#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	DICARE/MEDICAID CERTIFICATION A					
1. MEDICARE/MEDICAID PROVIDER NO.         (L1)       245427         2.STATE VENDOR OR MEDICAID NO.         (L2)       516240800         5. EFFECTIVE DATE CHANGE OF OWNERSHIP	<ol> <li>NAME AND ADDRESS OF FACILITY</li> <li>(L3) BETHESDA NH PLEASANTVIEW</li> <li>(L4) 901 SOUTHEAST WILLMAR AVENUE</li> <li>(L5) WILLMAR, MN</li> <li>7. PROVIDER/SUPPLIER CATEGORY</li> </ol>		Facility ID: 00792       4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other			
(L9)         6. DATE OF SURVEY       02/01/2016       (L34)         8. ACCREDITATION STATUS:	01 Hospital         05 HHA         09 ESRD           02 SNF/NF/Dual         06 PRTF         10 NF           03 SNF/NF/Distinct         07 X-Ray         11 ICF/III           04 SNF         08 OPT/SP         12 RHC	13 PTIP 22 CLIA 14 CORF D 15 ASC 16 HOSPICE	8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 09/30			
2 AOA         3 Other           11. LTC PERIOD OF CERTIFICATION         From (a):           To (b):         To (b):           12. Total Facility Beds         123 (L18)           13. Total Certified Beds         123 (L17)           14. LTC CERTIFIED BED BREAKDOWN         18 SNF         19 SNF           123         (L37)         (L38)         (L39)           16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE         10 SNF         10 SNF	10.THE FACILITY IS CERTIFIED AS:         X       A. In Compliance With         Program Requirements         Compliance Based On:        1. Acceptable POC         B. Not in Compliance with Program         Requirements and/or Applied Waivers:         ICF       IID         (L42)       (L43)	And/Or Approved Waivers Of The F 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A* 15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	<sup>2</sup> ollowing Requirements:			
17. SURVEYOR SIGNATURE     Date :     18. STATE SURVEY AGENCY APPROVAL     Date:						
Brenda Fischer, Unit Supervise	(L19)	Kate JohnsTon, Pro	(L20)			
PART II - TO     PART II - TO     PART II - TO     I. DETERMINATION OF ELIGIBILITY     1. Facility is Eligible to Participate     2. Facility is not Eligible     (L21)	20. COMPLIANCE WITH CIVIL RIGHTS ACT:	AL OFFICE OR SINGLE STATE AGENCY         21.       1. Statement of Financial Solvency (HCFA-2572)         2.       Ownership/Control Interest Disclosure Stmt (HCFA-1513)         3.       Both of the Above :				
22. ORIGINAL DATE     23. LTC AGREEM       OF PARTICIPATION     BEGINNING       02/01/1987     (L41)       25. LTC EXTENSION DATE:     27. ALTERNATIV	DATE ENDING DATE (L25)	26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimbursement         03-Risk of Involuntary Termination	(L30) <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement OTHER			
A. Suspension	of Admissions: (L44) spension Date: (L45)	04-Other Reason for Withdrawal	07-Provider Status Change 00-Active			
28. TERMINATION DATE: 2 (L28)	9. INTERMEDIARY/CARRIER NO. 03001 (L31)	30. REMARKS				
31. RO RECEIPT OF CMS-1539 3 (L32)	2. DETERMINATION OF APPROVAL DATE 01/19/2016 (L33)	Posted 03/01/2016 Co. DETERMINATION APPROV	'AL			



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245427 February 10, 2016

Mr. Brandon Pietsch, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

Dear Mr. Pietsch:

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 January 13, 2016 the above facility is certified for or recommended for:

123 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 123 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.

Bethesda Nursing Home Pleasantview February 10, 2016 Page 2

Sincerely,

moton Katot >

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered February 10, 2016

Mr. Brandon Pietsch, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5427026

Dear Mr. Pietsch:

On December 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 10, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 14, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 10, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 10, 2015, effective January 13, 2016 and therefore remedies outlined in our letter to you dated December 29, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Bethesda Nursing Home Pleasantview February 10, 2016 Page 2

Sincerely,

Kato Comston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245427 <sub>Y1</sub>	B. Wing	Y2	2/1/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHESDA NH PLEASANTVIEW		901 SOUTHEAST WILLMAR AVENUE		
		WILLMAR, MN 56201		

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).

ITE	м	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix Reg. #	F0164 483.10(e), 483.75	Correction (1)(4) Completed 01/13/2016	ID Prefix Reg. #	F0225 483.13( - (4)	(c)(1)(ii)-(iii), (c)(2)	Correction Completed 01/13/2016	ID Prefix Reg. #	F0226 483.13(c)		Correction Completed 01/13/2016
LSC		01/13/2016	LSC			01/13/2016	LSC			01/13/2016
ID Prefix	F0323	Correction	ID Prefix	F0356		Correction	ID Prefix	F0371		Correction
Reg. #	483.25(h)	Completed	Reg. #	483.30(	(e)	Completed	Reg. #	483.35(i)		Completed
LSC		01/13/2016	LSC			01/13/2016	LSC			01/13/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #			Completed	Reg. #			Completed
LSC			LSC				LSC			
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. # LSC		Completed	Reg. # LSC			Completed	Reg. # LSC			Completed
REVIEWE STATE AG		reviewed by (initials) BF/KJ	<b>date</b> 02/10/2	016	SIGNATURE OF SU	irveyor 10562			<b>DATE</b> 02/0	01/2016
REVIEWE CMS RO	REVIEWED BY CMS RO		DATE		TITLE				DATE	
<b>FOLLOW</b> 12/10/20	JP TO SURVEY CO 15	DMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?							

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT				
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01						
245427 <sub>Y1</sub>	B. Wing	Y2	1/14/2016	Y3			
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE					
BETHESDA NH PLEASANTVIEW		901 SOUTHEAST WILLMAR AVENUE					
		WILLMAR. MN 56201					

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).

ITE	м	DATE	ITEM		DATE	ITEM	DATE
Y4		Y5	Y4		Y5	Y4	Y5
ID Prefix Reg. # LSC	NFPA 101 K0056	Correction Completed 01/13/2016	ID Prefix Reg. # LSC K014	A 101 17	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC	Correction Completed
REVIEWE STATE AG REVIEWE CMS RO FOLLOWU 12/7/2015	BENCY	REVIEWED BY (INITIALS) TL/KJ REVIEWED BY (INITIALS)			347	S. WAS A SUMMARY OF	DATE 01/14/2016 DATE

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL TE SURVEY AGENCY	ID: KMNR Facility ID: 00792		
1. MEDICARE/MEDICAID PROVIDER N           (L1)         245427           2.STATE VENDOR OR MEDICAID NO.         (L2)           516240800         (L2)	0.	3. NAME AND ADDRESS OF FACILITY (L3) <b>BETHESDA NH PLEASANTVIEW</b> (L4) <b>901 SOUTHEAST WILLMAR AVENUE</b> (L5) <b>WILLMAR, MN</b>			(L6) <b>56201</b>	4. TYPE OF ACTION:     2 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SUP 01 Hospital	PLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
<ul> <li>6. DATE OF SURVEY</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited</li> <li>1 ADA</li> <li>2 AOA</li> <li>1 Other</li> </ul>	/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF       18/19 SNF         123         (L37)       (L38)         16. STATE SURVEY AGENCY REMARK	To       (b):       Program Requirements Compliance Based On:      2. Technical Personnel      6. Scope of Services Limit         12. Total Facility Beds       123       (L18)      1. Acceptable POC      4. 7-Day RN (Rural SNF)      8. Patient Room Size         13. Total Certified Beds       123       (L17)       X B. Not in Compliance with Program Requirements and/or Applied Waivers:       * Code:       B*       (L12)         14. LTC CERTIFIED BED BREAKDOWN       IS. FACILITY MEETS       1861 (e) (1) or 1861 (j) (1):       (L15)         12.3       (L37)       (L38)       (L39)       (L42)       (L43)         16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):							
17. SURVEYOR SIGNATURE	HFE NE II		01/12/2016	(L19)	Kate JohnsTon, Program Specialist 01/15/2016			
	PART II - TO	BE COMPLETEI	D BY HCFA RE	GIONAI	L OFFICE OR SINGLE STA	<b>TE AGENCY</b>		
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to Par</li> <li>2. Facility is not Eligible</li> </ol>			PLIANCE WITH CI ITS ACT:	WIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
22. ORIGINAL DATE	23. LTC AGREEME	ENT 24	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION <b>02/01/1987</b>	BEGINNING I	DATE	ENDING DATE		VOLUNTARY 01-Merger, Closure	00 INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursen 03-Risk of Involuntary Termination			
25. LTC EXTENSION DATE: (L27)	<ol> <li>ALTERNATIVE</li> <li>A. Suspension of</li> <li>B. Rescind Susp</li> </ol>	f Admissions:	(L44)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
			(L45)					
28. TERMINATION DATE:	29.	INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION O	OF APPROVAL DAT	Έ	Posted 01/19/2016 Co			
	(L32)			(L33)	DETERMINATION APPR	OVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered December 29, 2015

Mr. Brandon Pietsch, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

RE: Project Number S5427026

Dear Mr. Pietsch:

On December 10, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the December 10, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5427020.

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. In addition, at the time of the December 10, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5427020 that was found to be unsubstantiated.

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

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

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor St. Cloud A Survey Team Licensing & Certification Health Regulation Division Minnesota Department of Health Midtown Square 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (320)223-7338 Fax: (320)223-7348

### **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 January 19, 2016, 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 January 19, 2016 the following remedy will be imposed:

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by March 10, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 10, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

## **INFORMAL DISPUTE RESOLUTION**

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

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

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

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

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

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

> Mr. Tom Linhoff, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: <u>tom.linhoff@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

		ID HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245427	B. WING		12	2/10/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
BETHESD	A NH PLEASANTVIEW			901 SOUTHEAST WILLMAR AVENU	E	
				WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	i	F 00	00		
F 164 SS=E	as your allegation of 0 Department's accepta enrolled in ePOC, you at the bottom of the fi form. Your electronic be used as verification Upon receipt of an ac on-site revisit of your validate that substant regulations has been your verification. 483.10(e), 483.75(I)(4 PRIVACY/CONFIDEN	ance. Because you are ur signature is not required rst page of the CMS-2567 submission of the POC will n of compliance. cceptable electronic POC, an facility may be conducted to ial compliance with the attained in accordance with	F 16	54		1/13/16
	confidentiality of his of records. Personal privacy inclu- medical treatment, we communications, person meetings of family and does not require the f room for each resident Except as provided in section, the resident of release of personal a individual outside the The resident's right to and clinical records d resident is transferred	or her personal and clinical udes accommodations, ritten and telephone sonal care, visits, and id resident groups, but this facility to provide a private nt. In paragraph (e)(3) of this may approve or refuse the nd clinical records to any				
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
	cally Signed					01/06/2016

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

PRINTED: 01/15/2016

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	2: 01/15/2016 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245427	B. WING _				12/ <sup>,</sup>	10/2015
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BETHESD	A NH PLEASANTVIEW				1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE		(X5) COMPLETION DATE
F 164	The facility must keep contained in the resid the form or storage m release is required by healthcare institution; contract; or the reside This REQUIREMENT by: Based on observation failed to ensure audio (R59, R27, R85, R116 R71, R140 and R19) residents who resided unit where the facility system. Findings include: R59, R27, R85, R116 R71, R140 and R19 v currently reside in the facility. R59's quarterly Minim 10/16/15, indicated R impaired, and include dementia. R27's quarterly MDS, R27 had severe cogn diagnoses which inclu	<ul> <li>confidential all information ent's records, regardless of ethods, except when transfer to another law; third party payment int.</li> <li>is not met as evidenced</li> <li>n and interview, the facility privacy for 11 residents</li> <li>6, R82, R107, R55, R63, in the sample, of the 30</li> <li>I in the locked memory care utilized an audio monitoring</li> <li>, R82, R107, R55, R63, vere identified by facility to memory care unit of the</li> <li>um Data Set (MDS) dated</li> <li>59 was severely cognitively d diagnoses of Alzheimer's</li> <li>idated 11/6/15, indicated ition impairment, and ided anxiety disorder.</li> <li>dated 9/11/15 indicated R85 impairment, and diagnoses</li> </ul>	F1	64	Corrective Action For Residents At By Deficient Practice: To protect residents' privacy, both audio moni and corresponding audio receivers removed from the areas. Identification Of Other Residents H the Potential To Be Affected By De Practice: This had the potential to a all memory care unit residents, alou staff and visitors. Measures Or Systemic Changes M Ensure That Deficient Practice Will Recur: Both audio monitors and re were removed. Nursing staff were in-serviced on January 5 and 6, 20 regard to the removal of monitors, resident privacy rights, and approp approaches to resident safety and prevention. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Because monitors were removed for residen privacy, no further monitoring is ne	tors were laving ficien affect ng wi <sup>-</sup> Not eceive 16 in riate fall	e t th To ers	

