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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: L78P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00312

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245532**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803742600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA HERITAGE CENTER**
(L4) **1012 EAST THIRD STREET**
(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 **09/26/2016** (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 **125** (L18)

13.Total Certified Beds **125** (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
	125			
(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 — 09/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 10/19/2016 (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
01/10/1989
(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 10/27/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/06/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245532
October 19, 2016

Ms. Michelle Haefner, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, MN 56201

Dear Ms. Haefner:

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 September 12, 2016 the above facility is certified for or recommended for:

125 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 125 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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 19, 2016

Ms. Michelle Haefner, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, MN 56201

RE: Project Number S5532026

Dear Ms. Haefner:

On August 17, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 4, 2016. 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 September 26, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 13, 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 August 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 4, 2016, effective September 12, 2016 and therefore remedies outlined in our letter to you dated August 17, 2016, 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	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245532 Y1	A. Building B. Wing Y2	9/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET 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 F0282	Correction	ID Prefix F0314	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(l)	Completed
LSC	09/12/2016	LSC	09/12/2016	LSC	09/12/2016
ID Prefix F0334	Correction	ID Prefix F0371	Correction	ID Prefix F0441	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.65	Completed
LSC	09/12/2016	LSC	09/12/2016	LSC	09/12/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	09/12/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) BF/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 10562	DATE 09/26/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
8/4/2016

☐ 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)
245532	A. Building 01 - MAIN BUILDING B. Wing	9/13/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET 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 K0051	Correction Completed 09/12/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 09/12/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 09/12/2016
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

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 10/19/2016	SIGNATURE OF SURVEYOR 10562	DATE 09/13/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/2/2016	☐ 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 — ID: L78P

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00312

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245532**

2.STATE VENDOR OR MEDICAID NO.
(L2) **803742600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA HERITAGE CENTER**
(L4) **1012 EAST THIRD STREET**
(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 **08/04/2016** (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 **125** (L18)

13.Total Certified Beds **125** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:

X 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: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	125			
(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 :
Sarah Kacena, HFE NE II — 08/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/01/2016 (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
01/10/1989
(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 09/06/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 17, 2016

Ms. Michelle Haefner, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, MN 56201

RE: Project Number S5532026

Dear Ms. Haefner:

On August 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

Informal Dispute Resolution - 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 September 13, 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 September 13, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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 November 4, 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 February 4, 2017 (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, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING _____ B. WING _____	08/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On August 1, 2016 to August 4, 2016, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Bethesda Heritage Center was found to not be in compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. 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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement care planned interventions in regards to timely repositioning to reduce the risk of pressure ulcer	F 282	Corrective Action For Residents Affected By Deficient Practice: Resident # 97 care plan was updated. Nursing staff communicated his need for every 2 hour	9/12/16

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

Electronically Signed | 08/26/2016

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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	245532	A. BUILDING _____ B. WING _____	08/04/2016

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F 282	Continued From page 1 formation for 1 of 1 residents (R97) reviewed for pressure ulcers. In addition, the facility failed to monitor meal intake for 2 of 2 residents (R50, R12) reviewed with the care planned intervention. Findings include: Review of R97's quarterly Minimum Data Set (MDS) dated 7/14/16, identified R97 had intact cognition, required limited assistance with transfers, bed mobility and was at risk for pressure ulcers. R97's care plan dated 07/01/2016, indicated R97 had potential for skin integrity, and listed a goal of, "prevent pressure sores and skin breakdown". The care plan identified an intervention of, off load resident when in wheelchair every two hours. Review of R97's nursing progress noted dated 7/31/16, indicated R97 had two small open areas on his inner left buttocks which measured 0.4 centimeter (cm) by 0.3 cm and 0.4 cm by 0.2 cm. It further indicated R97 was to be repositioned every two hours and as needed. During continuous observation on 8/3/16 at 6:49 a.m. R97 was assisted with his shower by nursing assistant (NA)-A and was transferred to his wheelchair at 6:54 a.m. R97 was assisted to his room, and licensed practical nurse (LPN)-A completed R97's daily dressing change for the pressure ulcer on his right heel. At 7:20 a.m. R97 self propelled himself into the dining room for breakfast. He returned to his room at 8:53 a.m. and read the newspaper. At 9:02 a.m. NA-A went into R97's room and made his bed. NA-A made no attempt or offer to reposition R97. R97 remained in his room until 9:19 a.m. when	F 282	repositioning. Resident #12 (discharged) and Resident #50 consistently eats in her room. Intake is being monitored by nursing staff and was added to the Medication Administration Record (MAR). Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to ensure residents that need to be repositioned at determined intervals are care planned. A facility audit was completed to identify that meal monitor intakes are complete. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RN/LPNs will care plan repositioning schedule. Licensed nurses will ensure repositioning is completed in a timely manner during each shift. Dietary staff record intakes for each resident. If a resident eats in their room, nursing will be recording the intake. Each resident will have their meal monitored and intake recorded for every meal. Training and re-education was provided to all nursing staff starting August 31, 2016 regarding resident's repositioning needs and meal monitoring intakes. Training and re-education was provided to Dietary staff starting August 31, 2016 regarding meal monitoring intakes. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits of care	

