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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KMNR
Facility ID: 00792

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245427**

2. STATE VENDOR OR MEDICAID NO.
(L2) **516240800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA NH PLEASANTVIEW**
(L4) **901 SOUTHEAST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/01/2016** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12. Total Facility Beds **123** (L18)

13. Total Certified Beds **123** (L17)

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:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 02/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/10/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/01/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/19/2016
(L33)

DETERMINATION APPROVAL

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.

Sincerely,

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:

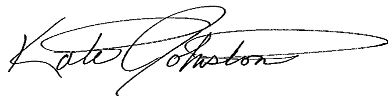
On December 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 10, 2015 . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with 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.

Sincerely,



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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245427	A. Building B. Wing	2/1/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0164 Reg. # 483.10(e), 483.75(l)(4) LSC	Correction Completed 01/13/2016	ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 01/13/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 01/13/2016
ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 01/13/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 01/13/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 01/13/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 02/10/2016	SIGNATURE OF SURVEYOR 10562	DATE 02/01/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/10/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?			☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245427	A. Building 01 - MAIN BUILDING 01 B. Wing	1/14/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 01/13/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 01/13/2016	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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 02/10/2016	SIGNATURE OF SURVEYOR 34764	DATE 01/14/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/7/2015	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KMNR
Facility ID: 00792

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245427**

2. STATE VENDOR OR MEDICAID NO.
(L2) **516240800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA NH PLEASANTVIEW**
(L4) **901 SOUTHEAST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/10/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **123** (L18)

13.Total Certified Beds **123** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 01/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 01/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 01/19/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

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

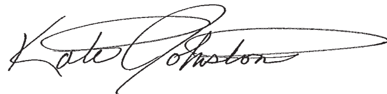
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		1/13/16

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

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The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, the facility failed to ensure audio privacy for 11 residents (R59, R27, R85, R116, R82, R107, R55, R63, R71, R140 and R19) in the sample, of the 30 residents who resided in the locked memory care unit where the facility utilized an audio monitoring system.

Findings include:

R59, R27, R85, R116, R82, R107, R55, R63, R71, R140 and R19 were identified by facility to currently reside in the memory care unit of the facility.

R59's quarterly Minimum Data Set (MDS) dated 10/16/15, indicated R59 was severely cognitively impaired, and included diagnoses of Alzheimer's dementia.

R27's quarterly MDS, dated 11/6/15, indicated R27 had severe cognition impairment, and diagnoses which included anxiety disorder.

R85's quarterly MDS dated 9/11/15 indicated R85 had severe cognition impairment, and diagnoses which included dementia and depression.

R116's admission MDS, dated 11/9/15, indicated

Corrective Action For Residents Affected By Deficient Practice: To protect residents' privacy, both audio monitors and corresponding audio receivers were removed from the areas.

Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: This had the potential to affect all memory care unit residents, along with staff and visitors.

Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Both audio monitors and receivers were removed. Nursing staff were in-serviced on January 5 and 6, 2016 in regard to the removal of monitors, resident privacy rights, and appropriate approaches to resident safety and fall prevention.

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Because monitors were removed for resident privacy, no further monitoring is needed.

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F 164	Continued From page 2 R116 had moderately impaired cognition, and diagnoses which included Alzheimer's dementia and anxiety. R82's significant change MDS, dated 11/13/15, indicated R82 had severe cognition impairment, and diagnoses which included dementia and anxiety disorder. R107's quarterly MDS, dated 8/28/15, indicated R107 had severe cognition impairment, and diagnoses which included Alzheimer's dementia. R55's quarterly MDS dated 10/2/15, indicated R55 had moderate cognition impairment, and diagnoses which included dementia. R63's quarterly MDS,dated 11/6/15, indicated R63 had severe cognition impairment, and diagnoses which included dementia and psychotic disorder. R71's quarterly MDS, dated 7/31/15, indicated R71 had severe cognition impairment, and diagnoses which included Alzheimer's dementia. R140's admission MDS, dated 10/15/15, indicated R140 had severe cognition impairment, and diagnoses which included amnesia. R19's significant change MDS, dated 10/23/15, indicated R19 had severe cognition impairment, and diagnoses which included dementia. During observation on the initial tour of the facility on 12/6/2015 at 1:33 p.m., two audio monitors, and two corresponding audio receivers were noted in use on the locked, memory care unit:	F 164		

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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 inch thick, with a protruding two inch antenna, hung flat on the wall about six feet from the floor between room C1 and the soiled utility room. The monitor was plugged in, and an LED light indicated it was operational. This monitor's corresponding receiver (a unit which receives and broadcasts signals) was located on a counter near the food service tables, on one end of a larger common area of the locked unit. A small red light indicated the receiver was functioning.

A second monitor was located at the far end of the "B" hallway, near the double-door locked entry in the memory unit. This monitor was positioned on south side wall, between room B12 and the storage room, approximate six feet from the floor. The monitor was plugged in and operating. A corresponding receiver was located on a counter, near the nursing station, on the opposite side of the large, open common area.

During each day of the survey, from 12/6/2015 to 12/10/2015, the audio monitors in the locked memory unit were observed to be on and operating. On 12/9/15 at 2:56 p.m., 12 residents and staff were seated around tables and were led in an activity by two staff members. Intermittently, voices from the receiver near the kitchen area could be heard.

In an interview on 12/10/2015 at 6:25 a.m., trained medication assistant (TMA)-A stated the hall monitors were on "all the time" during the

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night, but was not sure if that was the case during the day and evening hours. TMA-A stated "you can hear people talking" especially when the halls are more quite at night. TMA-A also stated if a resident had a TV on, "you can hear the conversation from the TV."

In an interview on 12/10/2015 at 6:33 a.m., licensed practical nurse (LPN)-A stated the monitors were on "all the time," and they were "just another aid" to hear residents who may need help. LPN-A stated the receivers amplified the TABS (a personal safety alarm device) alarms.

On 12/10/2015 at 6:58 a.m., from the receiver nearest the "B" hall nursing station, the following was heard in the receiver: "...do you know where [staff name] is?....I did [R55's] neb (a breathing treatment)...then [R55] he can go into the dining room, then." On 12/10/2015 at 7:15 a.m., from the receiver near the meal serving table, voices of residents and staff could be heard.

During a interview on 12/10/2015 at 6:59 a.m., LPN- B stated the monitors on the unit "helps us hear what is going on." LPN-B also stated the monitors helped the staff hear the call lights, or if a pad alarm or a TAB alarm goes off, and "just helps to monitor the hallway activity."

In an interview on 12/10/2015 at 2:05 p.m., the director of nursing (DON) stated the purpose of the monitors was for "the amplification of the pressure and TAB alarm," and also "to assist in fall prevention" for residents. The DON stated she did not know how long the facility had used the monitors, it could have been "for years," and that the monitors were used "before my time here." The DON acknowledged the monitors were on

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F 164	Continued From page 5 and operating "24/7." The DON said she was not aware of any concerns expressed or complaints by families, or others, with regard to possible infringement of privacy. The DON also stated the facility could look into "just turning them on at night." The DON stated presently, there was "no facility policy" regarding use of audio monitors, which might address frequency of use, who was responsible to turn off and on, or guidelines regarding privacy concerns. The DON then stated the facility "should look at the monitors" for their continued use.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225		1/13/16

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violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure allegations of neglect were immediately reported to the state agency (SA) and thoroughly investigated for 3 of 3 residents reviewed (R79, R87, R97) who had left the building without staff awareness.

Findings include:

R79's progress note dated 11/16/15, indicated the facility had received a call from R79's family member (FM)-A who reported R79 had left the facility and gone to her at her apartment in the attached assisted living, and that she had brought the resident back to the facility.