Event ID: KMNR11

Facility ID: 00792

If continuation sheet Page 2 of 30

		D HUMAN SERVICES				FORM	): 01/15/2016 APPROVED
STATEMENT O	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245427	B. WING		_	12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
BETHESD	A NH PLEASANTVIEW			001 SOUTHEAST WILLMA WILLMAR, MN 56201	R AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 164	R116 had moderately diagnoses which inclu and anxiety. R82's significant char indicated R82 had set and diagnoses which anxiety disorder. R107's quarterly MDS R107 had severe cog diagnoses which inclu R55's quarterly MDS R55 had moderate co diagnoses which inclu R63's quarterly MDS, R63 had severe cogn diagnoses which inclu psychotic disorder. R71's quarterly MDS, R71 had severe cogn diagnoses which inclu psychotic disorder. R71's quarterly MDS, R71 had severe cogn diagnoses which inclu psychotic disorder. R71's quarterly MDS, R71 had severe cogn diagnoses which inclu psychotic disorder. R140's admission MD indicated R140 had set and diagnoses which R19's significant char indicated R19 had set and diagnoses which During observation or on 12/6/2015 at 1:33 and two correspondin	impaired cognition, and ided Alzheimer's dementia age MDS, dated 11/13/15, vere cognition impairment, included dementia and 6, dated 8/28/15, indicated nition impairment, and ided Alzheimer's dementia. dated 10/2/15, indicated ignition impairment, and ided dementia. dated 11/6/15, indicated ition impairment, and ided dementia and dated 7/31/15, indicated ition impairment, and ided Alzheimer's dementia. %, dated 10/15/15, evere cognition impairment, included amnesia. age MDS, dated 10/23/15, vere cognition impairment,	F 164				

If continuation sheet Page 3 of 30

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/15/2016 // APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245427	B. WING				12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE,	ZIP CODE		
BETHESE	A NH PLEASANTVIEW				901 SOUTHEAST WILLMAR AVI WILLMAR, MN 56201	ENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRECTIVE CROSS-REFERENCED			(X5) COMPLETION DATE
F 164	transmits signals) was the "C" hallway, near entry to the memory disc-shaped, approxir diameter and one inclinch inch antenna, hung fla from the floor betweet utility room. The mon LED light indicated it we monitor's correspondir receives and broadca a counter near the foo end of a larger common small red light indicated functioning. A second monitor was the "B" hallway, near in the memory unit. To on south side wall, be storage room, approx The monitor was plug corresponding received near the nursing station the large, open common During each day of the 12/10/2015, the audion memory unit were obso operating. On 12/9/19 and staff were seated in an activity by two sivoices from the received could be heard. In an interview on 12// trained medication as	a unit which collects and s located on the far end of the locked, double door unit. The monitor, mately five inches in h thick, with a protruding two at on the wall about six feet n room C1 and the soiled litor was plugged in, and an was operational. This ng receiver (a unit which sts signals) was located on od service tables, on one on area of the locked unit. A ed the receiver was s located at the far end of the double-door locked entry this monitor was positioned etween room B12 and the imate six feet from the floor. ged in and operating. A er was located on a counter, on, on the opposite side of non area. e survey, from 12/6/2015 to o monitors in the locked served to be on and 5 at 2:56 p.m., 12 residents around tables and were led taff members. Intermittently, ver near the kitchen area	F	164				

Facility ID: 00792

If continuation sheet Page 4 of 30

		D HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/15/2016 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE COMP	SURVEY
		245427	B. WING		-	12/ <sup>,</sup>	10/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE		
BETHESD	A NH PLEASANTVIEW			01 SOUTHEAST WILLMAR /ILLMAR, MN 56201	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 164	the day and evening h can hear people talkin are more quite at nigh resident had a TV on, conversation from the In an interview on 12/ licensed practical nurs monitors were on "all "just another aid" to h help. LPN-A stated th TABS (a personal safe On 12/10/2015 at 6:5 nearest the "B" hall nur was heard in the rece [staff name] is?I did treatment)then [R55 room, then." On 12/1 the receiver near the residents and staff co During a interview on LPN- B stated the mo hear what is going on monitors helped the s a pad alarm or a TAB helps to monitor the h In an interview on 12/ director of nursing (D0 the monitors was for " pressure and TAB ala fall prevention" for res did not know how long monitors, it could have the monitors were use	e if that was the case during nours. TMA-A stated "you ng" especially when the halls it. TMA-A also stated if a "you can hear the e TV." 10/2015 at 6:33 a.m., se (LPN)-A stated the the time," and they were ear residents who may need he receivers amplified the ety alarm device) alarms. i8 a.m., from the receiver ursing station, the following iver: "do you know where d [R55's] neb (a breathing 0/2015 at 7:15 a.m., from meal serving table, voices of uld be heard. 12/10/2015 at 6:59 a.m., ponitors on the unit "helps us ." LPN-B also stated the taff hear the call lights, or if alarm goes off, and "just	F 164				

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/15/2016 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245427	B. WING			12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHESD	A NH PLEASANTVIEW				01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 164	and operating "24/7." aware of any concern by families, or others, infringement of privace facility could look into night." The DON stat facility policy" regarding which might address of responsible to turn off regarding privacy con- stated the facility "sho their continued use. 483.13(c)(1)(ii)-(iii), (c) INVESTIGATE/REPC ALLEGATIONS/INDIV The facility must not e- been found guilty of a mistreating residents had a finding entered registry concerning all of residents or misapp and report any knowle court of law against a indicate unfitness for other facility staff to th or licensing authoritie The facility must ensu- involving mistreatment including injuries of un- misappropriation of re- immediately to the ad to other officials in ac- through established p State survey and cert	The DON said she was not as expressed or complaints with regard to possible y. The DON also stated the "just turning them on at ed presently, there was "no ing use of audio monitors, frequency of use, who was and on, or guidelines cerns. The DON then build look at the monitors" for e)(2) - (4) WRT /IDUALS employ individuals who have busing, neglecting, or by a court of law; or have into the State nurse aide buse, neglect, mistreatment propriation of their property; edge it has of actions by a n employee, which would service as a nurse aide or ne State nurse aide registry s. ure that all alleged violations it, neglect, or abuse, nknown source and esident property are reported ministrator of the facility and cordance with State law rocedures (including to the		2225			1/13/16

		D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/15/2016 APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE			
		245427	B. WING			12/10/2015		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BETHESD	A NH PLEASANTVIEW		901 SOUTHEAST WILLMAR AVENUE					
DETTESD								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
TAG F 225	Continued From page violations are thoroug prevent further potent investigation is in prog The results of all invest to the administrator or representative and to with State law (includi certification agency) v incident, and if the all appropriate corrective This REQUIREMENT by: Based on interview a facility failed to ensure immediately reported and thoroughly invest reviewed (R79, R87, I building without staff a Findings include: R79's progress note of facility had received a member (FM)-A who of facility and gone to he attached assisted livin the resident back to th	<ul> <li>6</li> <li>hly investigated, and must ial abuse while the gress.</li> <li>stigations must be reported this designated other officials in accordance ing to the State survey and within 5 working days of the eged violation is verified action must be taken.</li> <li>is not met as evidenced</li> <li>in document review, the e allegations of neglect were to the state agency (SA) igated for 3 of 3 residents R97) who had left the awareness.</li> <li>lated 11/16/15, indicated the call from R79's family reported R79 had left the ar at her apartment in the ing, and that she had brought</li> </ul>		225		ted care ed to sk. S		
	9/18/15, indicated he impaired and required activities of daily living During an interview of	was severely cognitively assistance with all			R97 was re-assessed for elopement ri and it was determined that a Wanderg continues to be appropriate for R97. Identification Of Other Residents Havi	ard		

Facility ID: 00792

If continuation sheet Page 7 of 30

			0		OMB NO. 0938
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245427	B. WING		12/10/201
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
BETHESD	A NH PLEASANTVIEW			901 SOUTHEAST WILLMAR AVE WILLMAR, MN 56201	NUE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE) CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPL TO THE APPROPRIATE DA
F 225	Continued From page	97	F 22	25	
	<ul> <li>225 Continued From page 7 duty the day R79 had gone to the assisted living unassisted by staff. RN-B stated she was unsure whether if FM-A had called the facility when he'd gotten to the assisted living, or if FM-A brought him back. RN-B further stated R79, "has memory loss and he used to live there" in reference to the assisted living. RN-B also stated she was unaware how long R79 had been gone that day.</li> <li>During an interview with FM-A, on 12/9/15 at 2:17 p.m., FM-A stated R79 had gotten to the assisted living on his own that day (11/16/15). She further stated he'd been over there "about an hour" before she (FM-A) had brought him back. FM-A further stated, "I don't know what he would do if I wasn't home."</li> <li>Although the provider had been informed by FM-A the resident had left the nursing home to see her, no additional investigation of the incident, nor reporting of the incident as potential neglect of supervision had been completed by the facility.</li> <li>During an interview with the director of nursing (DON) on 12/8/15 at 1:21 p.m., identified the</li> </ul>			the Potential To Be Affect Practice: All residents w identified to be at risk for re-assessed per new elect the safety data risk obsect appropriate measures a were put in place and car updated.	tho have been r elopement were opement section in ervation and nd interventions
				Measures Or Systemic Ensure That Deficient P Recur: The facility Abus Policy and Procedure w revised to incorporate el safety data risk observa and revised to improve f elopement. An incident	ractice Will Not se Prevention as reviewed and lopement. The tion was reviewed the assessment of
				developed to document elopement episodes. RI were in-serviced regard safety risk data observa staff were in-serviced or 6th, 2016 regarding Vulu reporting Vulnerable Ad situations, the revised A	and track N Nurse Managers ing the revised tion. All nursing n January 5 and nerable Adults and ult incidents and buse Prevention
	go see his FM-A at th been investigated or Agency.			Policy and Procedure, a incident report. All nursi an updated copy of the Policy and Procedure.	ng staff received Abuse Prevention
	p.m., the DON stated R79 was gone.	interview on 12/8/15, at 2:04 she did not know how long ess note dated 10/16/15, at		How The Facility Will Mo Performance To Make S Solutions Are Sustained DON or designee will re of elopement to ensure	Sure That I: Administrator, view all instances
	3:31 p.m. indicated R "Called this morning a	87's family member (FM)-C, and talked to Medical busy so family member		Adult reporting guideline well as our Abuse Preve Procedure. DON, ADON audit 10 resident charts	es are followed as ention Policy and Nor designee will

Facility ID: 00792

If continuation sheet Page 8 of 30

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIE	PLE CONSTRUCTION	(X3) DAT	OMB NO. 0938-03 (X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,	3	· · ·	PLETED		
		245427	B. WING		12	/10/2015		
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CO	DE			
BETHESD	A NH PLEASANTVIEW			901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE		
F 225	Continued From page	e 8	F 22	25				
	[R87] that [FM-C] call him [FM-C]. [R87] sta Writer told him [R87] there. About 1/2 hour received a phone call a phone call and that [FM-C] house on his Writer did talk with So nurse (RN) about this his son's for lunch an walked back to facility safely. Social Service afternoon." A Resident Progress identified as a late en social worker) had sp 10/16/15, after the re FM-C's via motorized indicated FM-D did no facility campus in his accompanied by fami indicated R87 had rea hospitalization and up therapy had assessed wheelchair and deter to use the wheelchair outside only while on R87's record was rev Referral Interdepartm dated 9/21/15, verifie	try, indicated writer (licensed boken with R87 and FM-D on sident had returned from wheelchair. The note ot want R87 going off the motorized wheelchair unless ily. The note further cently had a long bon return occupational d his use of motorized mined that he could continue within the facility and		ensure the revised safety ris observation has been compl plans updated by RN Nurse The audit will be presented t Quality Assurance committee compliance has been attained	eted and care Managers. o the facility e to verify that			

If continuation sheet Page 9 of 30

						FORM	): 01/15/2016 1 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245427	B. WING		_	12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
			9	01 SOUTHEAST WILLMA	RAVENUE		
BETHESD	A NH PLEASANTVIEW		v				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 225	moderately cognitivel locomotion on and off wheelchair. Although the facility s some cognitive impain supposed to leave the been no further invest incident, nor had a re- neglect of supervision Agency. R97's quarterly MDS, R97 had severe cogn independent with loco no wandering behavio R97's care plan dtaeo was at risk for eloperr for the resident to rem grounds. R97's care p "Wander in the parkin his way somewhere." intervention which dim staff of resident's atte dated 10/20/15. R97's progress note o identified R97 had be be walking east of the facility. The note iden R97 stated he was go get his driver's license walk with him to ensu building safe he beca fine and could get bao	y impaired, independent with f unit, and used a electric taff were aware R87 had rment, and was not e campus alone, there had tigation of the 10/16/15 port regarding the alleged n been made to the State dated 11/6/15, indicated itive impairment, was pmotion on the unit, and had ors. d 10/20/15, identified R97 nent and the identified goal hain safe on the facility blan identified R97 would g lot and state that he is on And included an ected "Wanderguard to alert mpts to leave the facility", dated 3/13/15, at 4:00 p.m. en found by a van driver to e sidewalk in front of the tified, when the writer found Wellness Center parking lot. bing to the license bureau to e. When told writer would	F 225				