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F 282	Continued From page 2 observations were ceased and LPN-A was notified R97 had not been repositioned. R97 remained in his wheelchair without offloading from 6:49 a.m. through 9:19 a.m., 2 hours and 30 minutes without any offer or provision of assistance by staff. When interviewed on 8/3/16 at 11:51 a.m. NA-A stated R97 was unable to reposition himself and needed staff assistance to do so. NA-A further indicated R97 should be repositioned every two hours because he had two new pressure ulcers on his coccyx and stated, "I should have repositioned him, it was entirely my fault". During interview on 8/3/16, at 9:24 a.m. LPN-A stated R97 was at an increased risk for pressure ulcer development and had recently developed two new pressure ulcers on his buttocks. LPN-A stated R97 should have been repositioned every two hours as directed by his care plan. During interview on 8/3/16, at 1:47 p.m. registered nurse (RN)-A indicated R97 should have been offered, and assisted to reposition every two hours while in his wheelchair as directed by his care plan. When interviewed on 08/04/2016, at 10:25 a.m. R97 stated he preffered "being in my wheelchair" throughout the day. Review of facility policy titled, Pressure Ulcer Treatment Policy and Procedure dated 12/14, identified the primary goal of the facility was to prevent pressure ulcers from developing. Residents should be, "repositioned every two hours or more frequently if indicated." LACK OF INTAKE MONITORING:	F 282	plan and repositioning sheets. DON, ADON, or designee will also complete 8 care plan/repositioning sheet audits and 8 meal monitoring intakes monthly x 4 months or until the building is closed. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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R50's admission Minimum Data Set (MDS) dated 5/27/16, identified that resident was rarely understood but staff assessment of cognition noted that short and long term memory was "OK" . R50 received limited assistance of one with eating.

R50's care plan dated 6/17/16, identified a goal for R50 to maintain her weight, show no signs and symptoms of dehydration, and meet nutritional needs through oral intake of >50% of most meals and snacks. R50's care plan directed staff to, "Record food and fluid intake."

R50's Food Intake Monitor(s) dated 7/1/16 to 7/31/16, identified a calendar with each day having three separate columns labeled, "B [breakfast]", "D [dinner]," and, "S [supper]," which were used to record each respective meal intake. The form provided a legend at the bottom which directed staff to record the following codes for intakes:

- "0 = Nothing Eaten,"
- "1/4 = 25% [percent] Total Eaten,"
- "1/2 = 50% Total Eaten,"
- "3/4 = 75% Total Eaten,"
- "1 = 100% Total Eaten," and,
- "NAT = Not At Table."

R50's Food Intake Monitor identified 34 times of R50 being, "NAT" and an additional 21 times in which the column to record the intake was blank with no entries. The form did not identify the amount of meal or fluids consumed by R50 when identified to be "NAT."

On 8/3/16, at 11:44 a.m. the registered dietician

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(RD)-A stated that meal monitoring is completed by dietary staff on the Food Intake Monitor unless the residents eat in their room. RD-A stated if intake is recorded by nursing staff, it may be completed with a entry on the Intake Monitor or in a narrative note. In review of empty spaces present, RD-A commented the record reflected some refusals or alternate intake. RD-A stated that monthly reviews were completed for those residents who were on the high risk report and on a quarterly basis for those who are not high risk. RD-A stated if there were any concerns regarding review of records, RD-A would follow up with nursing staff.

On 8/3/16, at 11:48 a.m. the certified dietary manager (CDM) reviewed Food Intake Monitor results and stated that the empty spots on the Food Intake Monitor indicated that R50 didn't eat, or ate in her room. The CDM stated if there was a refusal of meals staff may not necessarily write "refused". The CDM acknowledged that there were some narrative notes to reflect refusals or alternate intake "but not that many."

On 8/4/16, at 8:04 a.m., registered nurse (RN)-A stated R50 has declined meals and nutritional supplements frequently but refusals should have been documented in the Food Intake Monitor. RN-A stated that recording information on the Food Intake Monitor is "something that we need to improve on." RN-A stated that R50 received Ensure three times a day due to recent weight loss and decreased intake. RN-A added that hospice had been discussed with family due to resident's recent decline including decreased appetite and refusal to eat.