R79's quarterly Minimum Data Set (MDS) dated 9/18/15, indicated he was severely cognitively impaired and required assistance with all activities of daily living.

During an interview on 12/9/15 at 9:51 a.m., registered nurse (RN)-B stated she had been on

F 225

Corrective Action For Residents Affected By Deficient Practice: R79 was re-assessed for elopement risk, and it was determined per assessment and care conference with family that R79 required secured placement and was relocated to our memory care unit on 12/18/2015.

R87 was re-assessed for elopement risk. 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 flag and slow moving sign were placed on his motorized wheelchair.

R97 was re-assessed for elopement risk, and it was determined that a Wandergard continues to be appropriate for R97.

Identification Of Other Residents Having

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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.

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."

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.

During an interview with the director of nursing (DON) on 12/8/15 at 1:21 p.m., identified the 11/16/15 incident was related to R79's leaving to go see his FM-A at the assisted living had not been investigated or reported to the State Agency.

During a subsequent interview on 12/8/15, at 2:04 p.m., the DON stated she did not know how long R79 was gone.

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.

F 225

the Potential To Be Affected By Deficient Practice: All residents who have been identified to be at risk for elopement were re-assessed per new elopement section in the safety data risk observation and appropriate measures and interventions were put in place and care plans were updated.

Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: The facility Abuse Prevention Policy and Procedure was reviewed and revised to incorporate elopement. The safety data risk observation was reviewed and revised to improve the assessment of elopement. An incident report was developed to document and track elopement episodes. RN Nurse Managers were in-serviced regarding the revised safety risk data observation. All nursing staff were in-serviced on January 5 and 6th, 2016 regarding Vulnerable Adults and reporting Vulnerable Adult incidents and situations, the revised Abuse Prevention Policy and Procedure, and the new facility incident report. All nursing staff received an updated copy of the Abuse Prevention Policy and Procedure.

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Administrator, DON or designee will review all instances of elopement to ensure the Vulnerable Adult reporting guidelines are followed as well as our Abuse Prevention Policy and Procedure. DON, ADON or designee will audit 10 resident charts x 3 months to

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F 225	Continued From page 8 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." 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. In addition, a quarterly minimum data set assessment dated 9/24/15, indicated R87 was	F 225	ensure the revised safety risk data observation has been completed and care plans updated by RN Nurse Managers. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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moderately cognitively impaired, independent with locomotion on and off unit, and used a electric wheelchair.

Although the facility staff were aware R87 had some cognitive impairment, and was not supposed to leave the campus alone, there had been no further investigation of the 10/16/15 incident, nor had a report regarding the alleged neglect of supervision been made to the State Agency.

R97's quarterly MDS, dated 11/6/15, indicated R97 had severe cognitive impairment, was independent with locomotion on the unit, and had no wandering behaviors.

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.

R97's progress note dated 3/13/15, at 4:00 p.m. identified R97 had been found by a van driver to be walking east of the sidewalk in front of the facility. The note identified, when the writer found R97, R97 was in the Wellness Center parking lot. R97 stated he was going to the license bureau to get his driver's license. When told writer would walk with him to ensure he got back to the building safe he became annoyed stating he was fine and could get back on his own. He was easily directed and returned to the facility. There was no indication the state agency was contacted about

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the elopement for possible neglect of care.

R97's annual Safety/Falls Risk Assessment dated 5/21/15, identified there were "no concerns for elopement, wandering, behavior."

On 12/10/15 at 8:26 a.m. RN-A stated a Wanderguard was placed on R97's walker, after he was found outside in the parking lot that same day (3/13/15). R97 was wanted to go to the department of motor vehicles to get his drivers license.

Although R97 had an elopement episode on 3/13/15, the facility had not immediately reported the incident to the state agency for neglect of care.

During interview with the director of nursing (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.

Review of the facility's Abuse Prevention Policy/Procedure revised 5/7/13, included: "All alleged violations of mistreatment, neglect, abuse, injury of unknown origin, and misappropriation of resident property will be reported immediately to the Administrator, Office

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F 225	Continued From page 11 of Health Facility Complaints (OHFC), and Common Entry Point (CEP)." The policy also included: "All alleged mistreatment, abuse, neglect, injuries of unknown origin, misappropriation of resident property will be investigated..." The policy defined neglect as, "The failure to provide goods and services..."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse prohibition policy which required all allegations of neglect to be immediately reported to the state agency (SA) and thoroughly investigated for 3 of 3 residents reviewed (R79, R87, R97) who had left the building without staff awareness. Findings include: The facility's Abuse Prevention Policy/Procedure revised 5/7/13, included: "All alleged violations of mistreatment, neglect, abuse, injury of unknown origin, and misappropriation of resident property will be reported immediately to the Administrator, Office of Health Facility Complaints (OHFC), and Common Entry Point (CEP)." The policy also included: "All alleged mistreatment, abuse, neglect, injuries of unknown origin,	F 226	Corrective Action For Residents Affected By Deficient Practice: R79 was re-assessed for elopement risk, and it was determined per assessment and care conference with family that R79 required secured placement and was relocated to our memory care unit on 12/18/2015. R87 was re-assessed for elopement risk. 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 flag and slow moving sign were placed on his motorized wheelchair. R97 was re-assessed for elopement risk,	1/13/16

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misappropriation of resident property will be investigated..." The policy defined neglect as, "The failure to provide goods and services..."

R79's progress note dated 11/16/15, indicated the 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 assisted living, and that she had brought the resident back to the facility.

R79's quarterly Minimum Data Set (MDS) dated 9/18/15, indicated he was severely cognitively impaired and required assistance with all activities of daily living.

During an interview on 12/9/15 at 9:51 a.m., registered nurse (RN)-B stated she had been on duty the day R79 had gone to the assisted living unassisted by staff. RN-B stated she was unsure whether 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.

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."

Although the provider had been informed by FM-A that R79 had left the nursing home to see her, no additional investigation of the incident, nor reporting of the incident as potential neglect of

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and it was determined that a Wandergard continues to be appropriate for R97.

Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: All residents who have been identified to be at risk for elopement were re-assessed per new elopement section in the safety data risk observation and appropriate measures and interventions were put in place and care plans were updated.

Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: The facility Abuse Prevention Policy and Procedure was reviewed and revised to incorporate elopement. The safety data risk observation was reviewed and revised to improve the assessment of elopement. An incident report was developed to document and track elopement episodes. RN Nurse Managers were in-serviced regarding the revised safety risk data observation. All nursing staff were in-serviced on January 5 and 6th, 2016 regarding Vulnerable Adults and reporting Vulnerable Adult incidents and situations, the revised Abuse Prevention Policy and Procedure, and the new facility incident report. All nursing staff received an updated copy of the Abuse Prevention Policy and Procedure.

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Administrator, DON or designee will review all instances of elopement to ensure the Vulnerable

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F 226	Continued From page 13 supervision to the state agency had been conducted by the facility. During an interview with the director of nursing (DON) on 12/8/15 at 1:21 p.m., identified that on 11/16/15 an incident related to R79's leaving to see FM-A at the assisted living had not been reported to the State Agency. During a subsequent interview on 12/8/15, at 2:04 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."	F 226	Adult reporting guidelines are followed as well as our Abuse Prevention Policy and Procedure. DON, ADON or designee will audit 10 resident charts x 3 months to ensure the revised safety risk data observation has been completed and care plans updated by RN Nurse Managers. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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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 campus.

Although the facility staff were aware R87 had some cognitive impairment, and was not supposed to leave the campus alone, there had been no further investigation of the 10/16/15 incident, nor had a report regarding the alleged neglect of supervision been made to the state agency.

R97's quarterly MDS, dated 11/6/15, indicated R97 had severe cognitive impairment, was independent with locomotion on the unit, and had no wandering behaviors.