If continuation sheet Page 10 of 30

		ID HUMAN SERVICES				FORM	D: 01/15/2016
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
		245427	B. WING			12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER	•	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHESD	A NH PLEASANTVIEW				01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 225	the elopement for pose R97's annual Safety/f 5/21/15, identified the elopement, wandering On 12/10/15 at 8:26 a Wanderguard was pla he was found outside day (3/13/15). R97 wa department of motor v license. Although R97 had an 3/13/15, the facility had the incident to the stat care. During interview with (DON) and social wor they stated they had in resident elopement in because they did not criteria for reporting s was injured. During interview 12/9 administrator stated h incidents for (R79, R8 did not report the inci- understanding that th requirement for repor- Review of the facility's Policy/Procedure revi- alleged violations of re- abuse, injury of unkno-	ssible neglect of care. Falls Risk Assessment dated re were "no concerns for g, behavior." a.m. RN-A stated a aced on R97's walker, after in the parking lot that same as wanted to go to the vehicles to get his drivers elopement episode on ad not immediately reported te agency for neglect of the director of nursing ker on 12/9/15 at 3:15 p.m., not reported any of the icidents (R79, R87, R97) feel the incidents met the ince none of the resident (15 at 3:30 p.m. the ne was aware of the 37 and R97) but the facility dents because it was not his e incidents met the ting. s Abuse Prevention sed 5/7/13, included: "All nistreatment, neglect,	F	225			

Facility ID: 00792

If continuation sheet Page 11 of 30

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/15/2016 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245427	B. WING			12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BETHESD	A NH PLEASANTVIEW		901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 225 F 226 SS=D	included: "All alleged neglect, injuries of un misappropriation of re investigated" The p "The failure to provide 483.13(c) DEVELOP/ ABUSE/NEGLECT, E The facility must deve policies and procedur	nplaints (OHFC), and (CEP)." The policy also mistreatment, abuse, known origin, esident property will be policy defined neglect as, e goods and services" IMPLMENT ETC POLICIES elop and implement written res that prohibit t, and abuse of residents		225			1/13/16
	by: Based on interview a facility failed to imple policy which required be immediately report and thoroughly invest reviewed (R79, R87, building without staff a Findings include: The facility's Abuse P revised 5/7/13, includ mistreatment, neglect origin, and misapprop will be reported imme Office of Health Facili	awareness. revention Policy/Procedure ed: "All alleged violations of t, abuse, injury of unknown viriation of resident property diately to the Administrator, ty Complaints (OHFC), and (CEP)." The policy also mistreatment, abuse,			Corrective Action For Residents Affect By Deficient Practice: R79 was re-assessed for elopement risk, and it was determined per assessment and conference with family that R79 require secured placement and was relocated our memory care unit on 12/18/2015. R87 was re-assessed for elopement ris R87 is alert and oriented and the BIMS score on his last assessment on 12/04/2015 was 15 out of 15. It was determined to have the following safety interventions in place: not to leave the campus without family present and a fl and slow moving sign were placed on I motorized wheelchair. R97 was re-assessed for elopement ris	are ed to sk. s / ag nis	

Event ID: KMNR11

Facility ID: 00792

If continuation sheet Page 12 of 30

		MEDICAID SERVICES				<u>NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245427	B. WING			2/10/2015
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
BETHESD	A NH PLEASANTVIEW			901 SOUTHEAST WILLMAR AVE WILLMAR, MN 56201	ENUE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE JIENCY)	(X5) COMPLETIC DATE
F 226	Continued From page	e 12	F 22	26		
	misappropriation of reinvestigated" The p	esident property will be policy defined neglect as, e goods and services"		and it was determined to continues to be approp	•	
	R79's progress note of	dated 11/16/15, indicated the		Identification Of Other I the Potential To Be Affe Practice: All residents y	ected By Deficient	
	facility had received a call from family member (FM)-A, who reported R79 had left the facility and gone to her at her apartment in the attached			identified to be at risk for re-assessed per new e	or elopement were lopement section in	
	assisted living, and the resident back to the fa	at she had brought the acility.		the safety data risk obs appropriate measures a were put in place and c	and interventions	
	R79's quarterly Minimum Data Set (MDS) dated 9/18/15, indicated he was severely cognitively			updated.		
	impaired and required activities of daily living			Measures Or Systemic Ensure That Deficient F Recur: The facility Abu	Practice Will Not	
	registered nurse (RN	n 12/9/15 at 9:51 a.m., )-B stated she had been on		Policy and Procedure v revised to incorporate e	vas reviewed and elopement. The	
	unassisted by staff. I	gone to the assisted living RN-B stated she was unsure		safety data risk observa and revised to improve	the assessment of	
	gotten to the assisted	Illed the facility when he'd living, or if FM-A brought		elopement. An incident developed to document	t and track	
	loss and he used to li assisted living. RN-B	er stated R79, "has memory ve there" in reference to the also stated she was 79 had been gone that day.		elopement episodes. R were in-serviced regard safety risk data observa staff were in-serviced o	ding the revised ation. All nursing	
		vith FM-A, on 12/9/15 at		6th, 2016 regarding Vu reporting Vulnerable Ac	dult incidents and	
	assisted living on his	ed R79 had gotten to the own that day (11/16/15). 'd been over there "about an		situations, the revised A Policy and Procedure, a incident report. All nurs	and the new facility	
	hour" before she (FM	-A) had brought him back. 'I don't know what he would		an updated copy of the Policy and Procedure.		
		had been informed by FM-A		How The Facility Will M Performance To Make		
	that R79 had left the additional investigation	nursing home to see her, no on of the incident, nor		Solutions Are Sustained DON or designee will re	d: Administrator, eview all instances	
	reporting of the incide	ent as potential neglect of		of elopement to ensure	the Vulnerable	

Event ID: KMNR11

Facility ID: 00792

If continuation sheet Page 13 of 30

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245427 B. WING 12/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 226 Continued From page 13 F 226 supervision to the state agency had been Adult reporting guidelines are followed as conducted by the facility. well as our Abuse Prevention Policy and Procedure. DON, ADON or designee will During an interview with the director of nursing audit 10 resident charts x 3 months to (DON) on 12/8/15 at 1:21 p.m., identified that on ensure the revised safety risk data 11/16/15 an incident related to R79's leaving to observation has been completed and care see FM-A at the assisted living had not been plans updated by RN Nurse Managers. reported to the State Agency. The audit will be presented to the facility Quality Assurance committee to verify that During a subsequent interview on 12/8/15, at 2:04 compliance has been attained. p.m., the DON stated she did not know how long R79 was gone. R87's quarterly MDS dated 9/24/15, indicated R87 was moderately cognitively impaired, independent with locomotion on and off unit, and used a electric wheelchair. R87's resident progress note dated 10/16/15, at 3:31 p.m. indicated R87's family member (FM)-C, "Called this morning and talked to Medical Secretary. [R87] was busy so family member [FM-C] asked that staff ask [R87] to call him. Writer did relay the message to [R87]. Writer told [R87] that [FM-C] called and wanted him to call him [FM-C]. [R87] stated, 'I will go up there.' Writer told him [R87] to call his son, not to go there. About 1/2 hour to 1 hours later writer received a phone call from [FM-D] saying she got a phone call and that [R87] went to his son's [FM-C] house on his motorized wheelchair. Writer did talk with Social Services and registered nurse (RN) about this matter. Resident did stay at his son's for lunch and then his daughter in law walked back to facility with him. He made it back safely. Social Services did talk with resident this afternoon."

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00792

If continuation sheet Page 14 of 30

PRINTED: 01/15/2016

		D HUMAN SERVICES					FORM	): 01/15/2016 APPROVED
STATEMENT (	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
				G				
		245427	B. WING			_	12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, ST			
BETHESD	A NH PLEASANTVIEW				1 SOUTHEAST WILLMA ILLMAR, MN 56201	RAVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	r	(EACH CORRE) CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 226	A Resident Progress i identified as a late en social worker) had sp 10/16/15, after the res FM-C's via motorized indicated FM-D did no facility campus in his accompanied by fami indicated R87 had rec hospitalization and up therapy had assessed wheelchair and detern to use the wheelchair outside only while on R87's record was revi Referral Interdepartm dated 9/21/15, verified therapist (COTA) had use his power wheelc outside, on campus. Although the facility s some cognitive impain supposed to leave the been no further invest incident, nor had a re neglect of supervision agency. R97's quarterly MDS, R97 had severe cogn independent with locc no wandering behavio	note dated 10/19/15, try, indicated writer (licensed oken with R87 and FM-D on sident had returned from wheelchair. The note of want R87 going off the motorized wheelchair unless ly. The note further cently had a long bon return occupational d his use of motorized mined that he could continue within the facility and the facility campus. We and a Resident ental Communication note d a certified occupational assessed R87 as safe to shair inside the facility and that fwere aware R87 had rment, and was not e campus alone, there had tigation of the 10/16/15 port regarding the alleged a been made to the state	F 2	26				

If continuation sheet Page 15 of 30

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/15/2016 // APPROVED ). 0938-0391
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE	
		245427	B. WING				12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER		-	s	STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
BETHESD	A NH PLEASANTVIEW				001 SOUTHEAST WILLMAR MILLMAR, MN 56201	AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 226	grounds. R97's care p "Wander in the parkin his way somewhere." intervention which dire staff of resident's atte dated 10/20/15. R97's progress note of identified R97 had be be walking east of the facility. The note ident R97, R97 was in the V R97 stated he was go get his driver's license walk with him to ensu building safe he becar fine and could get bac directed and returned indication the state ag the elopement for pos R97's annual Safety/F 5/21/15, identified the elopement, wandering On 12/10/15 at 8:26 a Wanderguard was pla he was found outside day (3/13/15). R97 wa department of motor v license. Although R97 had an 3/13/15, the facility ha the incident to the stat care.	hain safe on the facility olan identified R97 would ig lot and state that he is on And included an ected "Wanderguard to alert mpts to leave the facility", dated 3/13/15, at 4:00 p.m. en found by a van driver to e sidewalk in front of the tified, when the writer found Wellness Center parking lot. bing to the license bureau to e. When told writer would re he got back to the me annoyed stated he was ck on his own. He was easily to the facility. There was no gency was contacted about ssible neglect of care. Falls Risk Assessment dated are were "no concerns for g, behavior." a.m. RN-A stated a aced on R97's walker, after in the parking lot that same	F	226				