During interview on 8/4/16 at 8:19 a.m., nursing

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assistant (NA)-D stated dietary staff completed meal monitoring. NA-D stated although R50 does not eat in her room, she did receive fluids in her room. NA-D stated that when R50 is given fluids in her room the information was reported to the nurse for documentation.

A facility Care Planning Policy and Procedure dated 12/11/15, identified each resident will have a care plan used to, "Outline the care they require," and, "All personnel involved in the care of the resident will use the comprehensive care plan."
R12's admission Minimum Data Set (MDS) dated 4/11/16, identified R12 had intact cognition, and required supervision with eating.

R12's care plan dated 4/15/16, identified a goal for R12 to maintain her weight and directed staff to, "Record food and fluid intake."

R12's Food Intake Monitor(s) dated 4/5/16 to 5/5/16, identified a calendar with each day having three separate columns labeled, "B [breakfast]", "D [dinner]," and, "S [supper]," which were used to record each respective meal intake. The form provided a legend at the bottom which directed staff to record the following codes for intakes:

- "0 = Nothing Eaten,"
- "1/4 = 25% [percent] Total Eaten,"
- "1/2 = 50% Total Eaten,"
- "3/4 = 75% Total Eaten,"
- "1 = 100% Total Eaten," and,
- "NAT = Not At Table."

R12's Food Intake Monitor identified 30 times of R12 being, "NAT" and had an additional 17 times in which the column to record the intake was left

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F 282	Continued From page 6 blank with no codes being used as directed by the form. The form did not identify the amount of meal or fluids consumed by R12 when identified to be, "NAT." R12's corresponding progress notes, dated 4/5/16 to 5/5/16, identified only two times which staff recorded R12's meal intake for the blank entries on R12's Food Intake Monitor. During interview on 8/2/16, at 1:25 p.m. registered nurse (RN)-A stated R12 admitted to the facility for heart failure and had a poor appetite during her stay which resulted in some weight loss. RN-A reviewed R12's Food Intake Monitors and stated staff should of recorded R12's intake on the form for each meal, even when she ate in her room and NAT was identified, "They should be filled in." When interviewed on 8/2/16, at 2:00 p.m. the certified dietary manager (CDM) stated the Food Intake Forms were used when assessing R12 for nutritional interventions on the MDS to, "Check to see how much they've eaten," adding it should of been documented, "Somebody is not recording it." Further, CDM stated she had noticed more problems lately with intakes not being recorded consistently by the staff. During interview on 8/3/16, at 8:19 a.m. registered dietician (RD)-A stated staff should have recorded the intakes on R12's Food Intake Monitor or in the progress notes.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		9/12/16

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F 314	Continued From page 7 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, and implement care planed interventions related to timely repositioning to reduce the risk of pressure ulcer formation for 1 of 1 residents (R97) reviewed for pressure ulcers. Findings include: R97's quarterly Minimum Data Set (MDS) dated 7/14/16, identified R97 had intact cognition, required limited assistance with transfers, bed mobility and was at risk for pressure ulcers. R97's pressure ulcer Care Area Assessment (CAA) dated 10/2/15, identified R97 was at risk for pressure ulcers due to the need for extensive assistance with bed mobility. R97 also had diagnoses including diabetes, osteoarthritis and polyosteoarthritis. Review of R97's skin assessment dated 5/27/16, identified R97 was at risk for impaired skin integrity as R97 had an existing pressure ulcer to his right heel. Interventions included: inspection of heels daily, elevation of extremities, and cushioned protective boot to right foot. R97's	F 314	Corrective Action For Residents Affected By Deficient Practice: Resident # 97 care plan was updated. Nursing staff communicated his need for every 2 hour repositioning. Resident #97 was educated on pressure ulcer prevention. Repositioning schedules will be followed per individual care plan for each resident. Resident care sheets/care plans are available at the nurses' station on each floor and are used by CNAs daily. Repositioning sheets are at the nurses' station to document the times these tasks are completed. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice:A facility audit was completed to ensure residents that need to be repositioned at determined intervals are care planned. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RN/LPNs will care plan repositioning schedule. Licensed nurses will be monitoring that repositioning is	

