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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JMFW
Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245434**

2. STATE VENDOR OR MEDICAID NO. (L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/19/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **83** (L18)

13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gail Anderson, Unit Supervisor 09/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 12/31/2013 CO.
JMFW

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/20/2013** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

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

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 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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245434	A. Building B. Wing	6/11/2013

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	05/24/2013	ID Prefix F0311 Reg. # 483.25(a)(2) LSC	05/24/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	05/24/2013
ID Prefix F0371 Reg. # 483.35(i) LSC	05/30/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PK/cl	09/27/13	28034	06/11/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/25/2013				

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245434	01 - NURSING HOME	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0046	04/25/2013	ID Prefix Reg. # NFPA 101 LSC K0054	04/27/2013	ID Prefix Reg. # NFPA 101 LSC K0056	04/25/2013
ID Prefix Reg. # NFPA 101 LSC K0147	04/25/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	09/27/13	27200	08/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/24/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245434	02 - SUB ACUTE	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	05/17/2013	ID Prefix Reg. # NFPA 101 LSC K0038	04/27/2013	ID Prefix Reg. # NFPA 101 LSC K0046	04/25/2013
ID Prefix Reg. # NFPA 101 LSC K0054	04/27/2013	ID Prefix Reg. # NFPA 101 LSC K0056	04/25/2013	ID Prefix Reg. # NFPA 101 LSC K0072	04/25/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	09/27/13	27200	08/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/24/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Loveland, Jim (MDH)

From:	Suzuki, Jan M. (CMS/CQISCO) <Jan.Suzuki@cms.hhs.gov>
Sent:	Thursday, August 08, 2013 1:38 PM
To:	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

Name: Bethany Home

City, State: Alexandria, MN

DPNA Date: 07/25/2013

Termination Date: 10/25/2013

FMS Survey Date: 05/16/2013

Fed Surveyor: 32897

Contr Surveyor:

S/S	Tag	POC Date or Temporary Waiver ("TW") Date or Waiver ("AW")
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
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

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 David Hioss

Fax Number 1-443-380-7201

From Patrick McDonald

Telephone/Fax 1-320-762-5316

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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 01 - NURSING HOME B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 5/16/13 following a Minnesota Department of Public Safety survey on 4/24/13. At this Comparative Federal Monitoring Survey, Bethany Home was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Bethany Home facility was surveyed as four buildings as follows: Building-0104 Nursing Home, is 1-story structure with full basement of Type II (000) constructed in 1962 and 1977. Building-0204 Sub Acute, is 3-story structure with no basement of Type II (111) constructed in 2003. Building-0204 is connected to Building-0104 and separated by a 2-hour Fire Barrier. Building-0204 is also connected to an assisted living occupancy that was not surveyed because it was separated from the assisted living occupancy by a 2-hour fire barrier. Building-0304 Chapel, is a 1-story structure with no basement of Type IV (Heavy Timber) constructed in 2002. What is referred to as Building-0404 for survey purposes, Building-0404 is the 1-st floor of the east wing of Building-0104 and the South entrance area of Building-0204 that were both	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 6/19/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 01 - NURSING HOME B. WING ____	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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:	K 000		
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 01 - NURSING HOME B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor doors that meet the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.3, 19.3.6.3.1, 19.3.6.3.2 and 19.3.6.4. This deficient practice could affect all of the 77 residents and an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 3:50 pm, observation revealed that the double doors leading from the corridor into the Community Room would not shut and latch properly because they did not have a coordinator on them. 2. On 5/16/13 at 4:45 pm, observation revealed that the double doors leading into the STR Room would not shut and latch properly because they did not have a coordinator on them. 3. On 5/16/13 at 5:35 pm, observation revealed that the double bi-fold doors on the linen closet by Room 2128 do not automatically latch. 4. On 5/16/13 at 6:28 pm, observation revealed that the double bi-fold doors on the A-05 Linen closet do not automatically latch. 5. On 5/16/13 at 6:35 pm, observation revealed that the pair of bi-fold doors on the Activity Room	K 018	K018 SS=F 1. Door coordinator was placed on door. Date of Completion: 6/8/2013 2. Door coordinator was placed on door. Date of Completion:6/8/2013 3. Heinz construction contacted bid for door replacement accepted. To be completed by 7/24/2013. 4. Heinz construction contacted bid for door replacement accepted. To be completed by 7/24/2013. 5. Heinz construction contacted bid for door replacement accepted. To be completed by 7/24/2013. 6. Heinz construction contacted bid for door replacement accepted. To be completed by 7/24/2013. All bi-fold hallway closet doors, not up to code are to be replaced.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	245434	A. BUILDING 01 - NURSING HOME B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 did not close and latch because they did not have a coordinator on them. 6. On 5/16/13 at 6:37 pm, observation revealed that the double bi-fold doors on the linen closet near Room A-13 did not automatically latch. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide properly fire-stopped smoke barriers in accordance with LSC Section 19.3.7.3. This deficient practice could affect 8 of the 77 residents, as well as an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 3:30 pm, observation revealed a	K 025	K025 SS=E 1. Hole was sealed with ASTME 8-14, UL14979, UBC 7-5 Flame Buster Intumescent Silicone Sealant. Date of Completion: 6/4/2013 2. Hole was sealed with ASTME 8-14, UL14979, UBC 7-5 Flame Buster Intumescent Silicone Sealant. Date of Completion: 6/4/2013 Contractors installing radio equipment will be informed of the necessary fire codes before starting work. The maintenance director will inspect the work before paying contractors.	

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K 025	Continued From page 4 2" by 3" hole, 2" diameter hole, and a 1" diameter hole above the drop ceiling on the lower level between the Kitchen and the Locker Room. 2. On 5/16/13 at 3:37 pm, observation revealed a 5" by 4" hole and a 6" diameter hole with a 4" pipe passing through in the smoke compartment wall of the Staff Dining Room. These deficient practices were confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 025		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.2.1, 7.1.6, 7.2.5 and Table 7.2.6.2 (a). This deficient practice could affect approximately 14 of the 77 residents and an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 4:00 pm, observation revealed that the Electrical Room opened directly into Stair Shaft 13. 2. On 5/16/13 at 4:48 pm, observation revealed	K 038	K038 SS=E 1. Heinz construction contacted bid to move door accepted. To be completed by 7/24/2013. 2. Signs were placed on doors in Kalina dining room. Date complete: 6/4/2013 3. Alexandria Electronics contacted one handed door system to be installed by 7/24/2013 4. Deadbolt lock was caped and new one handed door operation was installed. Date completed: 6/7/2013 5. Deadbolt lock was caped and new one handed door operation was installed. Date completed: 6/7/2013 There are no other electrical panel room doors exiting into a stair shaft. Two handed operating locks will not be used. The signs are corrected.	