Facility ID: 00792

If continuation sheet Page 16 of 30

					FORM	2: 01/15/2016 1 APPROVED
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY
	245427	B. WING			12/	10/2015
ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
A NH PLEASANTVIEW				ENUE		
		<b>I</b>				0(5)
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	E ACTION SHOULD BE D TO THE APPROPRIAT		(X5) COMPLETION DATE
		F 226	1			
they stated they had r resident elopement in because they did not	not reported any of the cidents (R79, R87, R97) feel the incidents met the					
administrator stated h incidents for (R79, R8 did not report the incid understanding that the requirement for report	e was aware of the 7 and R97) but the facility dents because it was not his e incidents met the ting.					
		F 323				1/13/16
environment remains as is possible; and ea	as free of accident hazards ich resident receives					
by: Based on observation review the facility faile interventions to preve 3 residents (R79, R87 In addition the facility interventions for 1 of 3 identified falls. Findings include:	n, interview and document ed to implement nt further elopement for 2 of 7) reviewed for wandering. failed to implement fall 3 residents (R9) with		By Deficient Practice: R79 was re-assessed and it was determined and care conference w required secured place relocated to our memo 12/18/2015. Care plan R87 was re-assessed	for elopement risk per assessment /ith family that R7 ement and was ry care unit on was updated. for elopement risk	s, 9	
	S FOR MEDICARE & M DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER A NH PLEASANTVIEW SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page (DON) and social wor they stated they had r resident elopement in because they did not to criteria for reporting si was injured. During interview 12/9/ administrator stated h incidents for (R79, R8 did not report the incidents for (R79, R8 did not report the incident for report 483.25(h) FREE OF A HAZARDS/SUPERVIS The facility must ensure environment remains as is possible; and ear adequate supervision prevent accidents. This REQUIREMENT by: Based on observation review the facility failed interventions to prever 3 residents (R79, R87 In addition the facility interventions for 1 of 3 identified falls. Findings include:	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         245427         ROVIDER OF SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 16 (DON) and social worker on 12/9/15 at 3:15 p.m., they stated they had not reported any of the resident elopement incidents (R79, R87, R97) because they did not feel the incidents met the criteria for reporting since none of the resident was injured.         During interview 12/9/15 at 3:30 p.m. the administrator stated he was aware of the incidents for (R79, R87 and R97) but the facility did not report the incidents because it was not his understanding that the incidents met the requirement for reporting.         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 prevent further elopement for 2 of 3 residents (R79, R87) reviewed for wandering. In addition the facility failed to implement fall interventions for 1 of 3 residents (R9) with identified falls.	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES       (x1) PROVIDERSUPPLIERCLIA       (x2) MULTIPLE CONSTRUCTION         A BUILDING	MENT OF HEALTH AND HUMAN SERVICES       Corrective Action For Residents Affecte         SP FOR MEDICARE & MEDICAL DERVICES       (X1) PROVIDER/SUPPLIERCLIA         Deficiencies       (X1) PROVIDER/SUPPLIERCLIA         224527       B. WING         A NH PLEASANTVIEW       STREET ADDRESS, GTV, STATE, 2P CODE         SUMMARY STATEMENT OF DEFICIENCIES       91 SOUTHEAST WILLMAR AVENUE         REGULATORY OR LSC IDENTIFYING INFORMATION)       Tag         Continued From page 16       F 226         (DON) and social worker on 12/9/15 at 3:15 p.m., they stated they had not reported any of the resident elopement incidents (R79, R87, R77) because they did not feel the incidents met the criteria for reporting, 143.25(h) FREE OF ACCIDENT       F 226         During interview 12/9/15 at 3:30 p.m. the administrator stated the was aware of the incidents met the regularement for reporting, 483.25(h) FREE OF ACCIDENT       F 323         The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident teoevies adequate supervision and assistance devices to prevent accidents.       F 323         This RECUIREMENT is not met as evidenced by:       Corrective Action For Residents Affectee By Deficient Practice:         Interventions to prevent further elopement field in fall, fault to implement field falls.       Corrective Action For Residents Affectee By Deficient Practice:         This RECUIREMENT is not met as evidenced by:       R79 was re-assesseed for elopement risi and it was determin	MENT OF HEALTH AND HUMAN SERVICES FORM SFOR MEDICARE & MEDICALD SERVICES OMB NC prepercencies (X1) PROVERSUMPLENCIA IDENTIFICATION NUMBER 245427 8 (X1) ROWDER OR SUPPLER A IN PLEASANTVIEW AN IN PLEASANTVIEW SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 55201 SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 55201 SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 55201 SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 55201 FORM, MN 56201 SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 55201 SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 55201 FORM, MN 56201 FORM, SCI SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 56201 FORM, SCI SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 56201 FORM, SCI FORM, SCI SITURE TADRESS, CITY, STRIE, 2IP CODE 901 SOUTHEAST WILLIAMR AVENUE WILLMAR, MN 56201 FORM, SCI FORM, SCI SITURE TADRESS, CITY, STRIE, 2IP CODE 12/ CONTRECTION (STRIE, 2IP COD 12/ CONTRECTION (STRIE, 2IP COD 12/ CONTRECTION (STRIE, 2IP COD 12/ CONTRECTION (STR

Event ID: KMNR11

Facility ID: 00792

If continuation sheet Page 17 of 30

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245427 B. WING 12/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 17 F 323 9/18/15, indicated he was severely cognitively score on his last assessment on impaired, required assistance with all activities of 12/04/2015 was 15 out of 15. It was daily living and had no wandering behaviors. determined to have the following safety interventions in place: not to leave the R79's care plan dated 10/30/15 had a problem of campus without family present and a flag cognitive impairment and indicated he was "Often and slow moving sign were placed on his concerned about his wife and her whereabouts." motorized wheelchair. Care plan was There was no indication that R79 had any updated. wandering behaviors identified. R9's anti-tip bars were placed in the down position and locked into place. Care plan A facility admission Safety Falls Risk assessment on 6/19/15 identified, R79 had confusion, history was updated. of multiple falls, and did not mention any wandering risk for R79. The 9/18/15 quarterly Identification Of Other Residents Having review indicated safety were monitored The Potential To Be Affected By Deficient continuously however the assessment did not Practice: All residents who have been address if R79 was at risk for wandering identified to be at risk for elopement were behaviors. re-assessed per new elopement section in the safety data risk observation and A review of facility progress notes indicated on appropriate measures and interventions 11/16/15, the facility received a call from R79's were put in place and care plans were family member (FM)-A who reported R79 had left updated. the facility and came to her assisted living A facility audit was conducted to verify that apartment that day but was back in facility now. On 11/16/15 a subsequent progress note residents using anti-tip bars were assessed for appropriateness and that the indicated, R79 had vocalized to staff he wanted to go "upstairs" and visit FM-A. A progress note bar was down and in locked position. dated 11/26/15 indicated R79 was observed by staff wandering in hallways in his wheel chair, the Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not note further indicated R79 was confused and did not know where he was. A progress note dated Recur: The safety data risk observation 12/1/15, indicated R79 was observed by staff was reviewed and revised to improve the attempting to push the button that opened the assessment of elopement. RN Nurse doors leading to the assisted living wing of the Managers were in-serviced regarding the complex. R79 stated he was going to see FM-A. revised safety risk data observation. All Staff re-directed R79 after each event. nursing staff were in-serviced on following care plan interventions. There was no indication that R79 had been reassessed for his wandering risk even though he Maintenance staff were in-serviced on

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00792

If continuation sheet Page 18 of 30

PRINTED: 01/15/2016

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING 245427 B. WING 12/10/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA NH PLEASANTVIEW** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 18 F 323 had an elopement episode on 11/16/15, and how to appropriately place anti tip bars on made continued attempts to leave the nursing wheelchairs. RN Nurse Managers were in-serviced to assess appropriateness of home. anti-tip bars per safety data risk During an observation on 12/8/15, at 9:11 a.m., assessment. All nursing staff were R79 propelled himself toward to front entrance of in-serviced on proper placement and the facility and stated, "I'm looking for [FM-A]', positioning of anti-tip bars. and was re-directed by an unknown activity staff. How The Facility Will Monitor During an interview on 12/8/15, at 1:08 p.m., Performance To Make Sure That Solutions Are Sustained: Administrator, nursing assistant (NA)- J stated, R79 never tries to leave the unit. She stated FM-A comes every DON or designee will review all instances afternoon to visit him. NA- J was unaware of any of elopement to ensure the Vulnerable attempts by R79 to leave the facility but stated, Adult reporting guidelines are followed as "he makes statements that he wants to go see well as our Abuse Prevention Policy and [FM-A]." Procedure. DON, ADON or designee will audit 10 resident charts x 3 months to During an interview on 12/8/15, at 1:11 p.m., ensure the revised safety risk data health unit coordinator (HUC)-A stated, "I know observation has been completed and care he [R79] tries to go visit [FM-A] in assisted living," plans updated by RN Nurse Managers. She stated, he can't go by himself and FM-A The audit will be presented to the facility needs to come and get him. HUC-A stated, "He Quality Assurance committee to verify that has gotten over there" and further stated, if he is compliance has been attained. headed that direction, staff will intervene and DON, ADON or designee will do 10 bring him back to the unit. random audit checks of anti-tip bars monthly to ensure they are placed appropriately x 3 months. The audit will be During an interview on 12/8/15, at 1:14 p.m., registered nurse (RN)- A stated, R79 is usually up presented to the facility Quality Assurance before eight am, eats breakfast and rests in his committee to verify that compliance has room. RN- A stated R79 will try to find FM-A if she been attained. is not here. She further stated she was "not sure if he has gotten to assisted living. RN-A then stated, if R79 got to assisted living, she would ask FM-A if he could visit, if not she would bring him back to the facility. RN-A was "not sure" of the facilities procedure regarding a resident leaving the facility stating, "it depends on the situation." During an interview on 12/8/15, at 2:04 p.m., the

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00792

If continuation sheet Page 19 of 30

PRINTED: 01/15/2016

		D HUMAN SERVICES				FORM	0: 01/15/2016 APPROVED
STATEMENT (	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245427	B. WING			12/	10/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
BETHESD	A NH PLEASANTVIEW						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	DON stated she had of Watchmate ID bracele alert staff if a resident facility by sounding ar door.) on R79, but de doorway leading to th have a sensor. During an interview of family member (FM)-// the assisted living on he was there for "abo him back after they vi- she did not know what R79 from leaving the stated, "I don't know whome." During and interview of trained medication aid check on R79 often b system for checking h stated, she was award past but was not award During an interview of social worker (SW)-A for rehab." She stated the assisted living fac further stated, "he fixa constantly, he lived th go." "He gets it in his to get over there." She one time he got to the by staff. She stated sl interventions to monit Even though R79 had	discussed putting a et (a bracelet designed to cattempts to leave the n alarm and/or locking a cided against it because the e assisted living does not n 12/9/15, at 2:17 p.m., A stated R79 had gotten to his own that day. She stated ut an hour and she brought sited." FM-A further stated it staff was doing to prevent facility on his own and what he would do if I wasn't on 10/10/15, at 8:29 a.m., de (TMA)-C stated, staff ut stated there is no formal his whereabouts. TMA-A e of his wandering in the re of anything recently. n 12/10/15, at 8:45 a.m., stated, "I think R79 came in d he was unable to return to ility with his wife. SW-A ates on seeing her here so he knows where to head and will randomly try e stated she was aware on e assisted living unassisted he was unaware of any	F 32	3			

If continuation sheet Page 20 of 30

		D HUMAN SERVICES					FORM	): 01/15/2016 APPROVED ). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245427	B. WING				12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
BETHESD	A NH PLEASANTVIEW			9	01 SOUTHEAST WILLMAR AVENUE			
DETTESD				W	VILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
TAG F 323	Continued From page FM-A, the facility had elopement, or implem ensure R79's safety. R87's quarterly Minim 9/24/15, indicated he impaired, independen unit and used a electr further indicated he had with no injury and had During observation 12 was observed to be ri restorative nursing the R87's care plan dated dementia without beh motorized wheelchair facility and off campus indicated physical the of motorized wheelchair facility with family, to campus, but have sor when he goes off cam indicated he had rece himself against therap family does support the The care plan approa encourage him to sign facility with family, to cell phone with him. A Safety Falls Risk As	e 20 not reassessed his risk for rented any interventions to num Data Set (MDS) dated was moderately cognitively at with locomotion on and off ic wheelchair. The MDS ad one fall since admission a no wandering behaviors. 2/09/2015 at 9:28 a.m. R87 ding an exercise bike in the		323			TE	DATE
		Referral Interdepartmental 9/21/15, indicated from						

If continuation sheet Page 21 of 30

DEPARTMENT OF HEALTH AND HUMAN SERVICES						FORM	0: 01/15/2016 APPROVED
CENTERS FOR MEDICARE & MEDICARE           STATEMENT OF DEFICIENCIES         (X1)           AND PLAN OF CORRECTION         (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
2454		245427	B. WING			12/10/2015	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
BETHESDA NH PLEASANTVIEW			901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				(X5) COMPLETION DATE
F 323	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 323				

If continuation sheet Page 22 of 30

		D HUMAN SERVICES MEDICAID SERVICES				FORM	01/15/2016 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	
		245427	B. WING		_	12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
DETUERD	A NH PLEASANTVIEW		9	01 SOUTHEAST WILLMAR	RAVENUE		
DETHEOD			v	VILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 323	Continued From page Even though R87, had that facility had not re- risk, and implemented to ensure his safety. During interview 12/08 (NA)-K they try to kee stated there is no form we do throughout the During interview 12/08 stated that on Octobe facility and did not sig he went to his son's h worried about him, an to get to the home. R8 home, but fears some (R87). During interview 12/10 (COTA)-B stated he e strengthening, ADL's assessed his wheelch recommended that he when he goes off carr sometimes unaware of further stated R87 nee keep down his speed chair. The facility is ne had not been evaluate wheelchair to cross th curb to ensure his safe	e 22 d eloped from the facility, assessed R87's elopement d appropriate interventions 8/15, nursing assistant p an eye on him (R87), but nal monitoring system that day to keep him safe. 8/15, family member (FM)-D r 16th, 2015 R87 left the n himself out. FM-D stated ouse because he was d had to cross a city street 87 did make it safe to the ething could happen to him 0/15, at 8:15 a.m. with valuated R87 for (activity of daily living) and hair. COTA-B stated he have somebody with him hpus because he is of his surroundings. He eded to be reminded to when using the power ear a busy road and R87 ed with the use of his power ie road or go up and down a	F 323				DATE
	when off facility camp 10/16/15, the facility c	us, which occurred on lid not have appropriate to ensure R87's safety					

If continuation sheet Page 23 of 30

		D HUMAN SERVICES				FORM	01/15/2016 APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		245427	B. WING			12/*	10/2015
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
DETUEOD			9	01 SOUTHEAST WILLMA	R AVENUE		
DEINESD	A NH PLEASANTVIEW		v	VILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	23	F 323				
	A facility policy for elo none was provided.	pement was requested but					
	had diagnoses of cere movement disorder w symptoms often of po muscles, weak muscl paraplegia (impairment function of the lower of further indicated he mo on/off the unit and use R9's care plan dated risk for falls and injury with infantile cerebral seizure disorder, hype developmentally inapp hyperactivity and impur and a fall history. The included position uprig leg rests, and dycem During observations t On 12/06/15, at 5:33   wheelchair and the rig are fitted on wheelchat tipping over) was turr into place. On 12/07/15, at 9:33 a sitting up in wheelchat right anti-tip bar was to On 12/08/15, at 7:55 a dinning room chair sit anti-tip bars in same p On 12/10/15, at 8:44 a dinning room and right	or coordination, stiff es, and tremors) and nt in motor or sensory extremities). The MDS eeded extensive assistance ed a wheelchair. 07/08/15, indicated he is at v related to advanced age palsy, mental retardation, erkinetic disorder (which propriate inattention, ulsivity), spastic paraplegia, e care plan interventions ght in wheelchair, padded in wheelchair. he following was noted: p.m. R9 was up in his ght anti-tip bar (Anti-tip bars airs to prevent them from ned in 1 inch and not locked a.m. R9 was observed ir in his room and again the curned in 1 inch. a.m. R9 was sitting in ting up in wheelchair with					