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F 314	Continued From page 8 braden scale for prediction of pressure score risk assessment dated 6/17/16, identified R97 was "at risk" for pressure ulcer development and stated R97 was to be repositioned every two hours to relieve pressure when he was in his bed or chair. R97's care plan dated 7/1/16, indicated R97 had potential for skin integrity issues, and listed a goal of, "prevent pressure sores and skin breakdown". The care plan identified the intervention of off loading R97 every 2 hours when in the wheelchair. Review of R97's nursing progress noted dated 7/31/16, indicated R97 had two small open areas on his inner left buttocks which measured 0.4 centimeter (cm) by 0.3 cm and 0.4 cm by 0.2 cm. It further indicated R97 was to be repositioned every two hours and as needed. During continuous observation on 8/3/16, at 6:49 a.m. R97 was assisted with his shower by nursing assistant (NA)-A and was transferred to his wheelchair at 6:54 a.m. R97 was then brought to his room, and licensed practical nurse (LPN)-A completed R97's daily dressing change to the pressure ulcer on his right heel. At 7:20 a.m. R97 propelled himself into the dining room for breakfast. He returned to his room at 8:53 a.m. and read the newspaper. At 9:02 a.m. NA-A went into R97's room and made his bed. NA-A made no offer or attempt to reposition R97. R97 remained in his room until 9:19 a.m. when LPN-A was notified R97 had not been repositioned. Although R97's care plan identified R97 was at risk for pressure ulcer development, he remained in his wheelchair from 6:49 a.m. through 9:19 a.m., 2 hours and 30 minutes without any assistance by staff for repositioning. R97 was not	F 314	completed in a timely manner during each shift. Training and re-education was provided to all nursing staff starting August 31, 2016 regarding resident's repositioning needs. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits to confirm compliance that staff is following the individualized schedule for our residents and documenting completion of the task. 8 random audits will be done monthly x 4 months or until the building is closed. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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observed to attempt to reposition himself during this period of time.

On 8/3/16, at 11:51 a.m. NA-A stated R97 was unable to reposition himself and needed staff assistance to do so. NA-A further indicated R97 should be repositioned every two hours because he had two new pressure ulcers on his coccyx. NA-A stated, "I should have repositioned him, it was entirely my fault."

On 8/3/16, at 9:24 a.m. LPN-A stated R97 was at an increased risk for pressure ulcer development and had recently developed two new pressure ulcers on his buttocks over the last couple of days. Further, LPN-A stated R97 should have been repositioned every two hours as directed by his care plan.

On 8/3/16, at 1:47 p.m. registered nurse (RN)-A indicated R97 should have been offered, and assisted to reposition every two hours while in his wheelchair as directed by his care plan. RN-A further indicated R97 was at an increased risk for pressure ulcers and had two new pressure ulcers on his coccyx which had been identified a couple of days earlier.

On 8/4/16, at 10:25 a.m. R97 stated he preffered "being in my wheelchair" throughout the day. R97 further indicated he was not aware of receiving any education from facility staff on pressure ulcer prevention

Review of facility policy titled, "Pressure Ulcer Treatment Policy and Procedure" dated 12/14, identified the primary goal of the facility was to prevent pressure ulcers from developing. If a resident develops a pressure ulcer, the plan of

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F 314	Continued From page 10 care will be developed to treat the pressure ulcer and to prevent further ulcers from developing. Residents should be, "repositioned every two hours or more frequently if indicated."	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure justification for the use of Amitriptyline (antidepressant) for 2 of 5	F 329	Corrective Action For Residents Affected By Deficient Practice: Resident # 59 antipsychotic was reduced from 0.5 mg to	9/12/16