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K 038	Continued From page 5 that 2 doors in the Kalina Dining Room could visually be confused as exit doors but were not actual exit discharge doors and were not marked as not an exit. 3. On 5/16/13 at 6:10 pm, observation revealed that the 2nd floor east stair door by the E-Dining Room required holding a button in on the frame at approximately 5' high while turning the lever handle to open the door. This door required two operations to open. 4. On 5/16/13 at 6:45 pm, observation revealed that the MDS Room door had a Dead Bolt lock at approximately 5' high and a locking lever handle at approximately 4' high. This door required two operations to open. 5. On 5/16/13 at 6:50 pm, observation revealed that the RN Managers Office door had a Dead Bolt lock at approximately 5' high and a locking lever handle at approximately 4' high. This door required two operations to open. These deficient practices were confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 038		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of	K 051		

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K 051	Continued From page 6 nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records 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 - 1999 edition, Sections 2-1.3 and 2-1.3.2. This deficient practice could affect approximately all of the 77 residents and an undetermined number of staff and visitors. Findings include: On 5/16/13 at 4:14 pm, observation revealed in the Boiler Room that there was no smoke detector located over the Main Fire Alarm panel This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 051	K051 SS=F 1. Fire Fighter & Detect Alarm Company will install smoke detector over the main fire alarm panel. Date Completed:7/24/2013 Fire Fighter & Detect Alarm Company will tour facility and install any other missing alarms.	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		

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K 062 SS=F	Continued From page 7 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to test and maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2.2.1.1, 2-4.1.4, 9-7, 9-7.1 and Table 2-1. This deficient practice could affect all 77 residents and an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 3:51 pm, observation revealed that a sprinkler in the Women's Restroom by the Dry Storage Room had foreign material. 2. On 5/16/13 at 4:07 pm, observation revealed that a sprinkler in the Soiled Utility Room had a piece of a clear plastic bag hanging from it. 3. On 5/16/13 at 4:20 pm, observation revealed that a sprinkler in the Kitchen Hallway was missing the escutcheon ring. 4. On 5/16/13 at 4:25 pm, observation revealed in the Kitchen Chemical Storage Room that boxes were being stored within 8" of the sprinkler.	K 062	K062 SS=F 1. Sprinkler head was cleaned. Date completed: 6/4/2013 2. Plastic bag was removed: Date completed: 6/4/2013 3. Escutcheon ring was replaced. Date completed: 6/4/2013 4. Boxes removed and top shelf taken down to stop storage blocking sprinkler head. Date complete:6/4/2013 Sprinkler heads are placed on safety committee's inspection sheet; any dirty or painted sprinkler heads will be reported to maintenance and cleaned. Escutcheon rings are going to be placed on safety committee monthly audit sheets and missing will be reported to maintenance and replaced. New shelving won't allow storage within 8 inches of a sprinkler head.	

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K 062	Continued From page 8 This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 062		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 - 2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96 - 1998 edition, Section 3-2.2. This deficient practice could affect 28 of the 77 residents and an undetermined number of staff and visitors. Findings include: On 5/16/13 at 4:30 pm, observation revealed that a telephone was mounted under the kitchen hood suppression 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.	K 069	K069 SS=F 1. Telephone was moved. Date complete: 6/7/2013 No shelving or telephones will be installed in front of a pull station.	
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 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	K 073		

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K 073	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 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 073	K073 SS=E 1. Candle wick was clipped. Date Complete: 6/3/13 2. Candle wick was clipped. Date Complete: 6/3/13 Housekeeping is going to add candles to facility and room inspections, no candles with wicks are allowed with wicks, they will be clipped or removed.	
K 074 SS=E	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 NFPA 701. Newly introduced upholstered 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 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3	K 074		

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K 074	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide cubicle curtain and drapery materials meeting the requirements of NFPA 101 - 2000 edition, Sections 19.7.5.1 and 10.3.1. This deficient practice could affect 10 of the 77 residents and an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 3:48 pm, observation revealed that the cubicle curtains located in room WWHO did not have tags indicating that they were fire retardant. The facility had no documentation on the fire retardant nature of the cubicle curtain fabric and when asked if the cubicle curtains were fire retardant the Maintenance Coordinator replied. "I don't know." 2. On 5/16/13 at 6:05 pm, observation revealed that the window drapes located in rooms 2215, 2216, 2115, 2210, 2208, 2206, 2203, 2102, 2103, 2104, 2105, 2106, 2107, 2211, 2212, and 2214 did not have tags indicating that they were fire retardant. The facility had no documentation on the fire retardant nature of these window drape fabrics and the Maintenance Coordinator said "We don't have any information on those." This deficient practice was confirmed by the Maintenance Coordinator and the Education	K 074	K074 SS=E 1. Documentation on cubical curtains has been located. Only 2 types of curtains are used in our facility. Products are Click ezy, & Creative Healthcare Products labeled as permanently flame retardant cubical curtains. Fire rating labels were top left corner. Date complete: 6/5/2013 2. Window curtains are going to be treated for fire rating protection. Commercial Cleaners will treat all curtains in our resident rooms and facility that do not have flame spread ratings. Date complete 7/1/2013. Curtains purchased or replaced will be fire rated or treated. Documentation will be stored for fire marshal to be able to review.	

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K 074	Continued From page 11 Coordinator at the time of discovery.	K 074		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to prevent the improper use of power strips in accordance with LSC Sections 9.1.2 and 19.5.1 and NFPA 70, Sections 305-2 and 400.8, 1999 Edition. This deficient practice could affect 22 of the 77 residents, as well as an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 3:50 pm, observation revealed a floor fan was plugged into a power strip in the VJ Office. 2. On 5/16/13 at 4:16 pm, observation revealed in the Boiler Room that an electric junction box did not have a cover and the wires were hanging out of the box. 3. On 5/16/13 at 6:30 pm, observation revealed in the E-Dining Room by Room 2106 that there was a standard electrical outlet within 3' of a water faucet. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 147	K147 SS=E 1. Office fan was plugged into wall. Complete: 6/7/13 2. Junction box was covered. Complete: 6/7/13 3. Outlet is covered by first ground fault in the circuit. Complete: 6/7/13 Staff were educated about proper equipment allowed for power strips, quality committee will audit to make sure they are used properly	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245434	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUB ACUTE B. WING	(X3) DATE SURVEY COMPLETED 05/16/2013

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K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 5/16/13 following a Minnesota Department of Public Safety survey on 4/24/13. At this Comparative Federal Monitoring Survey, Bethany Home was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Bethany Home facility was surveyed as four buildings as follows: Building-0104 Nursing Home, is 1-story structure with full basement of Type II (000) constructed in 1962 and 1977. Building-0204 Sub Acute, is 3-story structure with no basement of Type II (111) constructed in 2003. Building-0204 is connected to Building-0104 and separated by a 2-hour Fire Barrier. Building-0204 is also connected to an assisted living occupancy that was not surveyed because it was separated from the assisted living occupancy by a 2-hour fire barrier. Building-0304 Chapel, is a 1-story structure with no basement of Type IV (Heavy Timber) constructed in 2002. What is referred to as Building-0404 for survey purposes, Building-0404 is the 1-st floor of the east wing of Building-0104 and the South entrance area of Building-0204 that were both	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Executive Direct (X6) DATE 6/18/13

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

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BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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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 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:	K 000		
K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide interior finish materials that meet the flame spread requirements of NFPA 101 - 2000 edition, Sections 19.3.3.1, 19.3.3.2 and 10.2.3. This deficient practice could affect 9 of the 77 residents, as well as an undetermined number of staff and visitors.	K 014		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245434	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - SUB ACUTE B. WING	(X3) DATE SURVEY COMPLETED 05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 014	Continued From page 2 Findings include: On 5/16/13 at 4:50 pm, observation revealed that in the main lobby area there was wood paneling up to 48 inches on all walls. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 014	K014 SS=E 1. Oak is rated at 100 by the ASTM. See Attached: Date complete: 6/7/2013 Fire rating and documentation on 2003 construction will be stored in the administrator's office for fire marshal to review.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to test and maintain its automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2.2.1.1, 2-4.1.4, 9-7, 9-7.1 and Table 2-1. This deficient practice could affect all 77 residents and an undetermined number of staff and visitors. Findings include: On 5/16/13 at 4:31 pm, observation revealed that a sprinkler in the Short Term Rehab Spa was not free of foreign material. This deficient practice was confirmed by the	K 062	K062 SS=E 1. Sprinkler head was cleaned of foreign material and paint. Date Complete: 6/4/2013 Sprinkler heads added to safety committee facility inspection sheet any foreign material will be replaced by maintenance.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 02 - SUB ACUTE B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 062		
K 103 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install all framing of interior walls of non-combustible construction in accordance with the requirements of NFPA 101 2000 edition, section 19.1.6.3. This deficient practice could affect approximately 12 of the 77 residents and an undetermined number of staff and visitors. Findings include: On 12/13/12 at 3:30 pm, observation revealed that the building was a non-combustible type of construction and interior walls in the Director of Nursing office were of wood framed construction. These deficient practices were confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 103		