Facility ID: 00792

If continuation sheet Page 24 of 30

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 01/15/2016 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE	
		245427	B. WING			_	12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
BETHESD	A NH PLEASANTVIEW				01 SOUTHEAST WILLMAR VILLMAR, MN 56201	RAVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	During interview 12/10 occupational therapis custom stilt and space and staff can tilt him b repositioning since he The OT-C stated the a down position to prev During interview 12/10 stated the anti-tip bars position and the bars and would fix them rig 483.30(e) POSTED N INFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number an by the following categ unlicensed nursing sta resident care per shiff - Registered nurse - Licensed practic vocational nurses (as - Certified nurse a o Resident census. The facility must post specified above on a of each shift. Data m o Clear and readable o In a prominent place residents and visitors. The facility must, upo make nurse staffing d	D/15, at 2:27 p.m. the t (OT)-C stated R9 has a e wheelchair from Gillette, wack every two hours for e refuses to lay down in bed. anti-tip bars should be in the ent him from tipping over. D/15, at 2:35 p.m. the DON is should be in the down were not effective for R9 pht away. IURSE STAFFING the following information on and the actual hours worked ories of licensed and aff directly responsible for the nurse staffing data dafined under State law). ides. the nurse staffing data daily basis at the beginning ust be posted as follows: format. e readily accessible to		323				1/13/16

If continuation sheet Page 25 of 30

		D HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 01/15/2016 MAPPROVED O. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245427	B. WING		1:	2/10/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	•	
BETHESD	A NH PLEASANTVIEW			901 SOUTHEAST WILLMAR AVENUE		
DETTEOD				WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 356	Continued From page standard.	25	F 356	3		
	staffing data for a min	tain the posted daily nurse imum of 18 months, or as , whichever is greater.				
	by: Based on observation review, the facility fail required nursing staffi basis at the beginning potential to affect all 1 facility and all visitors. Findings include: During initial tour on 1 facility staff posting da posted on a bulletin b Although the name of census, total and actu	2/06/15, at 1:00 p.m. the ated 12/04/15, was observed oard in the facility entryway.		Corrective Action For Reside By Deficient Practice: Nurse Information Posting policy an was reviewed and revised. P will be updated daily – includ weekends and holidays. Identification Of Other Reside the Potential To Be Affected I Practice: This had the poten all 110 current residents in th along with interested family visitors. Measures Or Systemic Chan Ensure That Deficient Practice	Staffing ad procedure Posting form ling on ents Having By Deficient tial to affect te facility, members and	
	assistant director of n weekend supervisor w the posting and had n information. A facility policy revise Hours indicated "The will be posted within t date." The policy furt coordinator or designar responsible for printin sheet for Saturday an	d 08/2013, Nurse Staffing staffing hours sheet report he facility and be kept up to her indicated the staffing ated person will be g and posting the staffing		Recur: Nurse Staffing Inform policy and procedure was rev revised. Staffing Coordinator Nurse Managers were in-ser policy and procedure. How The Facility Will Monitor Performance To Make Sure T Solutions Are Sustained: Sta Coordinator will audit weekly that the posting form had bee and updated over the weeke will be presented to the facilit Assurance committee to veri	nation Posting viewed and and RN viced on new r That ffing x 3 months en changed nd. The audit ty Quality	

Facility ID: 00792

If continuation sheet Page 26 of 30

TATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	D. 0938-039 SURVEY PLETED
		245427	B. WING			12/10/2015	
	ROVIDER OR SUPPLIER			90	IREET ADDRESS, CITY, STATE, ZIP CODE DI SOUTHEAST WILLMAR AVENUE /ILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ACTION SHOULD BE COMPL TO THE APPROPRIATE DA	
F 356 F 371 SS=E	putting out the censu current day. 483.35(i) FOOD PRC STORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	s/staffing hours for the DCURE, ERVE - SANITARY In sources approved or ory by Federal, State or local stribute and serve food		356	compliance has been attained.		1/13/16
	by: Based on observatio review, the facility fail served in a sanitary r dining rooms. This h of 30 residents who a Findings include: During continuous ob 5:10 p.m. to 5:47 p.n memory care unit wa assistant (DA)-D wor which held numerous including potato salad hot dogs, buns, and v individual serving bov also prepared in vario the food compartment was a scoop or slotte	T is not met as evidenced on, interview and document led to ensure food was manner in 1 of 2 resident ad the potential to affect 22 ate in the memory care unit.			Corrective Action For Residents Affected By Deficient Practice: Dietary Assistant (D) was re-educated on properly handlin and serving food on 12/06/2015 after facility was made aware of deficient practice. Identification Of Other Residents Having The Potential To Be Affected By Deficie Practice: All residents being served meals by this deficient practice have the potential to be affected. Measures Or Systemic Changes Made Ensure That Deficient Practice Will Not Recur: All dietary staff were in-serviced with regard to proper service and handli of food to ensure food is served in a sanitary manner.	ng g nt e To	

Facility ID: 00792

If continuation sheet Page 27 of 30

	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 01/15/2016 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		245427	B. WING			12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BETHESE	OA NH PLEASANTVIEW				1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	5:15 p.m., DA-D bega onto plates, which we their tables. At 5:17 p.m., with glov on the table, and with each of potato salad a DA-D placed sliced to the plate to a staff me were made similarly. hands, DA-D began le binder on the steam t with papers covered v and contained informa dietary needs. After f sheets with both glove located and read infor Next, DA-D set anoth opened, with the sam bun on this resident's other foods on the plate spoon, before passing be served to a resided Between 5:19 p.m. ar up nine resident plate regular-textured meal a hot dog bun, opene [DA-D also leafed thro additional four times. meals for residents w textures, and used late door, and retrieved ac on the steam table, and s	an dishing up foods onto re delivered to residents at wed hands, DA-D set a plate the scoop, placed a serving and beets. Using the tongs, matoes on top, and handed mber. Two additional plates At 5:19 p.m., with gloved eafing through a ringed able. The binder was filled with plastic sheet protectors, ation regarding residents' lipping through the plastic ed hands, DA-D then mation on the plastic sheet. er plate down, grasped and e gloved hands, a hot dog plate. DA-D then served ite, using the scoops and g the plate to a co-worker to nt. ad 5:29 p.m., DA-D dished s. For six residents with s, DA-D each time grasped d it with the gloved hands. bugh the binder an DA-D also dished up three ho received altered dles and scoops. ent to the cupboard behind	F 3	71	How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Dietary Manager, Clinical Dietician, or designe will do 10 random meal audits x 3 mor to ensure food is served appropriately sanitarily. The audit will be presented the facility Quality Assurance committe verify that compliance has been attain	ths and o ee to	

		D HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 01/15/2016 RM APPROVED
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		245427	B. WING		1:	2/10/2015
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CO	•	
BETHESD	A NH PLEASANTVIEW			01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 371	reading a page, place scooped other foods, p.m. and 5:40 p.m., D resident meals, four of textured meals, each handled with the glow referenced the binder more times. During the entire obse pair of gloves. DA-D cleanse hands or cha leafing through the pla information pages nut opening the cupboard food service. In an interview on 12/ stated she did not wa gloves after looking th order binder, and also cupboards in the kitch residents's meals, inc on plates with dirty gl easier "to grab the ho rather than using the open. During an interview of the dietary manager ( clean hands, only one the steam table dishir were to deliver the pla residents. The DM sta refer to the resident d something from the cu	e for a resident, and after d another hot dog bun, and on this plate. Between 5:30 A-D dished up six more f which were regular received a hot dog bun ed hands. DA-D also , with her gloved hands, two ervation DA-D wore only one did not wash or otherwise nge gloves, neither after astic-covered diet merous times, nor after I doors during the evening 6/2015 at 5:41 p.m., DA-D sh her hands or change mough the resident's diet o opening and closing nen, and continued to set up luding placing hot dog buns loves. DA-D stated it was t dog buns with her hands, tongs" to get the buns to n 12/10/2015 at 1:35 p.m., DM) stated to maintain e person was to be behind og up meals, and other staff ates and beverages to ated if the server needed to	F 371			

Facility ID: 00792

If continuation sheet Page 29 of 30

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 01/15/2016 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		CONSTRUCTION		(X3) DATE	
		245427	B. WING				12/	10/2015
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE,	ZIP CODE		
BETHESC	A NH PLEASANTVIEW				01 SOUTHEAST WILLMAR AV	ENUE		
				V	VILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVI CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 371	how they are trained. after opening the cup sheets, "could have w new gloves" before co cupboard handles an were considered uncl servers were not requ were trained to handl to use tongs and score said. The DM also sa tongs" to serve the ho the bread with bare h A facility policy, Servi revised 1/2015, indica "Good Personal Hygi	The DM also added DA-D, board or touching the plastic vashed her hands, or put on ontinuing. The DM stated d plastic-covered sheets	F	371				

Facility ID: 00792

If continuation sheet Page 30 of 30

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION AIN BUILDING 01		E SURVEY IPLETED
		245427	B. WING			12/	07/2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CC		
BETHES	DA NH PLEASANTVI	EW			JTHEAST WILLMAR AVENUE AR, MN 56201	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
K 000	INITIAL COMMEN	ГS	K 0	00			
	FIRE SAFETY						
	ALLEGATION OF O				<i>u</i> =		
	ON-SITE REVISIT VALIDATE THAT S WITH THE REGUL	F AN ACCEPTABLE POC, AN MAY BE CONDUCTED TO UBSTANTIAL COMPLIANCE ATIONS HAS BEEN ORDANCE WITH YOUR					2
	Minnesota Departm Fire Marshal Division the time of this sum Nursing Home Pleat compliance with the in Medicare/Medicat 483.70(a), Life Safe edition of National (NFPA) Standard 1	Survey was conducted by the nent of Public Safety, State on, on December 07, 2015. At vey, Building 01 of Bethesda asant View was found not in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), g Health Care Occupancies.				4 B 14 14 14	
	PLEASE RETURN CORRECTION FO DEFICIENCIES ( K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY			EPO	C	
	Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	Division Suite 145 -5145, or					
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 01/06/2
	ically Signed				be excused from correcting		

program participation.

		AND HUMAN SERVICES			0		APPROVED 0938-0391
		& MEDICAID SERVICES	1			1	SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		PLETED
		245427	B. WING			12/0	07/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHES	DA NH PLEASANTVI	EW			01 SOUTHEAST WILLMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	КO	00			
	Angela.Kappenmar	itney@state.mn.us> and					
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of v to correct the defici	what has been, or will be, done ency.			2		
	2. The actual, or pro	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency					
	View is a one-story The facility is fully fi was constructed as The original 1979 b of Type V(111) cons The 1994 building a of Type II(000) cons The 1999 building a of Type II(000) cons The facility has a fin detection in the cor corridors, which is n department notifica	uilding was determined to be struction; addition was determined to be struction; addition was determined to be					71

A REAL PROPERTY AND A REAL PROPERTY AND A REAL PROPERTY A

1 Statements

Facility ID: 00792

If continuation sheet Page 2 of 5

PRINTED: 01/13/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO.	01/13/2016 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
		245427	B. WING			07/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
BETHES	DA NH PLEASANTVI	EW		901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	The requirement at NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by:	K 00			1/13/16
K 056 SS=D	If there is an autom installed in accorda for the Installation of provide complete of building. The syste accordance with NF Inspection, Testing, Water-Based Fire F supervised. There supply for the syste systems are equipp	FETY CODE STANDARD atic sprinkler system, it is nce with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the m is properly maintained in FPA 25, Standard for the and Maintenance of Protection Systems. It is fully is a reliable, adequate water m. Required sprinkler bed with water flow and tamper e electrically connected to the system. 19.3.5	K 05	0		1/13/10
	Observations indic sprinkler system ha accordance with NF Installation of Sprin section 5-5.6. This fire to grow uncontr impact residents, vi Findings include: Observations during 07, 2015, between the following: 1) In room D8 the re	s not met as evidenced by: ated that the automatic is not been maintained in -PA 13 Standard for the kler System 1999 edition deficient practice may allow a rolled which will negatively sitors and staff. g the facility tour on December 10am and 2:30PM, revealed esident bathroom has been oset and shelves have been		Corrective Action For Resider By Deficient Practice: The she room D8's bathroom have bee to not impede the sprinkler he decorations hanging from the head in room D8 were remove Identification Of Other Reside the Potential To Be Affected B Practice: A facility audit was of ensure all resident rooms hav within 18 inches of the sprinkle Measures Or Systemic Change Ensure That Deficient Practice Recur: A facility audit tool wa	elves in en removed sad. The sprinkler ed. nts Having by Deficient completed to e no storage er heads. ges Made To e Will Not	