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F 329	Continued From page 11 residents (R59, R97) reviewed for unnecessary medications In addition the facility failed to ensure justification for antipsychotic medication for 1 of 1 resident (R59) reviewed for unnecessary medications. Findings include: R59's quarterly minimum data set (MDS) dated 7/5/16, indicated he was moderately cognitively intact, had troubles falling or staying asleep, and had no behavior problems. The MDS further indicated he received no anti-psychotic medications. R59's Care Area Assessment (CAA) dated 4/8/16, indicated "Resident stated he has been feeling down due to limitations with his arm. He also stated he has been feeling tired and is hoping his arm will heel quickly. Mood care plan in place r/t (related to) dx (diagnosis) of depression, psychosis, borderline personality disorder." R59's Observation Report dated 7/5/16, indicated he had no delirium and no mood/behavior. R59's Care Plan dated 7/5/16, indicated he had depression, psychosis and borderline personality disorder, had a history of hearing voices at night and complaints about sleep. The care plan further indicated on 9/18/14, he was hospitalized at a behavioral unit for delusions and paranoia and as of 7/5/16, he had no target behaviors. The care plan indicated staff was to attempt periodic dose reductions, place a do not disturb sign on door when he wished to rest during the day, and allow to verbalize feelings, involve in diversional activities and monitor behaviors on behavior sheet charting behaviors in progress notes as needed. A Psychotropic Drug Review sent to R59's physician dated 1/13/16, indicated R59's "mood generally stable no wandering, paranoia or delusions recently, occasional episodes of anger	F 329	0.25 mg on August 22, 2016. Resident #97 rationale for continued use of antidepressant was obtained from MD as to why he does not want a dose reduction at this time. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to ensure residents that are taking antipsychotic and hypnotic medications have GDR attempted according to CMS guidelines. If GDR is not attempted, rationale from the MD will be obtained and kept in the chart. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RN will be obtaining rationale from the MD/NP if GDR is not attempted. Training and re-education was provided to all RN staff on August 16th, 2016 regarding obtaining rationale if GDR not attempted. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits to confirm compliance of GDR attempts and rationale if not attempted. 6 random audits will be done monthly x 4 months or until the building is closed. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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or irritability but usually redirected." The physician's response was "D/C risperdal (anti-psychotic)".
R59's Progress Notes from 5/2/16 to 8/2/16, indicated the following for mood or behavior:
On 7/1/16, Resident had increased restless, and agitated behavior recently, has been more disoriented and confused at times. Repeating numbers, statements often. Urine output from indwelling catheter has been more concentrated with moderate sediment. In the past increased restless/agitated behavior has been an indicator of a urinary tract infection (UTI). The note indicated a fax was sent to his medical doctor (MD).
On 7/2/16, Resident has been restless and anxious this shift. Has been stopping all staff and visitors that walk by his room, when he is sitting in doorway. Has been focused on his picture outside of his door, saying "scaredy cat" and mumbling."
On 7/7/16, Resident went into another resident's room and yelled at staff because he couldn't find his pencil to fill out his supper menu. Staff informed resident that he can't be in another resident room and that they could help him shortly.
On 7/9/16, resident continues on Cipro (antibiotic) 500 mg (milligrams) for current UTI.
On 7/12/16, resident continues on Cipro as ordered for UTI. Resident stopped staff several times to repeat a sequence of numbers over and over to staff that he states is his phone number. Staff talk calmly to resident to redirect behaviors. Urine is amber no sediment.
On 7/28/16, resident displays anxious behaviors at times and makes repetitive statements, counts numbers, talks "nonsense" at times and makes frequent phone calls each day to niece. Resident

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recently just started on Risperdal for behaviors.
A Bethesda Heritage Center Problem Sheet/MD FAX dated 7/26/16, indicated resident continues to have repetitive and anxious behaviors, he has been repeating numbers, names and stories. Has "been calling family multiple times during the day seems like his dementia is progressing more increased confusion and disorientation. His dose of risperadahl was d/c in January. Now only on Depakote and gabapentin (mood stabilizers) for mood/behavior could we try maybe restarting risperdahl to see if that helps? Thank you." The Physician Response was "Ok to restart Risperdal 0.5 mg at HS. "
R59's Point Of Care Behavior Category Report (MDS 3.0) indicated he had no rejection of care or wandering from 5/1/16 to 8/2/16.
R59's Mood & Behavior Log dated 7/26/16, directed staff to document repeating numbers/names or flight of ideas and approaches bring to an activity, coloring, sing along and visit about family, siblings. The log indicated there was no mood or behaviors.
On 8/2/16, at 1:45 p.m. nursing assistant (NA)-J indicated R59 used to use the phone to call his family but has not noticed any delusions or hallucinations. In addition she indicated he has not hit or struck out at staff or any residents.
On 8/3/16, at 7:05 a.m. licensed practical nurse (LPN)-K stated a couple of weeks ago R59 had issues with calling his family but he has had no hitting or striking out and usually is very pleasant and has not delusions or hallucinations.
On 8/3/16, at 12:43 p.m. registered nurse (RN)-C stated he had an increase in his behaviors the beginning of July when he had a UTI. R59 took his antibiotic for a week and he continued to repeat numbers and didn't improve so his physician was contacted to restart his

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antipsychotic medication.

On 8/3/16, at 2:31 p.m. with the consulting pharmacist (CP), he stated he has not seen the resident since the middle of July. CP stated if he is not having hallucinations or delusions and just having repetitive behaviors he would only add an anti-psychotic medication as a last resort. In addition the CP stated he usually wouldn't recommend anti-psychotic medications unless someone is a threat to themselves or others and from what he could see R59 was not. The CP further stated maybe his mood stabilizer medications could have been increased or an anti-depressant could have been used.
R97's quarterly Minimum Data Set (MDS) dated 7/14/16, indicated R97 was cognitively intact with diagnoses of insomnia and major depressive disorder. R97's Psychotropic Drug Care Area Assessment (CAA) dated 10/2/15, specified R97's amitriptyline was used for insomnia.