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	245434	A. BUILDING 02 - SUB ACUTE B. WING	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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K 062	Continued From page 3 Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 062		
K 103 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior walls and partitions in buildings of Type I or Type II construction are noncombustible or limited-combustible materials. 19.1.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install all framing of interior walls of non-combustible construction in accordance with the requirements of NFPA 101 2000 edition, section 19.1.6.3. This deficient practice could affect approximately 12 of the 77 residents and an undetermined number of staff and visitors. Findings include: On 12/13/12 at 3:30 pm, observation revealed that the building was a non-combustible type of construction and interior walls in the Director of Nursing office were of wood framed construction. These deficient practices were confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 103	K103 SS=E 1. Heinz Construction is going to replace wood frame with steel to be completed by 7/24/2013. Wood frame construction will not be used in the future.	

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	245434	A. BUILDING 03 - CHAPEL AREA B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 5/16/13 following a Minnesota Department of Public Safety survey on 4/24/13. At this Comparative Federal Monitoring Survey, Bethany Home was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Bethany Home facility was surveyed as four buildings as follows: Building-0104 Nursing Home, is 1-story structure with full basement of Type II (000) constructed in 1962 and 1977. Building-0204 Sub Acute, is 3-story structure with no basement of Type II (111) constructed in 2003. Building-0204 is connected to Building-0104 and separated by a 2-hour Fire Barrier. Building-0204 is also connected to an assisted living occupancy that was not surveyed because it was separated from the assisted living occupancy by a 2-hour fire barrier. Building-0304 Chapel, is a 1-story structure with no basement of Type IV (Heavy Timber) constructed in 2002. What is referred to as Building-0404 for survey purposes, Building-0404 is the 1-st floor of the east wing of Building-0104 and the South entrance area of Building-0204 that were both	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive director (X6) DATE: 6/19/13

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 03 - CHAPEL AREA B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 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:	K 000		
K 015 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide interior finish materials that meet	K 015		

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	245434	A. BUILDING 03 - CHAPEL AREA B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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K 015	Continued From page 2 the flame spread requirements of NFPA 101 - 2000 edition, Sections 19.3.3.1, 19.3.3.2 and 10.2.3. This deficient practice could affect 10 of the 77 residents and an undetermined number of staff and visitors. Findings include: On 5/16/13 at 5:45 pm, observation revealed that there was 54 inches of wood paneling on all walls in the Chapel. The Maintenance Coordinator stated "I have no idea what the flame spread is for the wood paneling." This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 015	K015 SS=E 1. Oak is rated at100 by the ASTM. See attached: Date complete: 6/7/2013 Fire rating and documentation on 2003 construction will be stored in the administrator's office for fire marshal to review.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.2.1, 7.1.6, 7.2.6, 7.8.1, and Table 7.2.5.2 (a). This deficient practice could affect approximately 50 of the 77 residents and an undetermined number of staff and visitors. Findings include:	K 038		

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	245434	A. BUILDING 03 - CHAPEL AREA B. WING ____	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 3 1. On 5/16/13 at 5:46 pm, observation revealed that the north Chapel entrance has a 2" step at the threshold. 2. On 5/16/13 at 5:48 pm, observation revealed that the north Chapel entrance has a steep grade drop at the edge of the sidewalk, just outside of the exit door, of a 3' drop in a 5' foot distance and has no hand rail or guard rail. 3. On 5/16/13 at 5:50 pm, observation revealed that the delay egress doors out of the Chapel are set for a 30 second delay. When asked if the facility had approval from an AHJ for the 30 second delay egress locks, the Maintenance Coordinator said "I don't think so." These deficient practices were confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 038	K038 SS=E 1. Alexandria Welding bid has been received and approved a steel seam will be installed to level sidewalk. Date complete: 7/24/2013 2. Alexandria Welding bid has been received and approved handrail will be installed along sidewalk. Date complete: 7/24/2013 3. Alexandria Electronics to update door to current code. Date complete: 7/24/2013	
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 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 combustible decorations in accordance with NFPA 101 - 2000 edition, Section 19.7.5.4. This could affect approximately 60 of the 77 residents and an undetermined number of staff and visitors. Findings include: On 5/16/13 at 5:55 pm, observation revealed that	K 073	K073 SS=E 1. Candle wick was clipped. Date Complete: 6/3/13 Housekeeping is going to add candles to facility and room inspections, no candles with wicks are allowed with wicks, they will be clipped or removed.	

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	245434	A. BUILDING 04 - 2012 RENOVATED AREA B. WING ______	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 5/16/13 following a Minnesota Department of Public Safety survey on 4/24/13. At this Comparative Federal Monitoring Survey, Bethany Home was found to be not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Bethany Home facility was surveyed as four buildings as follows: Building-0104 Nursing Home, is 1-story structure with full basement of Type II (000) constructed in 1962 and 1977. Building-0204 Sub Acute, is 3-story structure with no basement of Type II (111) constructed in 2003. Building-0204 is connected to Building-0104 and separated by a 2-hour Fire Barrier. Building-0204 is also connected to an assisted living occupancy that was not surveyed because it was separated from the assisted living occupancy by a 2-hour fire barrier. Building-0304 Chapel, is a 1-story structure with no basement of Type IV (Heavy Timber) constructed in 2002. What is referred to as Building-0404 for survey purposes, Building-0404 is the 1-st floor of the east wing of Building-0104 and the South entrance area of Building-0204 that were both	K 000		

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

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 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:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall 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 NFPA 80, 1998 Edition. This deficient practice could affect 50 of the 77 residents, as well as an undetermined number of	K 011		

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	245434	A. BUILDING 04 - 2012 RENOVATED AREA B. WING ________	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 would not close and latch because they did not have a coordinator. This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 011	K011 SS=E 1. Door coordinator installed on doors. Date complete: 7/7/13	
K 014 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, 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: Based on observation and interview, the facility failed to provide interior finish materials that meet the flame spread requirements of NFPA 101 - 2000 edition, Sections 18.3.3.1, 19.3.3.2 and 10.2.3. This deficient practice could affect 9 of the 77 residents, as well as an undetermined number of staff and visitors. Findings include: On 5/16/13 at 4:50 pm, observation revealed that at the main lobby area there was wood paneling up to 48 inches on all walls.	K 014	K014 SS=E 1. Oak is rated at 100 by the ASTM. See Attached: Date complete: 6/7/2013 Fire rating and documentation on 2003 construction will be stored in the administrator's office for fire marshal to review.	