A STATE OF THE A

Facility ID: 00792

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION (X 01 - MAIN BUILDING 01		E SURVEY PLETED
		245427	B. WING			12/0	)7/2015
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHES	DA NH PLEASANTVII	EW			01 SOUTHEAST WILLMAR AVENUE /ILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
K 056	Assistance was nee head due to patient 2) In room D8 the r hanging from the s	eded to locate the sprinkler storage. esident had decorations prinkler head in the room.	ĸ	056	to be completed monthly by maintena personnel to verify that all resident ro have no storage within 18 inches of the sprinkler heads. Maintenance person were educated on the audit process. Education regarding appropriate stora was provided to residents at their neighborhood resident council meetin on January 8, 2015. Nursing staff we in-serviced on not having storage with 18 inches of a sprinkler head and to re maintenance if so.	oms ne nnel age ngs ere nin	
					How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: The residen room inspection for storage within 18 inches of a sprinkler head will be aud by the Administrator monthly x 3 mon The results of the audit will be presen to the facility Quality Assurance comm to verify that compliance has been maintained.	ited ths. nted	
K 147 SS=F	Electrical wiring and	FETY CODE STANDARD d equipment is in accordance onal Electrical Code. 9.1.2	K 1	47			1/13/16
	Observations revea installations are not "The National Elect deficiency could ne	s not met as evidenced by: aled that some electrical t in accordance with NFPA 70 rical Code 1999 edition. This gatively effect any resident, this area of the facility.			Corrective Action For Residents Affe By Deficient Practice: The extension in the front lobby was removed. The refrigerator in room D8 was plugged the outlet rather than the power strip. extension cord was removed from ro E9.	cord into The	

F.

Event ID: KMNR21

Facility ID: 00792

If continuation sheet Page 4 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE : COMPI	
		245427	B. WING		12/07	7/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
RETHES	DA NH PLEASANTVI	FW	1	001 SOUTHEAST WILLMAR AVENUE		
DETTIES				WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
K 147	Continued From pa	ngé 4	K 147			
¥1	07, 2015, between the following:	g the facility tour on December 10am and 2:30PM, revealed rd in the main lobby at the		Identification Of Other Residents H the Potential To Be Affected By Def Practice: All facility residents, visito and staff have the potential to be af by the deficient practice.	ficient ors,	
	2) Rm D-8 Refriger strip.	ator plugged into a power ug adapter plugged into an		Measures Or Systemic Changes M Ensure That Deficient Practice Will Recur: A facility audit tool was devi to be completed monthly by mainte personnel to verify that resident roc common areas, and offices are free	Not eloped nance oms, e from	
	The Facilities Main these findings durir	tenance Director (GR) Verified ng the facility tour.		extension cords and power strips a being used appropriately. Maintena personnel were educated on the co- use of electrical installations and th process. Education regarding appro- use of extension cords and power s was provided to residents at their neighborhood resident council mee on January 8, 2015.	ance orrect le audit opriate strips	
				How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: The audit findings will be audited by the Administrator monthly x 3 months. results of the audit will be presente facility Quality Assurance committe verify that compliance has been maintained. Nursing staff were in-s	The d to the e to	

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Ser California California

Facility ID: 00792

PRINTED: 01/13/2016

			AND HUMAN SERVICES		F	5(127025	FORM	01/13/2016 APPROVED 0938-0391
	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 02 - MEMORY UNIT	(X3) DAT	E SURVEY IPLETED
			245427	B. WING	·		12/	07/2015
ł	NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
	BETHES	DA NH PLEASANTVI	EW			01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201		
	(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	K 000	INITIAL COMMEN	TS	K	000			
		FIRE SAFETY						
		Minnesota Departn Fire Marshal Division the time of this sum Nursing Home Plea compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 18 New Ho Building 02 of Beth View consists of the additions. These a height, have a part sprinkler protected Type II(000) constr The facility has a fil detection in the cor corridors, which is department notification	Survey was conducted by the nent of Public Safety, State on, on December 07, 2015. At vey, Building 02 of Bethesda asant View was found in e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care Occupancies. esda Nursing Home Pleasant e 2005 and 2010 building idditions are one-story in ial basement, are fully fire , and were determined to be of uction. re alarm system with smoke tridors and spaces open to the monitored for automatic fire ation. The facility has a ds and had a census of 111 at			EPOC		
						7171 5		(X6) DATE
1		y DIRECTOR'S OR PROVI nically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		01/06/2016
į	20000					tion may be eveneed from correcting providin	a it is det	ermined that

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted December 29, 2015

Mr. Brandon Pietsch, Administrator Bethesda Nursing Home Pleasantview 901 Southeast Willmar Avenue Willmar, Minnesota 56201

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5427026

Dear Mr. Pietsch:

The above facility was surveyed on December 6, 2015 through December 10, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5427020 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

Bethesda Nh Pleasantview December 29, 2015 Page 2

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Brenda Fischer, Unit Supervisor at (320)223-7338.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Tomston

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

# PRINTED: 01/15/2016 FORM APPROVED

Minnesot	a Department of Healt	1				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>`</b> ,	CONSTRUCTION	(X3) DATE S COMPLI	
		00792	B. WING		12/1	0/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
BETHESD	A NH PLEASANTVIEW		HEAST WILLM 2, MN 56201	AR AVENUE		
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2 000	Initial Comments		2 000			
	*****ATTEN	TION*****				
	NH LICENSING C	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficience herein are not correction not corrected shall be with a schedule of finithe Minnesota Depart Determination of when corrected requires correquirements of the minnes number and MN Rule When a rule contains comply with any of the lack of compliance. It re-inspection with any	ther a violation has been mpliance with all ule provided at the tag number indicated below. several items, failure to e items will be considered .ack of compliance upon y item of multi-part rule will				
		ent of a fine even if the item ng the initial inspection was				
	that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a for non-compliance.				
	receipt of State licens the Minnesota Depar Informational Bulletin http://www.health.stat obul.htm The State delineated on the atta	articipate in the electronic sure orders consistent with ment of Health 14-01, available at te.mn.us/divs/fpc/profinfo/inf icensing orders are				
LABORATORY	partment of Health DIRECTOR'S OR PROVIDER/S cally Signed	SUPPLIER REPRESENTATIVE'S SIGNATURE	Ξ	TITLE		(X6) DATE 01/06/16

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
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		00792		710.0005	12/10/2015	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE			
BETHESD	A NH PLEASANTVIEW		R, MN 56201	AVENUE		
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2 000	Continued From page	e 1	2 000			
	you electronically. Al is necessary for State enter the word "corre text. You must then in State licensure proce completion date, the corrected prior to elec Minnesota Departme On 12/6 thru 12/10/1 Department's staff, vi the following correction Please indicate in you correction that you ha and identify the date Minnesota Departme the State Licensing C federal software. Tag assigned to Minnesot Nursing Homes. The appears in the far left Tag." The state statu listed in the "Summar column and replaces the correction order. the findings which are statute after the state as evidence by." Follo are the Suggested M Time period for Corre PLEASE DISREGAR FOURTH COLUMN V "PROVIDER'S PLAN APPLIES TO FEDER THIS WILL APPEAR THERE IS NO REQU	5, surveyors of this isited the above provider and on orders are issued. ur electronic plan of ave reviewed these orders, when they will be completed. nt of Health is documenting Correction Orders using numbers have been ta state statutes/rules for assigned tag number to column entitled "ID Prefix tte/rule out of compliance is ry Statement of Deficiencies" the "To Comply" portion of This column also includes e in violation of the state ement, "This Rule is not met owing the surveyors findings ethod of Correction and ection. D THE HEADING OF THE WHICH STATES, OF CORRECTION." THIS EAL DEFICIENCIES ONLY. ON EACH PAGE. JIREMENT TO SUBMIT A TON FOR VIOLATIONS OF				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
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	ROVIDER OR SUPPLIER	00792	ADDRESS, CITY, STATE		12	/10/2015
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BETHESD	A NH PLEASANTVIEW	WILLMA	AR, MN 56201			
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2 830	Continued From page	e 2	2 830			
2 830	MN Rule 4658.0520 Proper Nursing Care	Subp. 1 Adequate and ; General	2 830			
	receive nursing care custodial care, and se individual needs and the comprehensive re plan of care as desc 4658.0405. A nursing of bed as much as power written order from the	preferences as identified in esident assessment and ribed in parts 4658.0400 and g home resident must be out ossible unless there is a e attending physician that the i n bed or the resident				
	by: Based on observation review the facility fail interventions to preve 3 residents (R79, R8	ent further elopement for 2 of 7) reviewed for wandering. r failed to implement fall				
	Findings include:					
	9/18/15, indicated he impaired, required as	num Data Set (MDS) dated was severely cognitively sistance with all activities of o wandering behaviors.				
	cognitive impairment concerned about his	d 10/30/15 had a problem of and indicated he was "Often wife and her whereabouts." ion that R79 had any identified				

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00792	B. WING		12	2/10/2015
IAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		
ETHESD	A NH PLEASANTVIEW	901 SOL	JTHEAST WILLMAR	RAVENUE		
		WILLMA	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	23	2 830			
c c v r c a t t	on 6/19/15 identified, of multiple falls, and of wandering risk for R7 review indicated safe	9. The 9/18/15 quarterly ty were monitored r the assessment did not				
	11/16/15, the facility r family member (FM)-, the facility and came apartment that day bu On 11/16/15 a subsec indicated, R79 had vo go "upstairs" and visit dated 11/26/15 indica staff wandering in hal note further indicated not know where he w 12/1/15, indicated R7 attempting to push the doors leading to the a	at was back in facility now. quent progress note ocalized to staff he wanted to the FM-A. A progress note ted R79 was observed by lways in his wheel chair, the R79 was confused and did as. A progress note dated 9 was observed by staff e button that opened the assisted living wing of the he was going to see FM-A.				
	reassessed for his wa had an elopement ep	on that R79 had been andering risk even though he isode on 11/16/15, and npts to leave the nursing				
	R79 propelled himsel the facility and stated	n on 12/8/15, at 9:11 a.m., f toward to front entrance of , "I'm looking for [FM-A]', by an unknown activity staff.				
	During an interview o	n 12/8/15, at 1:08 p.m.,				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED
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NAME OF PI	ROVIDER OR SUPPLIER	L	DDRESS, CITY, STATE	, ZIP CODE		10/2010
BETHESD	A NH PLEASANTVIEW		THEAST WILLMAN R, MN 56201	RAVENUE		
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2 830	<ul> <li>830 Continued From page 4</li> <li>nursing assistant (NA)- J stated, R79 never tries to leave the unit. She stated FM-A comes every afternoon to visit him. NA- J was unaware of any attempts by R79 to leave the facility but stated, "he makes statements that he wants to go see [FM-A]."</li> <li>During an interview on 12/8/15, at 1:11 p.m., health unit coordinator (HUC)-A stated, "I know he [R79] tries to go visit [FM-A] in assisted living," She stated, he can't go by himself and FM-A needs to come and get him. HUC-A stated, "He has gotten over there" and further stated, if he is headed that direction, staff will intervene and</li> </ul>		2 830			
	registered nurse (RN before eight am, eats room. RN- A stated R is not here. She furth if he has gotten to as stated, if R79 got to a FM-A if he could visit back to the facility. R facilities procedure re	n 12/8/15, at 1:14 p.m., )- A stated, R79 is usually up breakfast and rests in his t79 will try to find FM-A if she er stated she was "not sure sisted living. RN-A then issisted living, she would ask , if not she would bring him N-A was "not sure" of the egarding a resident leaving depends on the situation."				
	DON stated she had Watchmate ID bracel alert staff if a residen facility by sounding a door.) on R79, but de	n 12/8/15, at 2:04 p.m., the discussed putting a et (a bracelet designed to t attempts to leave the n alarm and/or locking a scided against it because the ne assisted living does not				
	family member (FM)-	n 12/9/15, at 2:17 p.m., A stated R79 had gotten to his own that day. She stated				