R97's care plan dated 7/1/16, did not identify R97 was taking amitriptyline for insomnia.

R97's signed physician order sheet dated 5/27/16, identified R97 began taking amitriptyline 50 mg (milligrams) by mouth at bedtime for insomnia on 4/23/15.

R97's Consultant Pharmacist Medication Review dated 1/26/16, indicated R97 was taking amitriptyline and was at an increased risk for sedation/orthostatic hypotension (low blood pressure which occurs when sitting up or laying down) because of its anticholinergic properties. Further, the consult pharmacist (CP) suggested reducing R97's amitriptyline to 25 mg at bedtime and if successful to discontinue the medication if

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possible. R97's primary physician circled "rejected" on the Consultant Pharmacist Medication Review form and did not provide any rational for the continued use of amitriptyline. Again, on 5/27/16, the CP recommended reducing R97's amitriptyline or to provide clear documentation as to why the dose reduction was not recommended. R97's physician responded with "no change" and did not provide any rationalization for the continued use of amitriptyline at the current dose.

Review of physician progress notes from 8/1/15 through 7/18/16, did not identify any justification for the continued use of amitriptyline nor was there any documentation addressing the gradual dose reduction (GDR) for R97's Amitriptyline.

On 8/3/16, at 2:25 p.m. the CP stated he had sent R97's physician GDR requests on three separate occasions - on 5/27/16, 1/26/16 and 6/10/15 with no rationalization for the continued use of R97's amitriptyline. Futher, the CP stated he had talked to the Quality Assurance Committee about this issue at their last quarterly meeting in 2/16.

On 8/2/16, registered nurse (RN)- B stated R97 had been on the amitriptyline for approximately fourteen months and she was not aware of any GDR trials. RN-B further indicated the physician notes did not justify the continued use of amitriptyline and stated the physicians "are not good at giving rationalizations for medications."

On 8/3/16, at 1:48 p.m. registered nurse (RN)-A stated she could not find any justification for the continued use of R97's amitriptyline.

The facility policy titled, "Medication

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F 329	Continued From page 16 Management" dated 4/14, identified facility staff, attending physicians and consultant pharmacist will perform ongoing monitoring for appropriate, effective and safe medication use.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's	F 334		9/12/16

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F 334	Continued From page 17 legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their facility policy related to pneumococcal conjugate vaccine (PCV13) for 5 of 5 residents (R38, R52, R76, R82, R98) whose vaccination histories were	F 334	Corrective Action For Residents Affected By Deficient Practice: Resident # 38, #52, #76, and #82 will be offered the PCV13 vaccine. Resident # 98 has received both PPSV23 and PCV13 vaccines as of	

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F 334	Continued From page 18 reviewed. Findings include: Center for Disease Control and Prevention (CDC) identified, "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 [pneumococcal polysaccharide vaccine 23] should receive a dose of PCV13. The dose of PCV13 should be given at least 1 year after receipt of the most recent PPSV23 dose." R38's Immunizations Record, undated, indicated the 80 year old had received a Pneumococcal vaccination in November of 2004. However, it did not indicate which vaccine was given. A review of the record did not indicate additional follow up to determine what vaccine had been given previously, nor was there any additional documentation to reflect that R38 was offered the follow-up vaccination as outlined in the CDC guidelines. R52's Immunizations Record, undated, indicated the 85 year old had received a Pneumovax on 11/1/99. However, it did not indicate which vaccine was given. A review of the record did not indicate additional follow up to determine what vaccine had been given previously, nor was there any additional documentation to reflect that R52 was offered the follow-up vaccination as outlined in the CDC guidelines. R76's Immunizations Record, undated, indicated the 80 year old had received the Pneumovax on 5/7/01. However, it did not indicate which vaccine was given. A review of the record did not indicate additional follow up to determine which vaccine	F 334	March 7th, 2016. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to identify those residents who have not yet received the PCV13 vaccine and be offered it. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur:Training will be provided to nursing staff starting on August 31, 2016 regarding current CDC guidelines regarding the PCV13 vaccination. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits to confirm compliance of CDC guidelines in regards to PVC13 vaccine. 5 random audits will be done monthly x 4 months or until the building is closed. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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was given previously, nor was there any additional documentation to reflect that R76 was offered the additional vaccination as outlined in the CDC guidelines.

R82's Immunizations Record, undated, indicated the 94 year old had received the Pneumovax on 3/26/00. However, it did not indicate which vaccine was given. A review of the record did not indicate additional follow up to determine which vaccine had been given previously, nor was there any additional documentation to reflect that R82 was offered the additional vaccination as outlined in the CDC guidelines.