R97's care plan dtaed 10/20/15, identified R97 was at risk for elopement and the identified goal

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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.

R97's progress note dated 3/13/15, at 4:00 p.m. identified R97 had been found by a van driver to be walking east of the sidewalk in front of the facility. The note identified, when the writer found R97, R97 was in the Wellness Center parking lot. R97 stated he was going to the license bureau to get his driver's license. When told writer would walk with him to ensure he got back to the building safe he became annoyed stated he was fine and could get back on his own. He was easily directed and returned to the facility. There was no indication the state agency was contacted about the elopement for possible neglect of care.

R97's annual Safety/Falls Risk Assessment dated 5/21/15, identified there were "no concerns for elopement, wandering, behavior."

On 12/10/15 at 8:26 a.m. RN-A stated a Wanderguard was placed on R97's walker, after he was found outside in the parking lot that same day (3/13/15). R97 wanted to go to the department of motor vehicles to get his drivers license.

Although R97 had an elopement episode on 3/13/15, the facility had not immediately reported the incident to the state agency for neglect of care.

During interview with the director of nursing

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F 226	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.	F 226		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions to 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. Findings include: R79's quarterly Minimum Data Set (MDS) dated	F 323	Corrective Action For Residents Affected By Deficient Practice: R79 was re-assessed for elopement risk, and it was determined per assessment and care conference with family that R79 required secured placement and was relocated to our memory care unit on 12/18/2015. Care plan was updated. R87 was re-assessed for elopement risk. R87 is alert and oriented and the BIMS	1/13/16

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9/18/15, indicated he was severely cognitively impaired, required assistance with all activities of daily living and had no wandering behaviors.

R79's care plan dated 10/30/15 had a problem of cognitive impairment and indicated he was "Often concerned about his wife and her whereabouts." There was no indication that R79 had any wandering behaviors identified.

A facility admission Safety Falls Risk assessment on 6/19/15 identified, R79 had confusion, history of multiple falls, and did not mention any wandering risk for R79. The 9/18/15 quarterly review indicated safety were monitored continuously however the assessment did not address if R79 was at risk for wandering behaviors.

A review of facility progress notes indicated on 11/16/15, the facility received a call from R79's family member (FM)-A who reported R79 had left the facility and came to her assisted living apartment that day but was back in facility now. On 11/16/15 a subsequent progress note indicated, R79 had vocalized to staff he wanted to go "upstairs" and visit FM-A. A progress note dated 11/26/15 indicated R79 was observed by staff wandering in hallways in his wheel chair, the note further indicated R79 was confused and did not know where he was. A progress note dated 12/1/15, indicated R79 was observed by staff attempting to push the button that opened the doors leading to the assisted living wing of the complex. R79 stated he was going to see FM-A. Staff re-directed R79 after each event.

There was no indication that R79 had been reassessed for his wandering risk even though he

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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 flag and slow moving sign were placed on his motorized wheelchair. Care plan was updated.

R9's anti-tip bars were placed in the down position and locked into place. Care plan was updated.

Identification Of Other Residents Having The Potential To Be Affected By Deficient Practice: All residents who have been identified to be at risk for elopement were re-assessed per new elopement section in the safety data risk observation and appropriate measures and interventions were put in place and care plans were updated.

A facility audit was conducted to verify that residents using anti-tip bars were assessed for appropriateness and that the bar was down and in locked position.

Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: The safety data risk observation was reviewed and revised to improve the assessment of elopement. RN Nurse Managers were in-serviced regarding the revised safety risk data observation. All nursing staff were in-serviced on following care plan interventions.

Maintenance staff were in-serviced on

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had an elopement episode on 11/16/15, and made continued attempts to leave the nursing home.

During an observation on 12/8/15, at 9:11 a.m., R79 propelled himself toward to front entrance of the facility and stated, "I'm looking for [FM-A]', and was re-directed by an unknown activity staff.

During an interview on 12/8/15, at 1:08 p.m., 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]."

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 bring him back to the unit.

During an interview on 12/8/15, at 1:14 p.m., registered nurse (RN)- A stated, R79 is usually up before eight am, eats breakfast and rests in his room. RN- A stated R79 will try to find FM-A if she 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

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how to appropriately place anti tip bars on wheelchairs. RN Nurse Managers were in-serviced to assess appropriateness of anti-tip bars per safety data risk assessment. All nursing staff were in-serviced on proper placement and positioning of anti-tip bars.

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Administrator, DON or designee will review all instances of elopement to ensure the Vulnerable Adult reporting guidelines are followed as well as our Abuse Prevention Policy and Procedure. DON, ADON or designee will audit 10 resident charts x 3 months to ensure the revised safety risk data observation has been completed and care plans updated by RN Nurse Managers. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.
DON, ADON or designee will do 10 random audit checks of anti-tip bars monthly to ensure they are placed appropriately x 3 months. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.

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DON stated she had discussed putting a Watchmate ID bracelet (a bracelet designed to alert staff if a resident attempts to leave the facility by sounding an alarm and/or locking a door.) on R79, but decided against it because the doorway leading to the assisted living does not have a sensor.

During an interview on 12/9/15, at 2:17 p.m., family member (FM)-A stated R79 had gotten to the assisted living on his own that day. She stated 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.

During an interview on 12/10/15, at 8:45 a.m., social worker (SW)-A stated, "I think R79 came in for rehab." She stated he was unable to return to the assisted living facility with his wife. SW-A further stated, "he fixates on seeing her constantly, he lived there so he knows where to go." "He gets it in his head and will randomly try to get over there." She stated she was aware on one time he got to the assisted living unassisted by staff. She stated she was unaware of any interventions to monitor his whereabouts.

Even though R79 had eloped on 11/16/15, and continues to make requests and attempts to visit

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F 323	Continued From page 20 FM-A, the facility had not reassessed his risk for elopement, or implemented any interventions to ensure R79's safety. R87's quarterly Minimum Data Set (MDS) dated 9/24/15, indicated he was moderately cognitively impaired, independent with locomotion on and off unit and used a electric wheelchair. The MDS further indicated he had one fall since admission with no injury and had no wandering behaviors. 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. R87's care plan dated 10/19/15, indicated he had dementia without behavioral disturbance used a motorized wheelchair for mobility throughout the facility and off campus with family. The care plan indicated physical therapy (PT) assessed his use of motorized wheelchair and indicated he could use it independently in the facility and outside on campus, but have someone accompany him when he goes off campus. The care plan further indicated he had recently gone off campus by himself against therapy recommendation and family does support therapy's recommendation. The care plan approaches indicated staff are to encourage him to sign out when leaving the facility with family, to use orange flag and carry a cell phone with him. A Safety Falls Risk Assessment dated 9/17/15, indicated there is "no concern for elopement, wandering behavior." Review of a Resident Referral Interdepartmental Communication dated 9/21/15, indicated from	F 323		

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certified occupational therapist (COTA) that R87 was "ok" to use power wheelchair inside facility and outside on campus. There was no indication that R87, was able to use his power wheelchair alone without supervisor off campus.

A Resident Progress note dated 10/16/15, at 3:31 p.m., indicated residents son "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. [R87] stated 'I will go up there." Writer told him 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 sons house on his motorized wheelchair. Writer did talk with Social Services and registered nurse (RN) about this matter. Resident did stay at his sons 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."

A Resident Progress note dated 10/19/15, recorded as late entry on 10/19/15, indicated writer (licensed social worker) spoke with resident and his [FM-D] on 10/16/15 after he returned from his son's home via motorized wheelchair. Per [FM-D] family does not want him going off the Bethesda Campus with his motorized wheelchair unless accompanied by family. The note further indicated he recently had a long hospitalization and upon return (OT) assessed his use of motorized wheelchair and determined that he could continue to use the wheelchair within the facility and outside on the campus only.