	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00792	B. WING		12/10/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BETHESD	A NH PLEASANTVIEW		ITHEAST WILLMAR	RAVENUE		
			R, MN 56201			
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2 830	Continued From page	e 5	2 830			
	he was there for "about an hour and she brought him back after they visited." FM-A further stated she did not know what staff was doing to prevent R79 from leaving the facility on his own and stated, "I don't know what he would do if I wasn't home." During and interview on 10/10/15, at 8:29 a.m., trained medication aide (TMA)-C stated, staff check on R79 often but stated there is no formal system for checking his whereabouts. TMA-A stated, she was aware of his wandering in the past but was not aware of anything recently.					
	social worker (SW)-A for rehab." She stated the assisted living fac further stated, "he fixa constantly, he lived th go." "He gets it in his to get over there." Sh one time he got to the	here so he knows where to head and will randomly try e stated she was aware on e assisted living unassisted he was unaware of any				
	Even though R79 had continues to make re FM-A, the facility had	d eloped on 11/16/15, and quests and attempts to visit not reassessed his risk for nented any interventions to				
	9/24/15, indicated he impaired, independer unit and used a electr further indicated he h	num Data Set (MDS) dated was moderately cognitively nt with locomotion on and off ric wheelchair. The MDS ad one fall since admission d no wandering behaviors.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00792	B. WING		12	2/10/2015
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			THEAST WILLMAR			
SETHESD	A NH PLEASANTVIEW	WILLMA	R, MN 56201			
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2 830	Continued From page	e 6	2 830			
	During observation 12/09/2015 at 9:28 a.m. R87 was observed to be riding an exercise bike in the restorative nursing therapy room.					
	dementia without beh motorized wheelchain facility and off campu indicated physical th of motorized wheelch use it independently campus, but have so when he goes off car indicated he had rece himself against thera family does support to The care plan approa encourage him to sig facility with family, to cell phone with him.	d 10/19/15, indicated he had havioral disturbance used a r for mobility throughout the is with family. The care plan erapy (PT) assessed his use hair and indicated he could in the facility and outside on meone accompany him npus. The care plan further ently gone off campus by py recommendation and herapy's recommendation. aches indicated staff are to n out when leaving the use orange flag and carry a ssessment dated 9/17/15,				
	indicated there is "no wandering behavior."	concern for elopement,				
	Communication date certified occupationa was "ok" to use powe and outside on camp	t Referral Interdepartmental d 9/21/15, indicated from I therapist (COTA) that R87 er wheelchair inside facility us. There was no indication o use his power wheelchair isor off campus.				
	p.m., indicated reside and talked to Medica so family member [FI [R87] to call him. Wr	note dated 10/16/15, at 3:31 ents son "Called this morning I Secretary [R87] was busy M-C] asked that staff ask iter did relay the message to 87] that [FM-C] called and				

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00792	B. WING		1:	2/10/2015
IAME OF PI	ROVIDER OR SUPPLIER	I	DDRESS, CITY, STATE	, ZIP CODE		
RETHESD	A NH PLEASANTVIEW	901 SOU	ITHEAST WILLMAR	RAVENUE		
		WILLMA	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From page	e 7	2 830			
	there. About 1/2 hou received a phone call a phone call and that house on his motorize talk with Social Service (RN) about this matter sons for lunch and the walked back to facility safely. Social Service afternoon." A Resident Progress recorded as late entry writer (licensed socia and his [FM-D] on 100 from his son's home of Per [FM-D] family doe Bethesda Campus wi unless accompanied indicated he recently and upon return (OT) motorized wheelchair could continue to use facility and outside or Even though R87, ha that facility had not re- risk, and implemented to ensure his safety. During interview 12/0 (NA)-K they try to kee stated there is no for	y on 10/19/15, indicated I worker) spoke with resident /16/15 after he returned via motorized wheelchair. es not want him going off the th his motorized wheelchair by family. The note further had a long hospitalization assessed his use of and determined that he the wheelchair within the				
	stated that on Octobe facility and did not sig	8/15, family member (FM)-D er 16th, 2015 R87 left the In himself out. FM-D stated house because he was				

	a Department of Healt FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00792	B. WING		12	2/10/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
		901 SOL	JTHEAST WILLMAR	RAVENUE		
BETHESD	A NH PLEASANTVIEW	WILLMA	AR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page	e 8	2 830			
	worried about him, ar to get to the home. R	nd had to cross a city street 87 did make it safe to the ething could happen to him				
	(COTA)-B stated he estrengthening, ADL's assessed his wheelch recommended that he when he goes off can sometimes unaware of further stated R87 ne keep down his speed chair. The facility is n had not been evaluat	(activity of daily living) and hair. COTA-B stated he have somebody with him npus because he is of his surroundings. He eded to be reminded to when using the power ear a busy road and R87 ed with the use of his power he road or go up and down a				
	when off facility camp 10/16/15, the facility of	t been assessed for safety ous, which occurred on did not have appropriate to ensure R87's safety rounds.				
	A facility policy for elc none was provided.	ppement was requested but				
	had diagnoses of cen movement disorder w symptoms often of po muscles, weak muscl paraplegia (impairme function of the lower of	oor coordination, stiff les, and tremors) and int in motor or sensory extremities). The MDS eeded extensive assistance				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.			
		00792	B. WING		12	2/10/2015
AME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE			
BETHESD	A NH PLEASANTVIEW		JTHEAST WILLMAF NR, MN 56201	RAVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From page	9	2 830			
	with infantile cerebral seizure disorder, hype developmentally inap hyperactivity and imp and a fall history. The included position upri- leg rests, and dycem During observations t On 12/06/15, at 5:33 wheelchair and the rig are fitted on wheelcha tipping over) was turn into place. On 12/07/15, at 9:33 sitting up in wheelcha right anti-tip bar was to On 12/08/15, at 7:55 dinning room chair sit anti-tip bars in same p On 12/10/15, at 8:44 dinning room and righ inch and resident was 30 degrees. During interview 12/10 occupational therapis custom stilt and space and staff can tilt him to repositioning since he The OT-C stated the down position to prev During interview 12/10 stated the anti-tip bars and would fix them right	ulsivity), spastic paraplegia, e care plan interventions ght in wheelchair, padded in wheelchair. he following was noted: p.m. R9 was up in his ght anti-tip bar (Anti-tip bars airs to prevent them from ned in 1 inch and not locked a.m. R9 was observed ir in his room and again the turned in 1 inch. a.m. R9 was sitting in ting up in wheelchair with bosition as above. a.m. R9 was wheeling from nt anti-tip bar was tilted in 1 is tilted back approximately 0/15, at 2:27 p.m. the t (OT)-C stated R9 has a e wheelchair from Gillette, back every two hours for e refuses to lay down in bed. anti-tip bars should be in the ent him from tipping over. 0/15, at 2:35 p.m. the DON is should be in the down were not effective for R9 ght away.				
	The director of nursin	OD OF CORRECTION: g or designee, could and procedures related to				

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
		00792	B. WING		12	2/10/2015	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
BETHESD	A NH PLEASANTVIEW		JTHEAST WILLMAF NR, MN 56201	RAVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From page	e 10	2 830				
	proper assessment a implemented. They c these policies and pro- evaluating and monitor implementation of the developed, with the r brought to the facility Committee for review	ese policies could be esults of these audits being 's Quality Assurance					
21000	MN Rule 4658.0610 S Requirements-Hygier		21000				
	wash their hands and their arms with soap a washing facility befor as often as is necess after smoking, eating handling soiled equip	I the exposed portions of and warm water in a hand e starting work, during work ary to keep them clean, and , drinking, using the toilet, or ment or utensils. Dietary fingernails clean and					
	by: Based on observatior review, the facility fail served in a sanitary n dining rooms. This h	t is not met as evidenced n, interview and document led to ensure food was nanner in 1 of 2 resident ad the potential to affect 22 ite in the memory care unit.					
	Findings include:						
	-	servation on 12/6/2015 from n., the evening meal on the					

STATE FORM

6899

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
	00792	B. WING		12/10/2015	
AME OF PROVIDER OR SUPPLIE		ADDRESS, CITY, STATE	, ZIP CODE		
ETHESDA NH PLEASANTV	901 SO	UTHEAST WILLMAN	R AVENUE		
	WILLM	AR, MN 56201			
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21000 Continued From	page 11	21000			
memory care un assistant (DA)-D which held nume including potato hot dogs, buns, a individual serving also prepared in the food compar was a scoop or s tongs were press 5:15 p.m., DA-D onto plates, which their tables. At 5:17 p.m., with on the table, and each of potato sa DA-D placed slid the plate to a sta were made simil hands, DA-D beg binder on the ste with papers cove and contained in dietary needs. <i>A</i> sheets with both located and read Next, DA-D set a opened, with the bun on this resid other foods on th spoon, before pa be served to a re Between 5:19 p. up nine resident regular-textured a hot dog bun, o	it was being served. Dietary worked behind a steam table prous hot and cold foods, salad, sliced tomatoes, beets, and various dessert items, in g bowls. The food items were various textures, and in each of tments on the steam table, there slotted spoon for serving, and ent next to the hot dog buns. At began dishing up foods onto the were delivered to residents at an gloved hands, DA-D set a plate with the scoop, placed a serving alad and beets. Using the tongs, ed tomatoes on top, and handed ff member. Two additional plates arly. At 5:19 p.m., with gloved gan leafing through a ringed mat table. The binder was filled ered with plastic sheet protectors, formation regarding residents' fifer flipping through the plastic gloved hands, DA-D then information on the plastic sheet. mother plate down, grasped and same gloved hands, a hot dog ent's plate. DA-D then served the plate, using the scoops and tassing the plate to a co-worker to				

STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		00792	B. WING		12/10/2015	
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 12	
RETHESD	A NH PLEASANTVIEW	901 SOU	THEAST WILLMAN	R AVENUE		
		WILLMA	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21000	Continued From page	e 12	21000			
	meals for residents w textures, and used la					
	the steam table, and gloves, grasped the of door, and retrieved a on the steam table. If the plastic sheets in th hands, found the page reading a page, place scooped other foods, p.m. and 5:40 p.m., D resident meals, four of textured meals, each handled with the glov referenced the binder more times. During the entire obs pair of gloves. DA-D cleanse hands or cha- leafing through the pl information pages nut	vent to the cupboard behind still wearing the same cupboard handle, opened the dditional plates and set them DA-D again leafed through the binder, with both gloved ge for a resident, and after ed another hot dog bun, and on this plate. Between 5:30 DA-D dished up six more of which were regular received a hot dog bun ved hands. DA-D also r, with her gloved hands, two ervation DA-D wore only one did not wash or otherwise ange gloves, neither after lastic-covered diet imerous times, nor after d doors during the evening				
	stated she did not wa gloves after looking to order binder, and also cupboards in the kitcl residents's meals, inc on plates with dirty g easier "to grab the ho	/6/2015 at 5:41 p.m., DA-D ash her hands or change hrough the resident's diet o opening and closing hen, and continued to set up cluding placing hot dog buns loves. DA-D stated it was ot dog buns with her hands, tongs" to get the buns to				
		on 12/10/2015 at 1:35 p.m., (DM) stated to maintain				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00792	B. WING			12/10/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE	•	
BETHESD	A NH PLEASANTVIEW			RAVENUE		
			AR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T( DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21000	Continued From page	e 13	21000			
	the steam table dishin were to deliver the pla residents. The DM sta refer to the resident d something from the c the handles, she shou staff to turn the pages how they are trained. after opening the cup sheets, "could have w new gloves" before ca cupboard handles an were considered uncl servers were not requ were trained to handle to use tongs and score said. The DM also sa tongs" to serve the ho the bread with bare h A facility policy, Servi revised 1/2015, indica "Good Personal Hygi or ready to eat foods gloves or utensils." SUGGESTED METH The dietary director of procedures for safe for appropriate distribution dietray manager or do random audits of the appropriate care and	upboard, and had to touch uld have had asked another s, or to ask for help,"that is " The DM also added DA-D, board or touching the plastic vashed her hands, or put on ontinuing. The DM stated d plastic-covered sheets				

