIER BETHANY HOME     STREET ADORESS, CITY, STATE, 2P CODE 1020 LARK STREET ALEXANDRIA, MN 55306     04/24/2013       K 054     Continued From page 6 it was revealed that the facility was unable to provide any current smoke detector sensitivity test documentation at the time of the inspection. The most current testing documentation that was found during the inspection. The finate occordinator (0L).     K 054       K 056     NFPA 101 LIFE SAFETY CODE STANDARD provide omy current spream is propenty maintained in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, It is inspection, resiting, and Maintenance of the was dianged water-Based Fine Protection Systems, It is systems are equipped with water flow and tamper systems are equipped with water flow and tamper systems are electrically connected to the building fine astern system. 19.3.5     K 056       This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 (Secultade solution fine astern system. 19.3.5     Standard for the Installation of Sprinkler Systems (9). The failure to maintain the sprinkler system is not installed and maintained in accordance with NFPA 13 (Secultade) and maintained in accordance with NFPA 13 (Secultade) and maintained in accordance with NFPA 13 (Secultade) and maintained in accordance with NFPA 13 (Se	The second second second second second		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
NAME OF PROVIDER ON SUPPLIER     STREET ADDRESS, GITY, STATE, 2P CODE       BETHANY HOME     SITREET ADDRESS, GITY, STATE, 2P CODE       Image: State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State State	STATEMEN'I	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					
BETHANY HOME     1202 LARK STREET       (X4) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EQCH DEFICIENCY MUST BE PRECEDED BY FULL (EQCH DEFICIENCY ON ISO DETIFICIENCIES) (EQCH DEFICIENCY ON ISO DETIFICIENCIES) (EQCH DEFICIENCY ON ISO DETIFICIENCIES) (EQCH DEFICIENCY ON ISO DETIFICATION)     PREFIX TAG     PREVIX (EQCH DEFICIENCY)     Continued From page 6 it was revealed that the facility was unable to provide any current smoke detector sensitivity test documentation at the time of the inspection. The most current testing documentation that was found during the inspection was from 2010.     K 054     K 054     K 056       K 058     Fit here is an automatic sprinkler system, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 13, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5     K 056       This STANDARD Is not met as evidenced by: Based on observations, the automatic sprinkler systems are the stalled on definition accordance with NFPA 13 (Standard for the building fire alarm system. 19.3.5     Inspection has been added to our routine monthly maintenance task list.       This STANDARD Is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 (Section 3-2.7.2 the Standard for the installation of Sprinkler Systems (9). The failure to maintain the sprinkler system in compliance with NFPA 13 (Section 3-2.7.2 the Standard for the installed on and may also cause a penetration in the			245434	B. WING	-		04/2	24/2013
BETHANY HOME     ALEXANDRIA, MN 69308       (X4)01 PRETX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUATORY OR LSC DENTIFYING INFORMATION)     D PROVIDER'S FUNC ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY     COMEDICATION (EACH OPERCIENCY ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY     Come CROSS-REFERENCE TO CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY     Come CROSS-REFERENCE TO CROSS-REFERENCE TO CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY     CROSS-REFERENCE This SECTION THE APPROPRIATE DEFICIENCY     CROSS-REFERENCE This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 (99) could delay the sprinkler head activation and may also cause a penetration in the vertical II data Univer the VICLUS OF combustion to migrate to other locations of the     CROSS-REFERENCE TO CROSS-REFERENCE	NAME OF P	ROVIDER OR SUPPLIER						
PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LISC IDENTIFYING INFORMATION)       PREFIX TAG       CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE       CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE         K 054       Continued From page 6 it was revealed that the facility was unable to provide any current smoke detector sensitivity test documentation at the time of the inspection. The most current tasting documentation that was found during the inspection was from 2010.       K 056         K 056       NFPA 101 LIFE SAFETY CODE STANDARD SS=F       K 056         If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the inspection fees the isonal sprinkler system. It is fully supervised. There is a reliable, addeuta water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5       K 056         This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 (69) could detay the sprinkler head activation and may also cause a penetration in the vertical il (all owing the products of combustion to migrate to other locations of the       Net all could detay the sprinkler head activation and may also cause a penetration in the vertical il (all owing the products of combustion to migrate to other locations of the	BETHAN	YHOME						