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K 014	Continued From page 3 This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 014		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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: Based on observation and interview, the facility failed to provide means of egress in accordance with the requirements of NFPA 101 - 2000 edition, Sections 18.2.1, 7.1.6, 7.2.5 and Table 7.2.5.2 (a). This deficient practice could affect approximately 8 of the 77 residents and an undetermined number of staff and visitors. Findings include: 1. On 5/16/13 at 3:35 pm, observation revealed that Stair 13 discharge was not obvious because there was no exit sign above the door. 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.	K 038	K38 SS=E 1. Light bulb replaced and exit sign visible. Date complete 6/7/2013 2. Sign stating delayed egress installed. Date complete 6/7/2013 3. Alexandria electronics bid received and door alarm going to be installed and gate removed. Complete by 7/24/2013 4. Alexandria electronics bid received and door alarm going to be installed and gate removed. Complete by 7/24/2013	

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BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 4 4. On 5/16/13 at 6:10 pm, observation revealed that the door to the 2nd floor east stair by the E-Dining Room required holding a button in on the frame at approximately 5' high while turning the lever handle to open the door. This door required two actions to open the door. These deficient practices were confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 038		
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8 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. Findings include: On 5/16/13 at 6:25 pm, observation revealed that the exterior light fixture outside of the South Exit Doors was a single fixture and had only one light bulb. This deficient practice was confirmed by the Director of Building Maintenance at the time of	K 045	K045 SS=E 1. South exit light was repaired. Date complete: 6/3/2013 Exit light near chapel was inspected and placed on routine maintenance list for testing. Other exit lights checked monthly and tested.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 04 - 2012 RENOVATED AREA B. WING	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 045	Continued From page 5 discovery.	K 045		
K 051 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 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 18.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 2-1.3 and 2-1.3.2. This deficient practice could affect approximately all of the 77 residents and an undetermined number of staff and visitors. Findings include: On 5/16/13 at 5:57 pm, observation revealed that two smoke detectors were within the airflow of the ceiling diffuser.	K 051	K051 SS=E 1. Fire Fighter & Detection is contacted and will move smoke detectors. To be completed by 7/24/2103.	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 04 - 2012 RENOVATED AREA B. WING	05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 051	Continued From page 6 This deficient practice was confirmed by the Maintenance Coordinator and the Education Coordinator at the time of discovery.	K 051		

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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.

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

0

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

Have you reviewed the related Knowledge Base areas below?

(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 Methods of Tests and Classification System for Cigarette Ignition Resistance of Components of Upholstered Furniture.*

(2) Where required by the applicable provisions of this *Code*, mocked-up composites of the upholstered furniture, 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 Smoldering 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.

10.3.3* 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 Ignition Source*, or with ASTM E 1537, *Standard Method for Fire Testing of Real Scale Upholstered Furniture Items*, as follows:

(1) 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*, mattresses, 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 Fire Characteristics of Mattresses and Bedding Assemblies Exposed to Flaming Ignition Source*, or ASTM E 1590, *Standard Method for Fire Testing of Real Scale Mattresses*, as follows:

(1) 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 retain 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.*

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 3.3.33.

Flashover. See 3.3.79.

Interior Finish. See 3.3.112.

Interior Ceiling Finish. See 3.3.112.1.

Interior Floor Finish. See 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 cement 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:

(1) 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 *Code* 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 NFPA 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 classes in accordance with their flame spread and smoke development.

(a) *Class A Interior Wall and Ceiling Finish.* 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 Ceiling 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) *Class C 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.

10.2.3.3 The classification of interior finish specified in 10.2.3.2 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 Growth Contribution of Textile Wall Coverings,* shall comply with the criteria of 10.2.3.5.1 or 10.2.3.5.2. 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 Room 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 300 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 Room 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.

☐ I 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.

☐ I acknowledge 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).

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

Patient's Name: ______________________________

Signature will be recorded later	11/6/2013
Signature	Date

Submit

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245434	01 - NURSING HOME	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	07/24/2013	ID Prefix Reg. # NFPA 101 LSC K0025	06/24/2013	ID Prefix Reg. # NFPA 101 LSC K0038	07/24/2013
ID Prefix Reg. # NFPA 101 LSC K0051	07/24/2013	ID Prefix Reg. # NFPA 101 LSC K0062	06/04/2013	ID Prefix Reg. # NFPA 101 LSC K0069	06/07/2013
ID Prefix Reg. # NFPA 101 LSC K0073	06/03/2013	ID Prefix Reg. # NFPA 101 LSC K0074	06/05/2013	ID Prefix Reg. # NFPA 101 LSC K0147	06/07/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	09/27/13	27200	08/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
5/16/2013	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245434	02 - SUB ACUTE	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
ID Prefix Reg. # **NFPA 101** LSC K0014	Correction Completed **06/07/2013**	ID Prefix Reg. # **NFPA 101** LSC K0062	Correction Completed **06/04/2013**	ID Prefix Reg. # **NFPA 101** LSC K0103	Correction Completed **07/24/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	09/27/13	27200	08/19/13
CMS RO				

Followup to Survey Completed on: 5/16/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245434	03 - CHAPEL AREA	8/19/2013

Name of Facility	Street Address, City, State, Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0015	06/07/2013	ID Prefix Reg. # NFPA 101 LSC K0038	07/24/2013	ID Prefix Reg. # NFPA 101 LSC K0073	06/03/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	09/27/13	27200	08/19/13
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
5/16/2013	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245434	04 - 2012 RENOVATED AREA	8/19/2013

Name of Facility	Street Address, City, State, Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	07/07/2013	ID Prefix Reg. # NFPA 101 LSC K0014	06/07/2013	ID Prefix Reg. # NFPA 101 LSC K0038	07/24/2013
ID Prefix Reg. # NFPA 101 LSC K0045	06/03/2013	ID Prefix Reg. # NFPA 101 LSC K0051	07/24/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	09/27/13	27200	08/19/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/16/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JMFW
Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245434**
2. STATE VENDOR OR MEDICAID NO. (L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/25/2013** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **83** (L18)

13. Total Certified Beds **83** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Angela Hofmann, HFE NEII — 06/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist — 06/13/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 06/20/2013 CO.
JMFW

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<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;

- 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

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

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

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

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

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

Mr. 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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING ______ B. WING ______	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	F 282 Policy: The care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the resident/patient stay. The resident and/or their representative, along with the entire care team is involved in the care planning process. Care is planned to help attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well-being. Purpose: To assure continuity of care at admission; to assure residents' needs can be met at admission; and to provide a system for an ongoing process of developing and updating a comprehensive care plan with input from the resident, family, representative, and an interdisciplinary team (IDT).	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 2 residents (R17) related to fall prevention, and for 1 of 1 residents (R40) who required assistance with eating Findings include: R17's care plan dated 4/2012 identified the problem of falls, and listed various interventions which included: "wear gripper socks (sic) to be worn at all times during the night," and "to leave foot rest on recliner down, as resident doesn't know how to lower it and crawls out of chair with foot rest up."	F 282	Staff education provided regarding the expectation of following the plan of care, this education was provided via care tracker message on 4-30-13. NAR's are to carry and check their group list when providing care to each resident, as the group list is a mini version of the plan of care. They can also refer to the long version of the plan of care supplied in the care plan book at each station. On 4-25-13 the cord was immediately removed from resident R17 chair so that staff are no longer able to raise the foot of the chair. Any resident who is assessed and considered unsafe to operate a lift chair will have the cord removed or zip tied and notification attached that states do not use. On 4-29-13 staff education was provided for all staff working with Resident R17	6/3/13 Sanderson

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 5/17/2013

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.