R98's Immunizations Record, undated, indicated the 70 year old had received the Pneumovax on 3/1/11. However, no further documentation was in place to identify the type of vaccine which vaccine had been given previously, nor was there any additional documentation to reflect that R98 was offered the additional vaccination as outlined in the CDC guidelines.

During interview on 8/3/16, at 1:02 p.m., registered nurse (RN)-B, stated that she was unaware of any changes regarding the Pneumovax requirements. RN-B stated she would follow up with the director of nursing (DON) regarding any changes required with the pneumococcal vaccine. On 8/3/16 at 2:01 p.m., RN-B stated she had spoken to the DON and was notified that at the present time they are reviewing the recommendations from the CDC with the Medical Director, but have not implemented any change in the current process.

Review of the facility policy, Administration of Pneumococcal Vaccine, dated 3/16, identified all

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F 334	Continued From page 20 residents should be screened for the presence of any contraindications and precautions to the Pneumococcal vaccine. The policy did not reflect the most recent recommendations by the CDC for the pneumococcal vaccination.	F 334		
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 raw meat was stored in a safe manner to reduce the risk of cross contamination to other foods in 1 of 1 walk in cooler observed in the main kitchen. This had the potential to affect 20 of 20 residents who could have consumed the potentially affected foods that were stored under the raw product. Findings include: During the initial kitchen tour 8/1/16, at 1:15 p.m. a refrigerator was open and inspected. On the top shelf the facility had a 1/2 full plastic container which contained uncooked chicken parts in a plastic bag that was thawing. The shelf below that had a 10 pound ham bagged in a plastic	F 371	Corrective Action For Residents Affected By Deficient Practice: Of the residents who were affected by this practice, zero presented with food-related illnesses or symptoms following the meal. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: This deficient practice had the potential to affect the 20 residents who consumed the meal. Certified Dietary Manager and Dietician immediately re-educated dietary cooks to ensure the deficient practice would not reoccur and affect any other residents. Measures Or Systemic Changes Made To	9/12/16

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F 371	Continued From page 21 container. On the bottom shelf were four large pans of vegetable lasagna in foil covered pans. On 8/1/16, at 1:20 p.m. the certified dietary manager (CDM) stated the containers filled with thawing meat should have been on the bottom shelf and the staff must have put them in the wrong spots. On 8/2/16, at 9:10 a.m. the reregistered dietician (RD) stated meat should always be thawed on the bottom shelf and staff must have made the mistake of putting them in the incorrect spot. On 8/2/16, at 11:36 pm the CDM stated since the ham was below the chicken she replaced it with a new ham and placed all of the thawing meat on the bottom shelf. The CDM stated her concern was the lasagna that was below the meat thawing and that approximately 20 residents had eaten the vegetable lasagna for supper. The facility policy Thawing Foods revised 1/15, indicated food will be thawed "In refrigerator unit at a temperature not to exceed 41 degrees. Place the food items on the appropriate shelf by following the procedure noted for food storage." The Storage of Food policy reviewed 9/15, indicated Refrigerated foods: Store foods in designated refrigerators, if food products are stored together in a refrigerator, raw foods should be stored below cooked foods on the lowest shelf.	F 371	Ensure That Deficient Practice Will Not Recur:Food will be stored, prepared, distributed, and served under sanitary conditions. Training and re-education on properly handling and thawing food was provided immediately to all dietary cooks between 08/01/2016 and 08/02/2016. Policies and proper procedures were reviewed again with team beginning on August 31, 2016. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Certified Dietary Manager (CDM), Dietician, or designee will complete 8 random audits will be done monthly x 4 months or until the building is closed. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		9/12/16

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F 441	Continued From page 22 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an infection	F 441	Corrective Action For Residents Affected By Deficient Practice: On a daily basis,	