<ul> <li>it was revealed that the facility was unable to provide any current smoke detector sensitivity test documentation at the time of the inspection. The most current testing documentation that was found during the inspection was from 2010.</li> <li>K 056</li> <li>K 056</li> <li>NFPA 101 LIFE SAFETY CODE STANDARD</li> <li>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13. Standard for the Installed or accordance system. The system set equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</li> <li>This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed on accordance with NFPA 13. Section 3.2.7.2 the Standard for the Installed on accordance with NFPA 13 (99) could delay the sprinkler head activation and maintained in accordance with NFPA 13 (99) could delay the sprinkler head activation and may also cause a penetration in the vertical lid allowing the products of combustion to migrate to other locations of the</li> </ul>	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
of combustion to migrate to other locations of the	K 056	it was revealed that provide any current test documentation The most current to found during the inst This deficient cond Maintenance Coord NFPA 101 LIFE SA If there is an autom installed in accordat for the Installation of provide complete c building. The syste accordance with NI Inspection, Testing Water-Based Fire F supervised. There supply for the syste systems are equipp switches, which are building fire alarm s This STANDARD in Based on observat system is not instal accordance with NI Standard for the Instal (99). The failure to in compliance with	t the facility was unable to t smoke detector sensitivity at the time of the inspection. esting documentation that was spection was from 2010. ition was confirmed by the dinator (DL). AFETY CODE STANDARD natic sprinkler system, it is ance with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the em is properly maintained in FPA 25, Standard for the , and Maintenance of Protection Systems. It is fully is a reliable, adequate water em. Required sprinkler bed with water flow and tamper e electrically connected to the system. 19.3.5 is not met as evidenced by: tions, the automatic sprinkler led and maintained in FPA 13 section 3-2.7.2 the stallation of Sprinkler Systems maintain the sprinkler system NFPA 13 (99) could delay the			K-56 SS=F 1. Escutcheon rings were repl 2. 4.25.13 3. Inspection of escutcheon ri inspection has been added routine monthly maintenan	ng to our	
		of combustion to m	igrate to other locations of the		F-		otion abo	Page 7 of f

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>02 - SUB ACUTE</b>				(X3) DATE SURVEY COMPLETED	
245434			B. WING				24/2013	
	PROVIDER OR SUPPLIER			1020	r Address, City, State, ZIP Code Lark Street XANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
K 056 K 072 SS=D	facility thus affect a of the facility. Findings include: On facility tour betw 04/24/2013, observent numerous sprinkler from the sprinkler h facility. This deficient cond Maintenance Coord NFPA 101 LIFE SA Means of egress at of all obstructions of use in the case of f furnishings, decora exits, access to, eg 7.1.10 This STANDARD Based on observa the means of egress obstructions or imp the case of fire or of accordance with NI (2000 edition) Chap obstructions could and effective removisitors in an emerg	Il residents, visitors and staff ween 10:30 AM to 2:30 PM on rations reveled that there rescutcheon rings missing leads located throughout the ition was confirmed by the tinator (DL). FETY CODE STANDARD re continuously maintained free or impediments to full instant ire or other emergency. No tions, or other objects obstruct ress from, or visibility of exits.	KO	072	<ul> <li>K-72 SS=F</li> <li>1. Chairs were removed from hallway.</li> <li>2. 4.25.13</li> <li>3. Restorative and nursing were educated on the new keep hallways clear.</li> <li>4. Safety Committee staff monitor to ensure comp</li> </ul>	staff ed to will		

		AND HUMAN SERVICES				FORM	05/09/2013 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUB ACUTE			(X3) DATE SURVEY COMPLETED			
245434			B. WING		04/24/2013				
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K 072	Continued From pa	ge 8	кс	)72					
	Findings include:	6				2			
	04/24/2013, it was a several chairs locat primarily by wall mo locations were note facility for the surve being moved at 12:3 through.	veen 10:30 AM to 2:30 PM on observed that there were ed in rehab corridor located ounted computers. The chair d at 10:30 upon entry to the y and again noted as not 30 PM during the facility walk ce was confirmed by the inator (DL).							
	67(02-99) Previous Versions (	Obsolete Event ID: JMFW2			v ID: 00108		t Page 9 of 9		