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F 323	Continued From page 22 Even though R87, had eloped from the facility, that facility had not reassessed R87's elopement risk, and implemented appropriate interventions to ensure his safety. During interview 12/08/15, nursing assistant (NA)-K they try to keep an eye on him (R87), but stated there is no formal monitoring system that we do throughout the day to keep him safe. During interview 12/08/15, family member (FM)-D stated that on October 16th, 2015 R87 left the facility and did not sign himself out. FM-D stated he went to his son's house because he was worried about him, and had to cross a city street to get to the home. R87 did make it safe to the home, but fears something could happen to him (R87). During interview 12/10/15, at 8:15 a.m. with (COTA)-B stated he evaluated R87 for strengthening, ADL's (activity of daily living) and assessed his wheelchair. COTA-B stated he recommended that he have somebody with him when he goes off campus because he is sometimes unaware of his surroundings. He further stated R87 needed to be reminded to keep down his speed when using the power chair. The facility is near a busy road and R87 had not been evaluated with the use of his power wheelchair to cross the road or go up and down a curb to ensure his safety. Although R87 had not been assessed for safety when off facility campus, which occurred on 10/16/15, the facility did not have appropriate interventions in place to ensure R87's safety when he left facility grounds.	F 323		

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A facility policy for elopement was requested but none was provided.

R9 quarterly MDS dated 9/25/15, indicated he had diagnoses of cerebral palsy (permanent movement disorder with varies signs and symptoms often of poor coordination, stiff muscles, weak muscles, and tremors) and paraplegia (impairment in motor or sensory function of the lower extremities). The MDS further indicated he needed extensive assistance on/off the unit and used a wheelchair.
R9's care plan dated 07/08/15, indicated he is at risk for falls and injury related to advanced age with infantile cerebral palsy, mental retardation, seizure disorder, hyperkinetic disorder (which developmentally inappropriate inattention, hyperactivity and impulsivity), spastic paraplegia, and a fall history. The care plan interventions included position upright in wheelchair, padded leg rests, and dycem in wheelchair.
During observations the following was noted:
On 12/06/15, at 5:33 p.m. R9 was up in his wheelchair and the right anti-tip bar (Anti-tip bars are fitted on wheelchairs to prevent them from tipping over) was turned in 1 inch and not locked into place.
On 12/07/15, at 9:33 a.m. R9 was observed sitting up in wheelchair in his room and again the right anti-tip bar was turned in 1 inch.
On 12/08/15, at 7:55 a.m. R9 was sitting in dinning room chair sitting up in wheelchair with anti-tip bars in same position as above.
On 12/10/15, at 8:44 a.m. R9 was wheeling from dinning room and right anti-tip bar was tilted in 1 inch and resident was tilted back approximately 30 degrees.

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	245427	A. BUILDING ______ B. WING ______	12/10/2015

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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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 During interview 12/10/15, at 2:27 p.m. the occupational therapist (OT)-C stated R9 has a custom stilt and space wheelchair from Gillette, and staff can tilt him back every two hours for repositioning since he refuses to lay down in bed. The OT-C stated the anti-tip bars should be in the down position to prevent him from tipping over. During interview 12/10/15, at 2:35 p.m. the DON stated the anti-tip bars should be in the down position and the bars were not effective for R9 and would fix them right away.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356		1/13/16

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F 356	Continued From page 25 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently post the required nursing staffing information on a daily basis at the beginning of each shift. This had the potential to affect all 110 residents residing in the facility and all visitors. Findings include: During initial tour on 12/06/15, at 1:00 p.m. the facility staff posting dated 12/04/15, was observed posted on a bulletin board in the facility entryway. Although the name of the facility, date and census, total and actual hours were included in the posting, the posting was from two days prior. During interview on 12/7/15, at 3:30 p.m. the assistant director of nursing (ADON) stated the weekend supervisor was supposed to change out the posting and had not posted the current information. A facility policy revised 08/2013, Nurse Staffing Hours indicated "The staffing hours sheet report will be posted within the facility and be kept up to date." The policy further indicated the staffing coordinator or designated person will be responsible for printing and posting the staffing sheet for Saturday and Sunday and on the weekend the charge nurse will be responsible for	F 356	Corrective Action For Residents Affected By Deficient Practice: Nurse Staffing Information Posting policy and procedure was reviewed and revised. Posting form will be updated daily – including on weekends and holidays. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: This had the potential to affect all 110 current residents in the facility, along with interested family members and visitors. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Nurse Staffing Information Posting policy and procedure was reviewed and revised. Staffing Coordinator and RN Nurse Managers were in-serviced on new policy and procedure. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Staffing Coordinator will audit weekly x 3 months that the posting form had been changed and updated over the weekend. The audit will be presented to the facility Quality Assurance committee to verify that	

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F 356	Continued From page 26 putting out the census/staffing hours for the current day.	F 356	compliance has been attained.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a sanitary manner in 1 of 2 resident dining rooms. This had the potential to affect 22 of 30 residents who ate in the memory care unit. Findings include: During continuous observation on 12/6/2015 from 5:10 p.m. to 5:47 p.m., the evening meal on the memory care unit was being served. Dietary assistant (DA)-D worked behind a steam table which held numerous hot and cold foods, including potato salad, sliced tomatoes, beets, hot dogs, buns, and various dessert items, in individual serving bowls. The food items were also prepared in various textures, and in each of the food compartments on the steam table, there was a scoop or slotted spoon for serving, and tongs were present next to the hot dog buns. At	F 371	Corrective Action For Residents Affected By Deficient Practice: Dietary Assistant (D) was re-educated on properly handling 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 Deficient Practice: All residents being served meals by this deficient practice have the potential to be affected. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: All dietary staff were in-serviced with regard to proper service and handling of food to ensure food is served in a sanitary manner.	1/13/16

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F 371	Continued From page 27	F 371		

5:15 p.m., DA-D began dishing up foods onto onto plates, which were delivered to residents at their tables.

At 5:17 p.m., with gloved hands, DA-D set a plate on the table, and with the scoop, placed a serving each of potato salad and beets. Using the tongs, DA-D placed sliced tomatoes on top, and handed the plate to a staff member. Two additional plates were made similarly. At 5:19 p.m., with gloved hands, DA-D began leafing through a ringed binder on the steam table. The binder was filled with papers covered with plastic sheet protectors, and contained information regarding residents' dietary needs. After flipping through the plastic sheets with both gloved hands, DA-D then located and read information on the plastic sheet. Next, DA-D set another plate down, grasped and opened, with the same gloved hands, a hot dog bun on this resident's plate. DA-D then served other foods on the plate, using the scoops and spoon, before passing the plate to a co-worker to be served to a resident.

Between 5:19 p.m. and 5:29 p.m., DA-D dished up nine resident plates. For six residents with regular-textured meals, DA-D each time grasped a hot dog bun, opened it with the gloved hands. |DA-D also leafed through the binder an additional four times. DA-D also dished up three meals for residents who received altered textures, and used ladles and scoops.

At 5:30 p.m., DA-D went to the cupboard behind the steam table, and still wearing the same gloves, grasped the cupboard handle, opened the door, and retrieved additional plates and set them on the steam table. DA-D again leafed through the plastic sheets in the binder, with both gloved

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Dietary Manager, Clinical Dietician, or designee will do 10 random meal audits x 3 months to ensure food is served appropriately and sanitarily. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.

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F 371	Continued From page 28	F 371		

hands, found the page for a resident, and after reading a page, placed another hot dog bun, and scooped other foods,on this plate. Between 5:30 p.m. and 5:40 p.m., DA-D dished up six more resident meals, four of which were regular textured meals, each received a hot dog bun handled with the gloved hands. DA-D also referenced the binder, with her gloved hands, two more times.