RECEIVED
MAY 2 0 2013
MN Dept of Health
Fergus Falls

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING ______ B. WING ______	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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F 282	Continued From page 1 On 4/25/2013 at 7:34 a.m. R17 was observed alone in her room, sitting up on the side of the bed farthest from the door with both feet bare. R17's room was dark, except for a small amount of sunlight coming in through the drawn shades. R17 remained alone, seated on the side of the bed, bare feet resting on the floor, until 7:47 a.m., when nursing assistant (NA)-A entered the room. During an interview at 8:03 a.m., NA-A confirmed that R17 had not been wearing gripper socks when she entered the room and confirmed both of R17's feet were bare. On 4/25/2013 at 8:41 a.m., NA-B assisted R17 into the reclining chair in R17's room, and extended the foot rest of the recliner with R17's both legs resting on the foot rest. At 8:45 a.m. NA-B adjusted the television, then immediately exited R17's room. R40 remained alone, seated in a recliner with both feet resting on the foot rest of the recliner. On 4/25/2013 at 8:52 a.m., an interview with NA-B confirmed that R17 was a fall risk, had a history of falls, liked to "self transfer," and recalled she did so yesterday. NA-B confirmed she routinely extended the foot rest when R17 sat in the recliner chair in R17's room. During an interview on 4/25/2013 at 1:21 p.m., RN-B confirmed that R17 was cognitively impaired, had frequent falls and was at high risk for further falls. RN-B verified R17's care plan included the interventions of gripper sock use at all times during the night, and also, when R17 is seated in recliner, the leg rest was not to be	F 282	regarding the plan of care for gripper socks, and not raising the foot rest on her chair. Staff were also provided education as to the importance of these interventions for resident safety, fall prevention and to help reduce the possibility of injuries. This education was also provided by a posting at the nurses' station and will be provided at shift report. 4-30-13 Staff education was provided to staff on how to identify residents who require encouragement and assistance with meals as directed by the plan of care via care tracker message. On 4-30-13 R40 was moved to a table that more assistance and supervision is provided. All residents were observed in the dining room to assure they are at appropriate tables to receive assistance or supervision as required. Education provided to staff of notifying Nurse Managers or Dietary manager of any moves that may need to be made to assure residents are getting the assistance they require. 5-20-13 and 5-21-13 Education regarding the care plans, group lists, safety interventions and dietary cards was provided at staff meeting. Any resident in the facility with safety interventions in place has the potential to be affected. There for audits to assure that safety interventions are being followed as per the plan of care will be completed on random 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 affected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING ______ B. WING ______	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 extended. RN-B verified it was not acceptable that gripper socks were not utilized, and incorrect positioning in the recliner was done for R17. RN-B stated she would expect R17's fall prevention interventions as in the care plan to be followed at all times. R40 did not receive assistance to eat her evening meal as directed by the care plan. R40's plan of care dated March 2013, identified R40 required assist at meals due to dementia. Interventions directed staff to assist at meals with eating, encourage intake, assist with meal set-up, and resident required assist of one to finish completing her meal. During observation on 4/23/13 at 5:36 p.m., registered nurse (RN)-A brought R40 a plate of two pancakes, one round sausage patty, a souffle cup of syrup, and a banana and set the plate of food items next to a glass of water, juice and cup of coffee. RN-A handed the banana to R40, and the resident started to peel the banana, then RN-A immediately walked away from the table. R40 continued to handle the banana and peeling and took a bite. R40 put the banana on the plate,	F 282	Therefor audits on assisting and supervision of residents requiring assistance while eating 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 responsible Completion date 5-24-13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 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 the souffle cup from her plate and take a drink of the syrup, then picked 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,	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 282	Continued From page 4 revised 5/2011, indicated care plan interventions would be implemented to meet the individual resident needs.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary assistance with eating for 1 of 1 resident (R40) during dining observations. Findings Include: The quarterly Minimum Data Set (MDS), dated 2/20/13, identified R40 had severe cognitive impairment and required assistance of one for eating. R40's plan of care dated March 2013, identified R40 required assist at meals due to dementia. Interventions directed staff to assist at meals with eating, encourage intake, assist with meal set-up, and resident required assist of one to finish completing her meal. During observation on 4/23/13 at 5:29 p.m., R40 was sitting at a table alone in the dining room, looking at other residents and picking up/putting down the silverware on her table. At 5:32 p.m., R40 turned her wheelchair away from the table and wheeled herself out of the dining room,	F 311	F311 Policy: The care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the resident/patient stay. The resident and/or their representative, along with the entire care team is involved in the care planning process. Care is planned to help 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 that more assistance and supervision is provided. 4-30-13 Staff education was provided to staff on how to identify residents who require encouragement and or assistance with meals as directed by the plan of care via care tracker message. 5-20-13 and 5-21-13 Education regarding the care plans, group lists, safety interventions and dietary cards was provided at staff meeting. All resident in the facility requiring assistance and or supervision have the potential to be affected. Therefore on 4-29-13 all residents were observed in the dining room to assure they are at appropriate tables to receive assistance or supervision as required, table changes were provided as needed. Education provided to staff of notifying Nurse Managers or Dietary manager of any moves that may need to be made to assure residents are getting the assistance they require. Audits on assisting and supervision of residents requiring assistance while eating will be done weekly x 4 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 311	Continued From page 5 towards a hallway adjacent to the dining room. At 5:36 p.m., registered nurse (RN)-A assisted R40 from the hallway back to her table in the dining room. She brought R40 a plate of two pancakes, one round sausage patty, a souffle cup of syrup, and a banana and set the plate of food items next to a glass of water, juice and cup of coffee. RN-A handed the banana to R40, and the resident started to peel the banana, then RN-A immediately walked away from the table. R40 continued to handle the banana and peeling and took a bite. R40 put the banana on the plate, 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 the souffle cup from her plate and take a drink of the syrup, then picked up the sausage patty with her fingers and rolled it up in her hand like a taco. R40 did not take a bite of pancake or sausage patty, but continued to handle the sausage patty, pancake with her fingers, but did not take a bit of any food item. At 5:38 p.m., R40 wheeled away from table out of the dining room, toward an adjacent hallway. At 5:42 p.m., staff was observed wheeling R40 back to her table in the dining room and stated, "you better eat," and immediately walked away from R40. The staff member did not cut up the pancakes, sausage, or provide any other assistance or encouragement for R40. R40 then picked up her spoon, moved the spoon repeatedly over the surface of the sausage patty, before resting the spoon on the sausage patty. R40 picked up the partially peeled banana, and took a bite and set the banana back on the plate. R40 had not yet consumed any	F 311	Further audits will be completed if indicated. Audits will be conducted and results reported to the CQI team. Clinical Director or designee responsible Completion date 5-24-13	

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	245434	A. BUILDING ______ B. WING ______	04/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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F 311	Continued From page 6	F 311		

liquids from her juice glass, water glass, or coffee cup, and had not consumed any of the pancakes or sausage. No staff were observed to assist R40 or provide encouragement to eat. Again at 5:52 p.m., R40 wheeled herself out of the dining room into the hallway, no staff were observed to intervene. At 6:00 p.m., a staff member was observed to assist R40 back into the dining room to her table, then turned and walked away without providing assistance or encouragement. Then R40 immediately wheeled herself out of the dining room again for the last time, after consuming 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, revised 5/2011, indicated care plan interventions

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F 311	Continued From page 7 would be implemented to meet the individual resident needs.	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to minimize the risk of falls for 1 of 2 residents (R17) in the sample who had a history of falls. Findings include: R17's diagnoses included dementia, osteoporosis, Parkinson's disease and macular degeneration. The annual Minimum Data Set (MDS) assessment dated 4/10/2013 indicated R17 had severe cognition impairment. The Care Area Assessment (CAA) dated 4/10/2103, indicated R17 required assistance with dressing, grooming, toileting, transferring and ambulating; transfer and ambulation required the assist of one and use of a gait belt. The CAA also indicated R17 had a history of falling. A Fall Risk Assessment form dated 4/10/2013 indicated R17 was a high risk for falls, had	F 323	F323 Policy: To identify residents who are at risk for falls and develop individual fall precautions for those residents. To maintain a comfortable, safe, and secure environment 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 determine causal factors and implement appropriate interventions. Purpose: To provide a systematic way for the interdisciplinary team to prevent, monitor and assess resident falls occurring in the facility. On 4-25-13 the cord was immediately removed from resident R17 chair so that staff are no longer able to raise the foot of the chair. Any resident who is assessed and considered unsafe to operate a lift chair will have the cord removed or zip tied and notification attached that states do not use. On 4-29-13 staff education was provided for all staff working with Resident R17 regarding the plan of care for gripper socks, and not raising the foot rest on her chair.	