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00702	0792 B. WING			
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE		12	2/10/2015
	A NH PLEASANTVIEW		JTHEAST WILLMAN			
SETHESD		WILLMA	AR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
21855	Continued From page	e 14	21855			
21855	21855 MN St. Statute 144.651 Subd. 15 Patients Residents of HC Fac.Bill of Rights		21855			
	residents shall have t and privacy as it relat personal care program consultation, examina confidential and shall Privacy shall be respo- bathing, and other ac except as needed for assistance. This MN Requirement by: Based on observation failed to ensure audio (R59, R27, R85, R110	ation, and treatment are be conducted discreetly. ected during toileting, tivities of personal hygiene, patient or resident safety or at is not met as evidenced and interview, the facility privacy for 11 residents 6, R82, R107, R55, R63,				
	residents who resided	in the sample, of the 30 d in the locked memory care utilized an audio monitoring				
	Findings include:					
	R71, R140 and R19 v	6, R82, R107, R55, R63, were identified by facility to e memory care unit of the				
	10/16/15, indicated R	num Data Set (MDS) dated 59 was severely cognitively ed diagnoses of Alzheimer's				
	R27 had severe cogn	, dated 11/6/15, indicated ition impairment, and uded anxiety disorder.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00792	B. WING		12	2/10/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE	·	
BETHESD	A NH PLEASANTVIEW		JTHEAST WILLMAF AR, MN 56201	RAVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
21855	Continued From page	9 15	21855			
	had severe cognition which included deme					
	R116 had moderately	DS, dated 11/9/15, indicated impaired cognition, and uded Alzheimer's dementia				
	indicated R82 had se	nge MDS, dated 11/13/15, vere cognition impairment, included dementia and				
	R107 had severe cog	S, dated 8/28/15, indicated nition impairment, and uded Alzheimer's dementia.				
		dated 10/2/15, indicated ognition impairment, and uded dementia.				
	R63's quarterly MDS, R63 had severe cogn diagnoses which inclu psychotic disorder.	•				
	R71 had severe cogn	dated 7/31/15, indicated ition impairment, and uded Alzheimer's dementia.				
	R140's admission MI indicated R140 had s and diagnoses which	evere cognition impairment,				
		nge MDS, dated 10/23/15, vere cognition impairment, included dementia.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		00792	B. WING			10/10/0015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE		14	2/10/2015	
	A NH PLEASANTVIEW		ITHEAST WILLMAR				
DEINESD		WILLMA	R, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21855	Continued From page	e 16	21855				
on 12/6/2015 at 1:33 p.m and two corresponding a noted in use on the locke							
	One of the monitors (a unit which collects and transmits signals) was located on the far end of the "C" hallway, near the locked, double door entry to the memory unit. The monitor, disc-shaped, approximately five inches in						
	diameter and one inc inch antenna, hung fl from the floor betwee	h thick, with a protruding two at on the wall about six feet n room C1 and the soiled hitor was plugged in, and an					
	monitor's correspond receives and broadca a counter near the for	was operational. This ing receiver (a unit which asts signals) was located on od service tables, on one on area of the locked unit. A ed the receiver was					
	A second monitor wa the "B" hallway, near in the memory unit. T on south side wall, be storage room, approx The monitor was plug	s located at the far end of the double-door locked entry Fhis monitor was positioned etween room B12 and the timate six feet from the floor. gged in and operating. A er was located on a counter,					
	the large, open comm	on, on the opposite side of non area. ne survey, from 12/6/2015 to					
	12/10/2015, the audio memory unit were ob operating. On 12/9/1	o monitors in the locked					
	in an activity by two s	taff members. Intermittently, ver near the kitchen area					

STATE FORM

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		00702	B. WING		10/10/0015	
NAME OF P	ROVIDER OR SUPPLIER	00792	ADDRESS, CITY, STATE		14	2/10/2015
			JTHEAST WILLMAR			
BETHESD	A NH PLEASANTVIEW	WILLMA	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE ) THE APPROPRIATE	(X5) COMPLET DATE
21855	Continued From page	e 17	21855			
	trained medication as hall monitors were or night, but was not sur the day and evening can hear people talkii are more quite at nigh resident had a TV on conversation from the In an interview on 12. licensed practical nur monitors were on "all "just another aid" to the help. LPN-A stated the TABS (a personal safet On 12/10/2015 at 6:3 nearest the "B" hall n was heard in the rece- [staff name] is?1 die	2 TV." (10/2015 at 6:33 a.m., rse (LPN)-A stated the the time," and they were hear residents who may need he receivers amplified the fety alarm device) alarms. 58 a.m., from the receiver ursing station, the following eiver: "do you know where d [R55's] neb (a breathing				
	room, then." On 12/1	5] he can go into the dining 0/2015 at 7:15 a.m., from meal serving table, voices of ould be heard.				
	LPN-B stated the m hear what is going or monitors helped the s	12/10/2015 at 6:59 a.m., onitors on the unit "helps us n." LPN-B also stated the staff hear the call lights, or if alarm goes off, and "just nallway activity."				
	director of nursing (D the monitors was for pressure and TAB ala fall prevention" for res	/10/2015 at 2:05 p.m., the ON) stated the purpose of "the amplification of the arm," and also "to assist in sidents. The DON stated she g the facility had used the				

STATEMENT	a Department of Health OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		00792	B. WING		12	2/10/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	·	
BETHESD	A NH PLEASANTVIEW		ITHEAST WILLMAF .R, MN 56201	RAVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
21855	the monitors were us The DON acknowled and operating "24/7." aware of any concer- by families, or others, infringement of privac facility could look into night." The DON stat facility policy" regardi which might address responsible to turn of	e 18 e been "for years," and that ed "before my time here." ged the monitors were on The DON said she was not ns expressed or complaints with regard to possible cy. The DON also stated the "just turning them on at red presently, there was "no ng use of audio monitors, frequency of use, who was f and on, or guidelines accrns. The DON then	21855			
	their continued use. SUGGESTED METH The director of nursin the use of audio mon director of nursing or random audits of the appropriate care and	OD OF CORRECTION: g or designee, could review itors in the hallways. The designee, could conduct delivery of care; to ensure services are implemented. CORRECTION: Twenty-one				
21980	Maltreatment of Vulne Subd. 3. Timing of r reporter who has reas vulnerable adult is be or who has knowledg has sustained a phys reasonably explained information to the cor individual is a vulnera	report. (a) A mandated	21980			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00792	92 B. WING		12	12/10/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	• • •		
		901 SOU	THEAST WILLMAR	RAVENUE			
BETHESD	A NH PLEASANTVIEW	WILLMA	R, MN 56201				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FU		SUMMARY STATEMENT OF DEFICIENCIES     ID       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG		OF CORRECTION CTION SHOULD BE D THE APPROPRIATE NCY)	(X5) COMPLET DATE	
21980	Continued From page	e 19	21980				
	reporter is not require maltreatment of the ir to admission, unless:	ndividual that occurred prior					
	another facility and th	admitted to the facility from e reporter has reason to e adult was maltreated in the					
	<ul> <li>(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).</li> <li>(b) A person not required to report under the provisions of this section may voluntarily report</li> </ul>						
	as described above. (c) Nothing in this s	section requires a report of naltreatment, if the reporter					
	knows or has reason been made to the cor (d) Nothing in this s	to know that a report has nmon entry point. section shall preclude a					
	agency. (e) A mandated rep	porting to a law enforcement					
	626.5572, subdivision (5), occurred must ma subdivision. If the rep	an error under section 17, paragraph (c), clause ake a report under this porter or a facility, at any investigation by a lead					
	agency will determine the reported error was the criteria under sec	e or should determine that s not neglect according to tion 626.5572, subdivision use (5), the reporter or					
	facility may provide to directly to the lead ag how the event meets	o the common entry point or ency information explaining the criteria under section n 17, paragraph (c), clause					
	(5). The lead agency	/ shall consider this king an initial disposition of					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		00792	00792 B. WING		10	12/10/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	12	2/10/2015	
			ITHEAST WILLMAR				
BEINESD	A NH PLEASANTVIEW	WILLMA	R, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21980	Continued From page	e 20	21980				
	by: Based on interview a facility failed to ensur immediately reported and thoroughly invest	It is not met as evidenced nd document review, the e allegations of neglect were to the state agency (SA) tigated for 3 of 3 residents R97) who had left the awareness.					
	Findings include:						
	facility had received a member (FM)-A who facility and gone to he	dated 11/16/15, indicated the a call from R79's family reported R79 had left the er at her apartment in the ng, and that she had brought he facility.					
	registered nurse (RN duty the day R79 had unassisted by staff. I whether if FM-A had gotten to the assisted him back. RN-B furth loss and he used to li assisted living. RN-E	n 12/9/15 at 9:51 a.m., )-B stated she had been on I gone to the assisted living RN-B stated she was unsure called the facility when he'd I living, or if FM-A brought er stated R79, "has memory we there" in reference to the also stated she was 79 had been gone that day.					
	During an interview w 2:17 p.m., FM-A state assisted living on his She further stated he	vith FM-A, on 12/9/15 at ed R79 had gotten to the own that day (11/16/15). 'd been over there "about an I-A) had brought him back.					

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00792	B. WING		12	12/10/2015	
NAME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE			
BETHES	DA NH PLEASANTVIEW		THEAST WILLMAF R, MN 56201	RAVENUE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF COR       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION STAG       REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE ADDEFICIENCY)				CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE	
21980	<ul> <li>FM-A further stated, ' do if I wasn't home."</li> <li>Although the provider the resident had left t no additional investig reporting of the incide supervision had been</li> <li>During an interview w (DON) on 12/8/15 at 11/16/15 incident was go see his FM-A at th been investigated or Agency.</li> <li>During a subsequent p.m., the DON stated R79 was gone.</li> <li>R87's resident progree 3:31 p.m. indicated R "Called this morning a Secretary. [R87] was [FM-C] asked that stat Writer did relay the m [R87] that [FM-C] call him [FM-C]. [R87] stat Writer told him [R87] there. About 1/2 hour received a phone call a phone call and that [FM-C] house on his Writer did talk with So nurse (RN) about this his son's for lunch an walked back to facility</li> </ul>	'I don't know what he would I had been informed by FM-A he nursing home to see her, ation of the incident, nor ent as potential neglect of a completed by the facility. With the director of nursing 1:21 p.m., identified the s related to R79's leaving to be assisted living had not reported to the State interview on 12/8/15, at 2:04 she did not know how long ess note dated 10/16/15, at 187's family member (FM)-C,	21980		NCT)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:         00792         NAME OF PROVIDER OR SUPPLIER       STREET A			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/10/2015	
		00792				
		DDRESS, CITY, STATE	, ZIP CODE	12	10/2015	
DETUERD			THEAST WILLMAR			
BEINESD	A NH PLEASANTVIEW	WILLMA	R, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21980	Continued From page 22		21980			
	A Resident Progress note dated 10/19/15, identified as a late entry, indicated writer (licensed social worker) had spoken with R87 and FM-D on 10/16/15, after the resident had returned from FM-C's via motorized wheelchair. The note indicated FM-D did not want R87 going off the facility campus in his motorized wheelchair unless accompanied by family. The note further indicated R87 had recently had a long hospitalization and upon return occupational therapy had assessed his use of motorized wheelchair and determined that he could continue to use the wheelchair within the facility and outside only while on the facility campus. R87's record was reviewed and a Resident Referral Interdepartmental Communication note dated 9/21/15, verified a certified occupational therapist (COTA) had assessed R87 as safe to use his power wheelchair inside the facility and outside, on the campus.					
	moderately cognitivel	y minimum data set 24/15, indicated R87 was y impaired, independent with f unit, and used a electric				
	some cognitive impai supposed to leave the been no further inves incident, nor had a re	taff were aware R87 had rment, and was not e campus alone, there had tigation of the 10/16/15 port regarding the alleged n been made to the State				
	R97 had severe cogn	, dated 11/6/15, indicated itive impairment, was omotion on the unit, and had ors.				

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00792         NAME OF PROVIDER OR SUPPLIER       STREET			(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED	
		ADDRESS, CITY, STATE		12	12/10/2015		
ANIE OF PI	ROVIDER OR SUPPLIER		JTHEAST WILLMAF				
BETHESD	A NH PLEASANTVIEW		R, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT		
21980	Continued From page	23	21980				
	R97's care plan dtaed 10/20/15, identified R97 was at risk for elopement and the identified goal for the resident to remain safe on the facility grounds. R97's care plan identified R97 would "Wander in the parking lot and state that he is on his way somewhere." And included an intervention which directed "Wanderguard to alert staff of resident's attempts to leave the facility", dated 10/20/15.						
	identified R97 had be be walking east of the facility. The note iden R97, R97 was in the R97 stated he was go get his driver's license walk with him to ensu building safe he beca fine and could get ba directed and returned	me annoyed stating he was ck on his own. He was easily to the facility. There was no gency was contacted about					
		Falls Risk Assessment dated ere were "no concerns for g, behavior."					
	he was found outside day (3/13/15). R97 w	a.m. RN-A stated a aced on R97's walker, after in the parking lot that same as wanted to go to the vehicles to get his drivers					
	3/13/15, the facility ha	elopement episode on ad not immediately reported te agency for neglect of					

STATE FORM

Minnesota Department of Health         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         00792		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00792			12	12/10/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
BETHESD	A NH PLEASANTVIEW		THEAST WILLMAR	RAVENUE		
			R, MN 56201			
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21980	Continued From page	e 24	21980			
	(DON) and social wor they stated they had resident elopement in because they did not criteria for reporting s was injured. During interview 12/9 administrator stated h incidents for (R79, R8 did not report the inci- understanding that the requirement for report Review of the facility' Policy/Procedure revi- alleged violations of r abuse, injury of unkno- misappropriation of re- reported immediately of Health Facility Cor Common Entry Point included: "All alleged neglect, injuries of un- misappropriation of re- investigated" The p "The failure to provide SUGGESTED METH The director of nursin- all residents to assure necessary treatment/ systems for reporting as appropriate. The designee, could cond	he was aware of the B7 and R97) but the facility dents because it was not his he incidents met the ting. s Abuse Prevention ised 5/7/13, included: "All mistreatment, neglect, own origin, and esident property will be to the Administrator, Office mplaints (OHFC), and (CEP)." The policy also mistreatment, abuse, aknown origin, esident property will be policy defined neglect as, e goods and services"				

6899

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 12/10/2015		
		00792					
			ADDRESS, CITY, STATE, ZIP CODE			12/10/2013	
ETHESD	OA NH PLEASANTVIEW		JTHEAST WILLMAR R, MN 56201	RAVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLE <sup>-</sup> DATE	
21980	1 0	e 25 CORRECTION: Twenty-one					