During the entire observation DA-D wore only one pair of gloves. DA-D did not wash or otherwise cleanse hands or change gloves, neither after leafing through the plastic-covered diet information pages numerous times, nor after opening the cupboard doors during the evening food service.

In an interview on 12/6/2015 at 5:41 p.m., DA-D stated she did not wash her hands or change gloves after looking through the resident's diet order binder, and also opening and closing cupboards in the kitchen, and continued to set up residents's meals, including placing hot dog buns on plates with dirty gloves. DA-D stated it was easier "to grab the hot dog buns with her hands, rather than using the tongs" to get the buns to open.

During an interview on 12/10/2015 at 1:35 p.m., the dietary manager (DM) stated to maintain clean hands, only one person was to be behind the steam table dishing up meals, and other staff were to deliver the plates and beverages to residents. The DM stated if the server needed to refer to the resident diet orders, or needed something from the cupboard, and had to touch the handles, she should have had asked another staff to turn the pages, or to ask for help,"that is

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F 371	Continued From page 29 how they are trained." The DM also added DA-D, after opening the cupboard or touching the plastic sheets, "could have washed her hands, or put on new gloves" before continuing. The DM stated cupboard handles and plastic-covered sheets were considered unclean surfaces. Food servers were not required to wear gloves, and were trained to handle plates by the edges, and to use tongs and scoops when serving, the DM said. The DM also said DA-D "should have used tongs" to serve the hot dog buns, and not touched the bread with bare hands, or "unclean gloves." A facility policy, Service of Food, reviewed and revised 1/2015, indicated under the section "Good Personal Hygiene": "Do not touch cooked or ready to eat foods with bare hands. Use gloves or utensils."	F 371		

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	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING	12/07/2015

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 07, 2015. At the time of this survey, Building 01 of Bethesda Nursing Home Pleasant View was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000		

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

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Building 01 of Bethesda Nursing Home Pleasant View is a one-story building with full basement. The facility is fully fire sprinkler protected, and was constructed as follows:
The original 1979 building was determined to be of Type V(111) construction;
The 1994 building addition was determined to be of Type II(000) construction;
The 1999 building addition was determined to be of Type II(000) construction.

The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 123 beds and had a census of 111 at time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Observations indicated that the automatic sprinkler system has not been maintained in accordance with NFPA 13 Standard for the Installation of Sprinkler System 1999 edition section 5-5.6. This deficient practice may allow a fire to grow uncontrolled which will negatively impact residents, visitors and staff. Findings include: Observations during the facility tour on December 07, 2015, between 10am and 2:30PM, revealed the following: 1) In room D8 the resident bathroom has been converted into a closet and shelves have been installed directly under the sprinkler head.	K 056	Corrective Action For Residents Affected By Deficient Practice: The shelves in room D8's bathroom have been removed to not impede the sprinkler head. The decorations hanging from the sprinkler head in room D8 were removed. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to ensure all resident rooms have no storage within 18 inches of the sprinkler heads. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility audit tool was developed	1/13/16

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K 056	Continued From page 3 Assistance was needed to locate the sprinkler head due to patient storage. 2) In room D8 the resident had decorations hanging from the sprinkler head in the room. The Facilities Maintenance Director (GR) Verified these findings during the facility tour.	K 056	to be completed monthly by maintenance personnel to verify that all resident rooms have no storage within 18 inches of the sprinkler heads. Maintenance personnel were educated on the audit process. Education regarding appropriate storage was provided to residents at their neighborhood resident council meetings on January 8, 2015. Nursing staff were in-serviced on not having storage within 18 inches of a sprinkler head and to notify maintenance if so. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: The resident room inspection for storage within 18 inches of a sprinkler head will be audited by the Administrator monthly x 3 months. The results of the audit will be presented to the facility Quality Assurance committee to verify that compliance has been maintained.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Observations revealed that some electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. This deficiency could negatively effect any resident, staff and visitors in this area of the facility. Findings include:	K 147	Corrective Action For Residents Affected By Deficient Practice: The extension cord in the front lobby was removed. The refrigerator in room D8 was plugged into the outlet rather than the power strip. The extension cord was removed from room E9.	1/13/16

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K 147	Continued From page 4 Observations during the facility tour on December 07, 2015, between 10am and 2:30PM, revealed the following: 1) An extension cord in the main lobby at the Christmas tree. 2) Rm D-8 Refrigerator plugged into a power strip. 3) Rm E-9 Multi-plug adapter plugged into an extension cord. The Facilities Maintenance Director (GR) Verified these findings during the facility tour.	K 147	Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: All facility residents, visitors, and staff have the potential to be affected by the deficient practice. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility audit tool was developed to be completed monthly by maintenance personnel to verify that resident rooms, common areas, and offices are free from extension cords and power strips are being used appropriately. Maintenance personnel were educated on the correct use of electrical installations and the audit process. Education regarding appropriate use of extension cords and power strips was provided to residents at their neighborhood resident council meetings on January 8, 2015. 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. The results of the audit will be presented to the facility Quality Assurance committee to verify that compliance has been maintained. Nursing staff were in-serviced on not using extension cords and to inform maintenance if one is in use.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245427	A. BUILDING **02 - MEMORY UNIT** B. WING ______	**12/07/2015**

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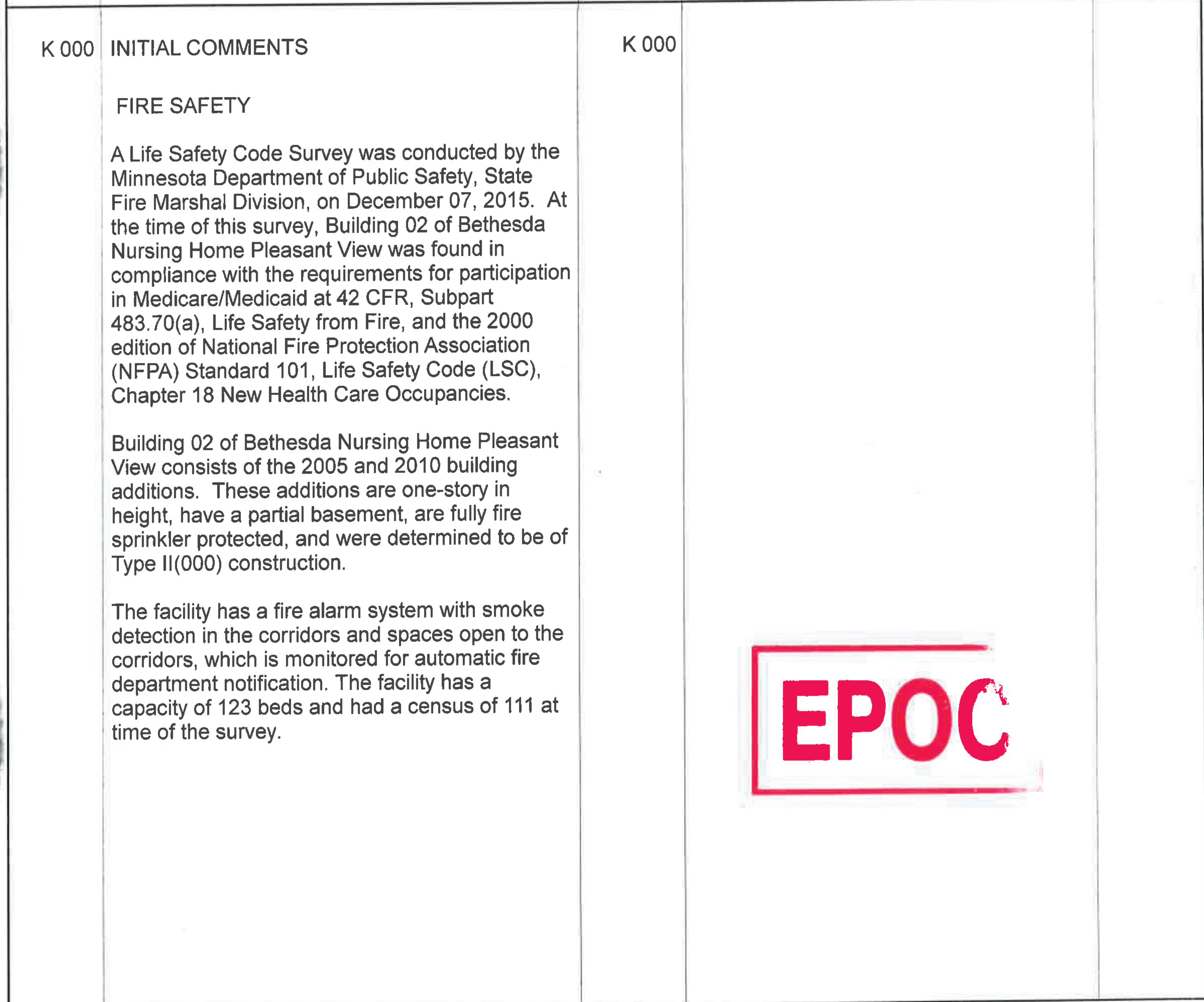