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F 323	Continued From page 8 several falls this quarter, and ambulated with a walker and an assist of one person. R17's care plan dated 4/2012 identified the problem of falls, and listed various interventions which included: "wear gripper socks (sic) to be worn at all times during the night," and "to leave foot rest on recliner down, as resident doesn't know how to lower it and crawls out of chair with foot rest up." Review of the Resident Incidents log for R17 indicated between 10/16/2012 and 3/9/2013, R17 had experienced thirteen falls. A review of the Interdisciplinary Progress Notes (IPN) revealed R17 had experienced three additional falls on: 3/23/2013, 3/28/2013, and 4/13/2013. The IPN dated 3/23/2013 at 2:05 p.m. noted R17 was found sitting on floor next to toilet. No new assessments and no new interventions were documented at that time. The IPN dated 3/28/2013 revealed at 2:25 a.m. R17 was found sitting on her bottom at the foot of her bed. Gripper socks were applied and intervention added that "gripper socks were to be applied at all times during noc (night time) to decrease the resident's risk of falling if she self transfers." The IPN dated 4/13/2013 revealed at 2:31 p.m. R17 was found on floor in front of toilet, the IPN notes indicated "will monitor." The notes lacked documentation of any further assessments or new interventions put in place at that time. On 4/25/2013 at 7:34 a.m. R17 was observed alone in her room, sitting up on the side of the bed farthest from the door with both feet bare. R17's room was dark, except for a small amount of sunlight coming in through the drawn shades.	F 323	Staff were also provided education as to the importance of these interventions for resident safety, fall prevention and to help reduce the possibility of injuries. This education was also provided by a posting at the nurses' station and will be provided at shift report. Resident R17 falls were reviewed with a new fall assessment completed on 5-16-13 interventions implemented, care plan, care sheets updated and staff informed of interventions. Licensed staff were provided with education that "will monitor" is not an acceptable intervention via care tracker message. Guidelines for investigating a fall to help find an appropriate intervention was also provided. Any resident in the facility with safety interventions in place has the potential to be affected. Audits to assure that safety interventions are being followed as per the plan of care will be completed on random basis on all residents with safety interventions. Weekly x2 weeks then monthly x2 . Further audits will be completed if indicated. Audits will be conducted and results reported to the CQI team. Clinical Director or designee responsible Completion date 5-24-13	

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F 323	Continued From page 9 R7 remained alone, seated on the side of the bed, bare feet resting on the floor, until 7:47 a.m., when nursing assistant (NA)-A entered the room. During an interview at 8:03 a.m., NA-A confirmed that R17 had not been wearing gripper socks when she entered the room and confirmed both of R17's feet were bare. On 4/25/2013 at 8:41 a.m., NA-B assisted R17 into the reclining chair in R17's room, and extended the foot rest of the recliner with R17's both legs resting on the foot rest. At 8:45 a.m. NA-B turned on, adjusted the television, then immediately exited R17's room. R40 remained alone, seated in a recliner with both feet resting on the foot rest of the recliner. On 4/25/2013 at 8:52 a.m., an interview with NA-B confirmed that R17 was a fall risk, had a history of falls, liked to "self transfer," and recalled she did so yesterday. NA-B confirmed she routinely extended the foot rest when R17 sat in the recliner chair in R17's room. During an interview on 4/25/13 at 9:52 a.m., NA-C confirmed R17 needed assistance to stand up, walk, when toileting and when attempting to transfer. NA-C stated he was aware R17 had fallen in the recent past. During an interview on 4/25/2013 at 1:21 p.m., RN-B confirmed the current facility policy. She confirmed R17 was cognitively impaired, had frequent falls and was at high risk for further falls. RN-B verified R17's care plan included the interventions of gripper sock use at all times during the night, and also, when R17 is seated in	F 323		

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F 323	Continued From page 10 recliner, the leg rest was not to be extended. RN-B verified it was not acceptable that gripper socks were not utilized, and incorrect positioning in the recliner was done for R17. RN-B stated she would expect R17's fall prevention interventions as in the care plan to be followed at all times. The facility policy titled, "Fall Prevention," revised 9/2010 indicated individualized fall precaution interventions would be developed and implemented for all residents at risk for falls.	F 323	F 371 Dietary Plan of Correction: A. A citation was received from the State Inspection Review noting a dirty fan located in the dishwashing area. Correction: The Maintenance Dept. has been responsible for cleaning the fans in the Dietary Dept. The revision will be that cleaning of the fans will be added to the monthly dietary cleaning list and will be cleaned by the dietary staff. The dietary staff has been educated on the new process and will be instructed by maintenance how to correctly do the cleaning on May 30, 2013. A long term goal of Bethany is to redo the air exchange system in the kitchen to eliminate use of the fans. The fan cleanliness will also be added to the monthly Sanitation Assessment that is completed by the Production Supervisor or her assistant. B. Citation of cupboard doors and drawer fronts soiled and buildup around handles. Correction: Cupboard doors and drawer fronts will be sanded and repainted. The dining door will also be sanded and refinished. Daily wiping down of cupboard doors and drawer fronts will be added to the daily cleaning list of the serving kitchen of both day and evening shifts. It will also be added to the monthly Sanitation Checklist. C. Citation of frozen food items that were not sealed, labeled and dated in serving kitchen freezer.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow equipment sanitation procedures to promote sanitation and food safety in the main kitchen and 1 of 2 kitchenettes having the potential to affect 76 of 79 residents residing in the facility. In addition, there was unsafe storage and undated food items in the main kitchen and in 1 of 2 kitchenettes having the potential to affect 76 of 79 residents residing in the facility.	F 371		

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F 371	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 the dishroom belt. - outer cabinet and drawer fronts in the main dining room kitchenette (MDR) located on the second floor were soiled with dried food splatter and had a buildup of a brown material around the cabinet and drawer handles. In total, five cabinets above the serving area on the back wall, were dirty with a brown material substance around the handles and had food splatter running down the cabinets. Eighteen drawers below the serving counter had a brown dirty buildup around the handles and sixteen cabinets below the drawers were soiled with brown splattered substance and one cabinet was soiled with dried food particles. - the refrigerator/freezer in the first floor kitchenette was observed to contain food items that were not labeled nor dated. The refrigerator contained an opened one half gallon Stoney Creek 2% milk that was not dated. The following foods were not labeled nor dated in the freezer: a nearly empty one and one half quart of lactose free ice cream carton, three pre-portioned sherbet cups with plastic covers (one cracked	F 371	Correction: All food items will be sealed, labeled and dated when placing in serving kitchen freezer. For assurance the process is being followed, it will be added to the daily stocking list as the freezer is checked daily. The freezer will also be monitored biweekly and documented by diet aide for correct follow through for a period of 6 months and 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 cook on duty for expiration dates and disposed of accordingly as appropriate. This process will be added to the cooks daily checklist of duties that are signed off for follow through. This will be done, in addition to following the current policy of checking expiration dates upon delivery and following FIFO out procedure. The Dietary Manager has held an in-service with the dietary staff on May 1st to review citations and provide training on how to follow correct procedures. She will also follow through with monitoring of the correction follow through procedures at the next CQI project for the coming quarter. Respectfully Submitted, Val Jerzak, CDM, CFPP Director of Director of Dining	