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 07, 2015. At the time of this survey, Building 02 of Bethesda Nursing Home Pleasant View was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Bethesda Nursing Home Pleasant View consists of the 2005 and 2010 building additions. These additions are one-story in height, have a partial basement, are fully fire sprinkler protected, and were determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 123 beds and had a census of 111 at time of the survey.	K 000	EPOC	

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

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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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

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.

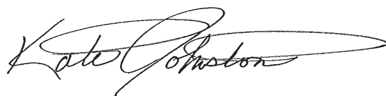
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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,



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00792	A. BUILDING: ______ B. WING ______	12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. 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.
On 12/6 thru 12/10/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued.
Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.
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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.
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2 830	Continued From page 2	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN 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. Findings include: R79's quarterly Minimum Data Set (MDS) dated 9/18/15, indicated he was severely cognitively impaired, required assistance with all activities of daily living and had no wandering behaviors. R79's care plan dated 10/30/15 had a problem of cognitive impairment and indicated he was "Often concerned about his wife and her whereabouts." There was no indication that R79 had any wandering behaviors identified.	2 830		

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2 830	Continued From page 3	2 830		

A facility admission Safety Falls Risk assessment on 6/19/15 identified, R79 had confusion, history of multiple falls, and did not mention any wandering risk for R79. The 9/18/15 quarterly review indicated safety were monitored continuously however the assessment did not address if R79 was at risk for wandering behaviors.

A review of facility progress notes indicated on 11/16/15, the facility received a call from R79's family member (FM)-A who reported R79 had left the facility and came to her assisted living apartment that day but was back in facility now. On 11/16/15 a subsequent progress note indicated, R79 had vocalized to staff he wanted to go "upstairs" and visit FM-A. A progress note dated 11/26/15 indicated R79 was observed by staff wandering in hallways in his wheel chair, the note further indicated R79 was confused and did not know where he was. A progress note dated 12/1/15, indicated R79 was observed by staff attempting to push the button that opened the doors leading to the assisted living wing of the complex. R79 stated he was going to see FM-A. Staff re-directed R79 after each event.

There was no indication that R79 had been reassessed for his wandering risk even though he had an elopement episode on 11/16/15, and made continued attempts to leave the nursing home.

During an observation on 12/8/15, at 9:11 a.m., R79 propelled himself toward to front entrance of the facility and stated, "I'm looking for [FM-A]', and was re-directed by an unknown activity staff.

During an interview on 12/8/15, at 1:08 p.m.,

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2 830	Continued From page 4	2 830		

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]."

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 bring him back to the unit.

During an interview on 12/8/15, at 1:14 p.m., registered nurse (RN)- A stated, R79 is usually up before eight am, eats breakfast and rests in his room. RN- A stated R79 will try to find FM-A if she 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 DON stated she had discussed putting a Watchmate ID bracelet (a bracelet designed to alert staff if a resident attempts to leave the facility by sounding an alarm and/or locking a door.) on R79, but decided against it because the doorway leading to the assisted living does not have a sensor.

During an interview on 12/9/15, at 2:17 p.m., family member (FM)-A stated R79 had gotten to the assisted living on his own that day. She stated

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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.

During an interview on 12/10/15, at 8:45 a.m., social worker (SW)-A stated, "I think R79 came in for rehab." She stated he was unable to return to the assisted living facility with his wife. SW-A further stated, "he fixates on seeing her constantly, he lived there so he knows where to go." "He gets it in his head and will randomly try to get over there." She stated she was aware on one time he got to the assisted living unassisted by staff. She stated she was unaware of any interventions to monitor his whereabouts.

Even though R79 had eloped on 11/16/15, and continues to make requests and attempts to visit FM-A, the facility had not reassessed his risk for elopement, or implemented any interventions to ensure R79's safety.

R87's quarterly Minimum Data Set (MDS) dated 9/24/15, indicated he was moderately cognitively impaired, independent with locomotion on and off unit and used a electric wheelchair. The MDS further indicated he had one fall since admission with no injury and had no wandering behaviors.

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2 830	Continued From page 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.

R87's care plan dated 10/19/15, indicated he had dementia without behavioral disturbance used a motorized wheelchair for mobility throughout the facility and off campus with family. The care plan indicated physical therapy (PT) assessed his use of motorized wheelchair and indicated he could use it independently in the facility and outside on campus, but have someone accompany him when he goes off campus. The care plan further indicated he had recently gone off campus by himself against therapy recommendation and family does support therapy's recommendation. The care plan approaches indicated staff are to encourage him to sign out when leaving the facility with family, to use orange flag and carry a cell phone with him.

A Safety Falls Risk Assessment dated 9/17/15, indicated there is "no concern for elopement, wandering behavior."

Review of a Resident Referral Interdepartmental Communication dated 9/21/15, indicated from certified occupational therapist (COTA) that R87 was "ok" to use power wheelchair inside facility and outside on campus. There was no indication that R87, was able to use his power wheelchair alone without supervisor off campus.

A Resident Progress note dated 10/16/15, at 3:31 p.m., indicated residents son "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. [R87] stated 'I will go up

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there." Writer told him 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 sons house on his motorized wheelchair. Writer did talk with Social Services and registered nurse (RN) about this matter. Resident did stay at his sons 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."

A Resident Progress note dated 10/19/15, recorded as late entry on 10/19/15, indicated writer (licensed social worker) spoke with resident and his [FM-D] on 10/16/15 after he returned from his son's home via motorized wheelchair. Per [FM-D] family does not want him going off the Bethesda Campus with his motorized wheelchair unless accompanied by family. The note further indicated he recently had a long hospitalization and upon return (OT) assessed his use of motorized wheelchair and determined that he could continue to use the wheelchair within the facility and outside on the campus only.

Even though R87, had eloped from the facility, that facility had not reassessed R87's elopement risk, and implemented appropriate interventions to ensure his safety.

During interview 12/08/15, nursing assistant (NA)-K they try to keep an eye on him (R87), but stated there is no formal monitoring system that we do throughout the day to keep him safe.

During interview 12/08/15, family member (FM)-D stated that on October 16th, 2015 R87 left the facility and did not sign himself out. FM-D stated he went to his son's house because he was

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worried about him, and had to cross a city street to get to the home. R87 did make it safe to the home, but fears something could happen to him (R87).