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F 371	Continued From page 12 top), ready to heat opened packages of 4 waffles, 7 pancakes, 3 french toast were not sealed, labeled nor dated. The facility's Cleaning/Maintenance of kitchen fans policy dated 5/10/10, stated "fans located in the kitchen will be cleaned every other month or as needed and requested of dietary by the Maintenance department." During an interview on 4/23/13 at 1:20 p.m. with DM-C and the maintenance coordinator (MC), DM -C verified the fan was dusty and dirty, but stated she had completed a maintenance work order on 4/19/13 for the dirty vents to be cleaned. MC confirmed the findings and stated he had no specific date when to clean them, "We have a lot of work orders." The facility's Cleaning Cabinets and Drawer policy dated 4/08, stated, "cabinets and drawers will be free of food particles and dirt. They should be cleaned at least twice a month." Review of the Dining Rooms/Serving Kitchens section of the facility's Sanitation Kitchen Inspection Check-lists for January 17 thru April 19th, 2013.did not list the cleaning of cabinets and drawers in the kitchenettes. Although the policy did indicate "cleaning schedule is followed consistently" for the kitchenettes, the weekly cleaning schedule for the MDR kitchenette also did not list the cleaning of cabinets and drawers. Furthermore, the same checklist did indicate the kitchenette "refrigerator is clean, food labeled and dated." Two of the four months indicated the refrigerator needed cleaning, however, did not indicate if food was appropriately labeled and	F 371		

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F 371	Continued From page 13 dated. During the follow-up kitchen tour on 4/25/13 at 2:35 p.m. with the clinical dietary manager (DM) -B, the following was observed: - the walk in cooler contained thirteen Yoplait 4oz yogurt cups with an expiration date of 4/22/13. The facility's Food Expiration Dating policy dated 6/10 indicated "all purchased, sealed food items will be utilized in a manner that follows the manufactures (sic) 'use by' date and that foods not used by this date will be disposed of." The policy further indicated "when shelving new items upon delivery, check expiration dates of stored items already on shelf." When interviewed on 4/25/13 at 2:35 p.m., DM-B confirmed the above findings and stated, "They must have missed them."	F 371		

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

F 5434022

PRINTED: 05/09/2013
FORM APPROVED
OMB NO. 0938-0391

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	245434	A. BUILDING 01 - NURSING HOME B. WING ______	04/24/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Bethany Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	RECEIVED MAY 22 2013 POC ok 5-28-13	

DC: 06.04.2013

EXIT: 04.25.2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 5/17/2013

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

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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was surveyed as 2 building. Bethany Home was constructed at 5 different times. The original building (01 Main building) was constructed in 1964, is 1-story, with a basement and was determined to be of Type II(000) construction. In 1979, a 1-story addition, with a basement was constructed to the west side of the building that was determined to be of Type II(000) construction. In 1995, two 1-story additions were constructed to the south side and the middle of the south wings, between the 1964 and 1979 buildings and was determined to be of Type V(111) construction. In 2003 the Sub Acute building was constructed to the north of the 1964 building, is 3 stories and was determined to be Type II (111) construction. Also in 2003 a chapel addition was constructed to the east of the 1964 building, is 1-story and Type V (111) construction. Both of these additions are separated by 2-hour	K 000	Per MW - The facility was surveyed as 2 buildings (see initial comments) CMS surveyed as 4 buildings	

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K 000	Continued From page 2 fire barriers. The 01 Main building is divided into 5 smoke zones on the each floor and the 02 Sub Acute building is divided into 2 smoke zones on each floor by fire barriers of 30-minutes, 1-hour and 2-hours. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 79 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on an interview with staff, the facility has failed to ensure that 3 of 4 emergency lights have been tested in accordance with NFPA LSC (00)	K 046	K-46 SS=F 1. The 3 lights were tested. 2. 4.25.2013 3. The lights were added to monthly check list 4. Any new lights added will be added to the audits after construction.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 01 - NURSING HOME B. WING	04/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 046	Continued From page 3 Section 7.9, 19.2.9.1. This deficient practice could affect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, during the review of available emergency battery back up exit lighting maintenance documentation and interview with the Maintenance Coordinator (DL) revealed the following deficient practices, 1. that the facility failed to document the 12 monthly 30 second maintenance tests for 3 of 4 emergency battery back up exit lights, and 2. that the facility failed to document the annual 90 minute test for 3 of 4 emergency battery back up exit lights. These deficient conditions were confirmed by the Maintenance Coordinator (DL).	K 046		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke	K 054	K-54 SS=F 1. Facility did conduct sensitivity test, records have been added to life safety log book. 2. 4.27.2013 3. Informed Fire Fighter Detect that we need more accurate record keeping. 4. Maintenance will review to ensure proper forms are supplied.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING	**04/24/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET** **ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 054	Continued From page 4 detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, during a documentation review of the available fire alarm testing documentation and an interview with the Maintenance Coordinator (DL), 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. This deficient condition was confirmed by the Maintenance Coordinator (DL).	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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, 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	K-56 SS=F 1. Escutcheon rings were replaced. 2. 4.25.13 3. Inspection of escutcheon ring inspection has been added to our routine monthly maintenance task list.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING ______	04/24/2013

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K 056	Continued From page 5 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 (99). The failure to maintain the sprinkler system in compliance 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 facility thus affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, observations reveled that there numerous sprinkler escutcheon rings missing from the sprinkler heads located throughout the facility. This deficient condition was confirmed by the Maintenance Coordinator (DL).	K 056		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had several electrical appliances found not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect 6 of 83 residents, staff and	K 147	K-147 SS=C 1. Missing electrical plates were installed. 2. 4.25.13 3. Painting contractors will be instructed that covers must be replaced before leaving. 4. Maintenance will inspect any painting project to ensure done properly and safely.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING	**04/24/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET** **ALEXANDRIA, MN 56308**

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K 147	Continued From page 6 visitors. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, it was observed that there were 3 light switches located in the dietary dry storage room that were not equipped with the required protective covers thus allowing access to the energized electrical wires that are connected to the switches. This deficient condition was confirmed by the Maintenance Coordinator (DL).	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING	**04/24/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET** **ALEXANDRIA, MN 56308**