During interview 12/10/15, at 8:15 a.m. with (COTA)-B stated he evaluated R87 for strengthening, ADL's (activity of daily living) and assessed his wheelchair. COTA-B stated he recommended that he have somebody with him when he goes off campus because he is sometimes unaware of his surroundings. He further stated R87 needed to be reminded to keep down his speed when using the power chair. The facility is near a busy road and R87 had not been evaluated with the use of his power wheelchair to cross the road or go up and down a curb to ensure his safety.

Although R87 had not been assessed for safety when off facility campus, which occurred on 10/16/15, the facility did not have appropriate interventions in place to ensure R87's safety when he left facility grounds.

A facility policy for elopement was requested but none was provided.

R9 quarterly MDS dated 9/25/15, indicated he had diagnoses of cerebral palsy (permanent movement disorder with varies signs and symptoms often of poor coordination, stiff muscles, weak muscles, and tremors) and paraplegia (impairment in motor or sensory function of the lower extremities). The MDS further indicated he needed extensive assistance on/off the unit and used a wheelchair.
R9's care plan dated 07/08/15, indicated he is at

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risk for falls and injury related to advanced age with infantile cerebral palsy, mental retardation, seizure disorder, hyperkinetic disorder (which developmentally inappropriate inattention, hyperactivity and impulsivity), spastic paraplegia, and a fall history. The care plan interventions included position upright in wheelchair, padded leg rests, and dycem in wheelchair.
During observations the following was noted:
On 12/06/15, at 5:33 p.m. R9 was up in his wheelchair and the right anti-tip bar (Anti-tip bars are fitted on wheelchairs to prevent them from tipping over) was turned in 1 inch and not locked into place.
On 12/07/15, at 9:33 a.m. R9 was observed sitting up in wheelchair in his room and again the right anti-tip bar was turned in 1 inch.
On 12/08/15, at 7:55 a.m. R9 was sitting in dinning room chair sitting up in wheelchair with anti-tip bars in same position as above.
On 12/10/15, at 8:44 a.m. R9 was wheeling from dinning room and right anti-tip bar was tilted in 1 inch and resident was tilted back approximately 30 degrees.
During interview 12/10/15, at 2:27 p.m. the occupational therapist (OT)-C stated R9 has a custom stilt and space wheelchair from Gillette, and staff can tilt him back every two hours for repositioning since he refuses to lay down in bed. The OT-C stated the anti-tip bars should be in the down position to prevent him from tipping over.
During interview 12/10/15, at 2:35 p.m. the DON stated the anti-tip bars should be in the down position and the bars were not effective for R9 and would fix them right away.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review/revise policies and procedures related to

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2 830	Continued From page 10 falls, accident and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on these policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food was served in a sanitary manner in 1 of 2 resident dining rooms. This had the potential to affect 22 of 30 residents who ate in the memory care unit. Findings include: During continuous observation on 12/6/2015 from 5:10 p.m. to 5:47 p.m., the evening meal on the	21000		

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21000	Continued From page 11 memory care unit was being served. Dietary assistant (DA)-D worked behind a steam table which held numerous hot and cold foods, including potato salad, sliced tomatoes, beets, hot dogs, buns, and various dessert items, in individual serving bowls. The food items were also prepared in various textures, and in each of the food compartments on the steam table, there was a scoop or slotted spoon for serving, and tongs were present next to the hot dog buns. At 5:15 p.m., DA-D began dishing up foods onto onto plates, which were delivered to residents at their tables. At 5:17 p.m., with gloved hands, DA-D set a plate on the table, and with the scoop, placed a serving each of potato salad and beets. Using the tongs, DA-D placed sliced tomatoes on top, and handed the plate to a staff member. Two additional plates were made similarly. At 5:19 p.m., with gloved hands, DA-D began leafing through a ringed binder on the steam table. The binder was filled with papers covered with plastic sheet protectors, and contained information regarding residents' dietary needs. After flipping through the plastic sheets with both gloved hands, DA-D then located and read information on the plastic sheet. Next, DA-D set another plate down, grasped and opened, with the same gloved hands, a hot dog bun on this resident's plate. DA-D then served other foods on the plate, using the scoops and spoon, before passing the plate to a co-worker to be served to a resident. Between 5:19 p.m. and 5:29 p.m., DA-D dished up nine resident plates. For six residents with regular-textured meals, DA-D each time grasped a hot dog bun, opened it with the gloved hands. |DA-D also leafed through the binder an additional four times. DA-D also dished up three	21000		

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meals for residents who received altered textures, and used ladles and scoops.

At 5:30 p.m., DA-D went to the cupboard behind the steam table, and still wearing the same gloves, grasped the cupboard handle, opened the door, and retrieved additional plates and set them on the steam table. DA-D again leafed through the plastic sheets in the binder, with both gloved hands, found the page for a resident, and after reading a page, placed another hot dog bun, and scooped other foods,on this plate. Between 5:30 p.m. and 5:40 p.m., DA-D dished up six more resident meals, four of which were regular textured meals, each received a hot dog bun handled with the gloved hands. DA-D also referenced the binder, with her gloved hands, two more times.

During the entire observation DA-D wore only one pair of gloves. DA-D did not wash or otherwise cleanse hands or change gloves, neither after leafing through the plastic-covered diet information pages numerous times, nor after opening the cupboard doors during the evening food service.

In an interview on 12/6/2015 at 5:41 p.m., DA-D stated she did not wash her hands or change gloves after looking through the resident's diet order binder, and also opening and closing cupboards in the kitchen, and continued to set up residents's meals, including placing hot dog buns on plates with dirty gloves. DA-D stated it was easier "to grab the hot dog buns with her hands, rather than using the tongs" to get the buns to open.

During an interview on 12/10/2015 at 1:35 p.m., the dietary manager (DM) stated to maintain

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clean hands, only one person was to be behind the steam table dishing up meals, and other staff were to deliver the plates and beverages to residents. The DM stated if the server needed to refer to the resident diet orders, or needed something from the cupboard, and had to touch the handles, she should have had asked another staff to turn the pages, or to ask for help,"that is how they are trained." The DM also added DA-D, after opening the cupboard or touching the plastic sheets, "could have washed her hands, or put on new gloves" before continuing. The DM stated cupboard handles and plastic-covered sheets were considered unclean surfaces. Food servers were not required to wear gloves, and were trained to handle plates by the edges, and to use tongs and scoops when serving, the DM said. The DM also said DA-D "should have used tongs" to serve the hot dog buns, and not touched the bread with bare hands, or "unclean gloves."

A facility policy, Service of Food, reviewed and revised 1/2015, indicated under the section "Good Personal Hygiene": "Do not touch cooked or ready to eat foods with bare hands. Use gloves or utensils."

SUGGESTED METHOD OF CORRECTION:
The dietary director oor designee, could review procedures for safe food handling to assure appropriate distribution of food is in place. The dietray manager or designee, could conduct random audits of the delivery of food; to ensure appropriate care and services are implemented.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure audio privacy for 11 residents (R59, R27, R85, R116, R82, R107, R55, R63, R71, R140 and R19) in the sample, of the 30 residents who resided in the locked memory care unit where the facility utilized an audio monitoring system. Findings include: R59, R27, R85, R116, R82, R107, R55, R63, R71, R140 and R19 were identified by facility to currently reside in the memory care unit of the facility. R59's quarterly Minimum Data Set (MDS) dated 10/16/15, indicated R59 was severely cognitively impaired, and included diagnoses of Alzheimer's dementia. R27's quarterly MDS, dated 11/6/15, indicated R27 had severe cognition impairment, and diagnoses which included anxiety disorder.	21855		

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R85's quarterly MDS dated 9/11/15 indicated R85 had severe cognition impairment, and diagnoses which included dementia and depression.

R116's admission MDS, dated 11/9/15, indicated R116 had moderately impaired cognition, and diagnoses which included Alzheimer's dementia and anxiety.