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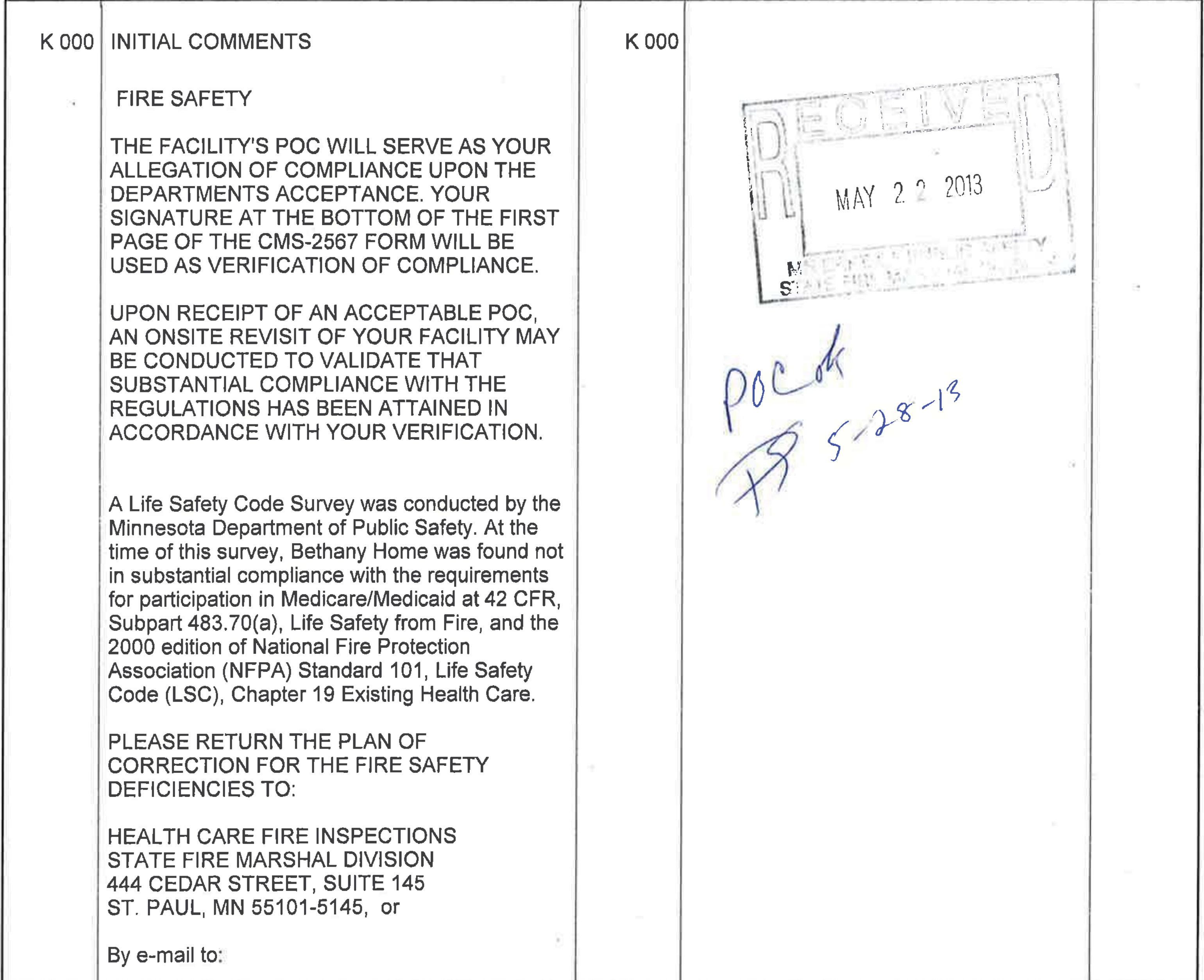
K 000	INITIAL COMMENTS	K 000		



FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Bethany Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

By e-mail to:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 5/17/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING	04/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was surveyed as 2 building. In 2003 the Sub Acute building was constructed to the north of the 1964 building, is 3 stories and was determined to be Type II (111) construction. Also in 2003 a chapel addition was constructed to the east of the 1964 building, is 1-story and Type V (111) construction. Both of these additions are separated by 2-hour fire barriers. The 02 Sub Acute building is divided into 2 smoke zones on each floor by fire barriers of 30-minutes, 1-hour and 2-hours. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING ______	04/24/2013

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K 000	Continued From page 2 National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 79 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall 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. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Observations revealed that there was penetration in a fire barriers within the facility that did not meet the rated requirements for two hour fire separation and are not in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.3,. These deficient practices could allow the products of combustion to travel from one building to another, which could negatively impact all the residents, staff and visitors of the facility.	K 011	K-11 SS=D 1. Penetration around electrical conduit was sealed. 2. 5.17.2013 3. Contractors are informed prior to construction that fire barrier must be sealed upon completion. 4. Maintenance staff will inspect contractors work to ensure holes are sealed before contractors are paid.	

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K 011	Continued From page 3 Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, observation revealed, that the 2 hour fire separation wall separating the memory care wing from the senior apartments was found to have a penetration. The penetration was found around the electrical conduit above the ceiling tile that is located over the china hutch. The penetration is passing through the 2 hours separation wall and is not sealed with an approved through penetration fire rated intumescent fire caulking. This deficient condition was confirmed by the Maintenance Coordinator (DL).	K 011		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a clear un-obstructed for 1 of several means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, 7.2.1.6.1(d), 7.7.2 (1) and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect all residents. Findings include:	K 038	K-38 SS=D 1. Sidewalk was cleared. 2. 4.27.2013 3. Maintenance will tour facility after every snow to ensure fire exits are clear.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 4 On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, observation revealed that the facility failed to maintain the rehab south exit clear of snow. The snow was approximately 2 feet deep on the egress discharge to the public way and was banking towards the facility. This deficient condition made the rehab south exit discharge inaccessible for egress in the event of an emergency. The snow was also blocking rehab south exit door limiting the door swing down to an approximately 18 inches of clear width also limiting the access to the exit discharge. These deficient practices were confirmed by the Maintenance Coordinator (DL).	K 038		
K 046 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on an interview with staff, the facility has failed to ensure that 3 of 4 emergency lights have been tested in accordance with NFPA LSC (00) Section 7.9, 19.2.9.1. This deficient practice could affect all residents, staff and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, during the review of available emergency battery back up exit lighting maintenance documentation and interview with	K 046	K-46 SS=F 1. The 3 lights were tested. 2. 4.25.2013 3. The lights were added to monthly check list	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 046	Continued From page 5 the Maintenance Coordinator (DL) revealed the following deficient practices, 1. that the facility failed to document the 12 monthly 30 second maintenance tests for 3 of 4 emergency battery back up exit lights, and 2. that the facility failed to document the annual 90 minute test for 3 of 4 emergency battery back up exit lights. These deficient conditions were confirmed by the Maintenance Coordinator (DL).	K 046		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and review of available documentation, the facility has not been conducting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, during a documentation review of the available fire alarm testing documentation and an interview with the Maintenance Coordinator (DL),	K 054	K-54 SS=F 1. Facility did conduct sensitivity test, records have been added to life safety log book. 2. 4.27.2013 3. Informed Fire Fighter Detect that we need more accurate record keeping. 4. Maintenance will review to ensure proper forms are supplied.	

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	245434	A. BUILDING **02 - SUB ACUTE** B. WING ____	04/24/2013

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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 was from 2010. This deficient condition was confirmed by the Maintenance Coordinator (DL).	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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, 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 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 (99). The failure to maintain the sprinkler system in compliance 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	K 056	K-56 SS=F 1. Escutcheon rings were replaced. 2. 4.25.13 3. Inspection of escutcheon ring inspection has been added to our routine monthly maintenance task list.	

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K 056	Continued From page 7 facility thus affect all residents, visitors and staff of the facility. Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, observations reveled that there numerous sprinkler escutcheon rings missing from the sprinkler heads located throughout the facility. This deficient condition was confirmed by the Maintenance Coordinator (DL).	K 056		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observations the facility failed to keep the means of egress continuous and free of all obstructions or impediments to full instant use in the case of fire or other emergency, in accordance with NFPA Life Safety Code 101 (2000 edition) Chapter 7, Section 7.1.10. These obstructions could interfere with the convenient and effective removal all residents, staff and visitors in an emergency situation, and impede fire fighting operations during a fire emergency.	K 072	K-72 SS=F 1. Chairs were removed from hallway. 2. 4.25.13 3. Restorative and nursing staff were educated on the need to keep hallways clear. 4. Safety Committee staff will monitor to ensure compliance.	

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K 072	Continued From page 8 Findings include: On facility tour between 10:30 AM to 2:30 PM on 04/24/2013, it was observed that there were several chairs located in rehab corridor located primarily by wall mounted computers. The chair locations were noted at 10:30 upon entry to the facility for the survey and again noted as not being moved at 12:30 PM during the facility walk through. This deficient practice was confirmed by the Maintenance Coordinator (DL).	K 072		