R82's significant change MDS, dated 11/13/15, indicated R82 had severe cognition impairment, and diagnoses which included dementia and anxiety disorder.

R107's quarterly MDS, dated 8/28/15, indicated R107 had severe cognition impairment, and diagnoses which included Alzheimer's dementia.

R55's quarterly MDS dated 10/2/15, indicated R55 had moderate cognition impairment, and diagnoses which included dementia.

R63's quarterly MDS,dated 11/6/15, indicated R63 had severe cognition impairment, and diagnoses which included dementia and psychotic disorder.

R71's quarterly MDS, dated 7/31/15, indicated R71 had severe cognition impairment, and diagnoses which included Alzheimer's dementia.

R140's admission MDS, dated 10/15/15, indicated R140 had severe cognition impairment, and diagnoses which included amnesia.

R19's significant change MDS, dated 10/23/15, indicated R19 had severe cognition impairment, and diagnoses which included dementia.

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During observation on the initial tour of the facility on 12/6/2015 at 1:33 p.m., two audio monitors, and two corresponding audio receivers were noted in use on the locked, memory care unit:

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 inch thick, with a protruding two inch antenna, hung flat on the wall about six feet from the floor between room C1 and the soiled utility room. The monitor was plugged in, and an LED light indicated it was operational. This monitor's corresponding receiver (a unit which receives and broadcasts signals) was located on a counter near the food service tables, on one end of a larger common area of the locked unit. A small red light indicated the receiver was functioning.

A second monitor was located at the far end of the "B" hallway, near the double-door locked entry in the memory unit. This monitor was positioned on south side wall, between room B12 and the storage room, approximate six feet from the floor. The monitor was plugged in and operating. A corresponding receiver was located on a counter, near the nursing station, on the opposite side of the large, open common area.

During each day of the survey, from 12/6/2015 to 12/10/2015, the audio monitors in the locked memory unit were observed to be on and operating. On 12/9/15 at 2:56 p.m., 12 residents and staff were seated around tables and were led in an activity by two staff members. Intermittently, voices from the receiver near the kitchen area could be heard.

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In an interview on 12/10/2015 at 6:25 a.m., trained medication assistant (TMA)-A stated the hall monitors were on "all the time" during the night, but was not sure if that was the case during the day and evening hours. TMA-A stated "you can hear people talking" especially when the halls are more quite at night. TMA-A also stated if a resident had a TV on, "you can hear the conversation from the TV."

In an interview on 12/10/2015 at 6:33 a.m., licensed practical nurse (LPN)-A stated the monitors were on "all the time," and they were "just another aid" to hear residents who may need help. LPN-A stated the receivers amplified the TABS (a personal safety alarm device) alarms.

On 12/10/2015 at 6:58 a.m., from the receiver nearest the "B" hall nursing station, the following was heard in the receiver: "...do you know where [staff name] is?....I did [R55's] neb (a breathing treatment)...then [R55] he can go into the dining room, then." On 12/10/2015 at 7:15 a.m., from the receiver near the meal serving table, voices of residents and staff could be heard.

During a interview on 12/10/2015 at 6:59 a.m., LPN- B stated the monitors on the unit "helps us hear what is going on." LPN-B also stated the monitors helped the staff hear the call lights, or if a pad alarm or a TAB alarm goes off, and "just helps to monitor the hallway activity."

In an interview on 12/10/2015 at 2:05 p.m., the director of nursing (DON) stated the purpose of the monitors was for "the amplification of the pressure and TAB alarm," and also "to assist in fall prevention" for residents. The DON stated she did not know how long the facility had used the

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21855	Continued From page 18 monitors, it could have been "for years," and that the monitors were used "before my time here." The DON acknowledged the monitors were on and operating "24/7." The DON said she was not aware of any concerns expressed or complaints by families, or others, with regard to possible infringement of privacy. The DON also stated the facility could look into "just turning them on at night." The DON stated presently, there was "no facility policy" regarding use of audio monitors, which might address frequency of use, who was responsible to turn off and on, or guidelines regarding privacy concerns. The DON then stated the facility "should look at the monitors" for their continued use. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review the use of audio monitors in the hallways. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21855		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated	21980		

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reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(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).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

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This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure allegations of neglect were immediately reported to the state agency (SA) and thoroughly investigated for 3 of 3 residents reviewed (R79, R87, R97) who had left the building without staff awareness.

Findings include:

R79's progress note dated 11/16/15, indicated the facility had received a call from R79's family member (FM)-A who reported R79 had left the facility and gone to her at her apartment in the attached assisted living, and that she had brought the resident back to the facility.

R79's quarterly Minimum Data Set (MDS) dated 9/18/15, indicated he was severely cognitively impaired and required assistance with all activities of daily living.

During an interview on 12/9/15 at 9:51 a.m., registered nurse (RN)-B stated she had been on 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.

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.

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FM-A further stated, "I don't know what he would do if I wasn't home."

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.

During an interview with the director of nursing (DON) on 12/8/15 at 1:21 p.m., identified the 11/16/15 incident was related to R79's leaving to go see his FM-A at the assisted living had not been investigated or reported to the State Agency.

During a subsequent interview on 12/8/15, at 2:04 p.m., the DON stated she did not know how long R79 was gone.

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."

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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.

In addition, a quarterly minimum data set assessment dated 9/24/15, indicated R87 was moderately cognitively impaired, independent with locomotion on and off unit, and used a electric wheelchair.

Although the facility staff were aware R87 had some cognitive impairment, and was not supposed to leave the campus alone, there had been no further investigation of the 10/16/15 incident, nor had a report regarding the alleged neglect of supervision been made to the State Agency.

R97's quarterly MDS, dated 11/6/15, indicated R97 had severe cognitive impairment, was independent with locomotion on the unit, and had no wandering behaviors.

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	00792	A. BUILDING: ______ 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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.

R97's progress note dated 3/13/15, at 4:00 p.m. identified R97 had been found by a van driver to be walking east of the sidewalk in front of the facility. The note identified, when the writer found R97, R97 was in the Wellness Center parking lot. R97 stated he was going to the license bureau to get his driver's license. When told writer would walk with him to ensure he got back to the building safe he became annoyed stating he was fine and could get back on his own. He was easily directed and returned to the facility. There was no indication the state agency was contacted about the elopement for possible neglect of care.

R97's annual Safety/Falls Risk Assessment dated 5/21/15, identified there were "no concerns for elopement, wandering, behavior."

On 12/10/15 at 8:26 a.m. RN-A stated a Wanderguard was placed on R97's walker, after he was found outside in the parking lot that same day (3/13/15). R97 was wanted to go to the department of motor vehicles to get his drivers license.

Although R97 had an elopement episode on 3/13/15, the facility had not immediately reported the incident to the state agency for neglect of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00792	A. BUILDING: ______ B. WING ______	12/10/2015

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BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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21980	Continued From page 24	21980		

Continued From page 24

During interview with the director of nursing (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.

Review of the facility's Abuse Prevention Policy/Procedure revised 5/7/13, included: "All alleged violations of mistreatment, neglect, abuse, injury of unknown origin, and misappropriation of resident property will be reported immediately to the Administrator, Office of Health Facility Complaints (OHFC), and Common Entry Point (CEP)." The policy also included: "All alleged mistreatment, abuse, neglect, injuries of unknown origin, misappropriation of resident property will be investigated..." The policy defined neglect as, "The failure to provide goods and services..."

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents to assure they are receiving the necessary treatment/services to to ensure systems for reporting are in place for all residents as appropriate. The director of nursing or designee, could conduct random audits; to ensure appropriate reporting procedures are implemented.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00792	A. BUILDING: ______ 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**

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21980	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		