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F 441	Continued From page 23 control program to provide timely monitoring, trending, and analysis of infections to reduce transmission within the facility. This had the potential to affect all 90 residents, staff and guests in the facility. In addition the facility failed to ensure handwashing was completed to reduce the potential spread of infection for 1 of 5 residents (R50) observed during provision of cares. Findings include: The infection control logs from 4/16, to 6/16, titled Culture Log, identified the following information: date, unit, resident, site, results, and comments. The Nosocomial Infection Control Summary-Bethesda Heritage was also reviewed and contained the following information: resident name, location, age, sex, admission date, onset of symptoms, symptoms including classification of infection, cultures done, and treatments. The logs did not identify the date the symptoms resolved. There was no evidence of tracking infectious symptoms not being treated with antibiotics. On 8/3/16, at 1:02 p.m. registered nurse (RN)-B, who assisted with the infection control process, stated the logs were completed at the end of each quarter. The logs were not kept in current time in order to track and trend any current active infections. Following the completion of the quarter a record review was completed for residents who had been treated with antibiotic therapy. At that time, the medical record was reviewed for completeness, which included initial symptoms, temperature, whether hospitalized, if a culture	F 441	the Infection Control nurse will continue to be given all infection related lab results for the evaluation, analysis and interpretation of data. Immediate precautions and timely analysis will be implemented to reduce transmission of infection within the facility. As part of the Infection Control Program, Infection Control logs will be kept in current time to track and trend any current active infections, will identify the date infection symptoms resolved, and will provide evidence of tracking infections not being treated with antibiotics. Surveillance Data will continue to be discussed and collected during RN meetings and Nutritional Risk meetings. Handwashing will be done by all Nursing staff before and after each medication administration that requires gloving. Facility will continue to follow the 2 policies of Handwashing and Putting on and Removal of Gloves. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: This had the potential to affect all 90 current residents in the facility. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Infection Control Program was reviewed with nursing administration team and revisions were made to ensure the program provides timely monitoring, trending, and analysis of infections to reduce transmissions within the facility. Re-education will be provided to nursing staff starting on August 31, 2016 regarding current policy of Handwashing	

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	245532	A. BUILDING _____ B. WING _____	08/04/2016

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F 441	Continued From page 24 had been done, verification the organism had been sensitive to antibiotic prescribed, and medication allergies. This information was provided to the infection control nurse and reviewed. The information was then categorized for the type of infection, and how the infection was acquired. RN-B stated the information gathered was reviewed by the infection control nurse with the medical director on a quarterly basis and more frequently as needed. RN-B stated data was available for April, May and June (second quarter), however, data for July had not been gathered or tracked at this time. RN-B stated the data was gathered for review at the end of the quarter by running a report of antibiotics that had been prescribed during the defined period of time. RN-B stated logs were not in place for tracking current infections actively being treated. RN-B stated that if it were needed, this information could be gathered from the medication administration record (MAR). RN-B stated if there were an acute event, where multiple people came down with symptoms, it would be followed utilizing a tracking form. RN-B provided a sample of the influenza-like illness (ILI) line list form and the gastrointestinal outbreak flowsheet. The ILI line list included; name, room number, age, sex, immunization status, onset of symptoms, duration of symptoms, symptoms presented, lab results, pneumonia, hospitalized, whether resident died, whether an antiviral had been used, and if isolation precautions were put into place. The information included on the Gastrointestinal Outbreak Flowsheet included resident name, symptom start date, nausea, vomiting, loose stools, temp, and date the symptoms stopped. RN-B stated that data gathered helped them to determine if there were any further precautions needed within the	F 441	and Putting on and Removal of Gloves. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits to confirm compliance of the 2 policies of handwashing and Putting on and Removal of Gloves. 6 random audits will be done monthly x 4 months or until the building is closed. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 441	Continued From page 25	F 441		

facility, based on the illness or presentation of illness. The facility infection control practitioner was not available for interview.

The policy, Surveillance Policy, dated 3/2/12 identified "The surveillance system enables the the facility to analyze clusters and/or significant increases in the rate of infection. Surveillance data is collected by the infection control nurse primarily from regular (at least weekly) rounds of resident care units." In addition to gathering of the data, use of criteria to determine if infection is present, and tabulation/consolidation of data, the policy also highlighted surveillance consists of evaluation, analysis, and interpretation of data and dissemination of the information to appropriate person.

HANDWASHING

During observation on 8/3/16, at 2:40 p.m. observed staff member licensed practical nurse (LPN)-C removing gloves and exiting the room of R50. LPN-C stated she had administered a suppository and proceeded to walk out of room, holding used gloves in hand. LPN-C walked down the hallway, to the med cart, and placed the gloves enfolded upon one another on the top of the med cart. LPN-C entered data into the computer on top of the med cart. LPN-C walked to the sink, disposed of the gloves in the garbage container at the side of the sink, and proceeded to complete handwashing. Handwashing was completed and hands were dried, disposing of towel after drying, and turning off the faucet with a clean paper towel. LPN-C stated the gloves should have been removed and disposed in the room, followed by handwashing in the room, prior

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F 441	Continued From page 26 to exiting room. The policy, Putting On and Removal of Gloves Policy and Procedure, dated 12/14, outlined under procedure: Removing Gloves, number 7., Drop both gloves into waste receptacle. 8. Wash hands. Dry with paper towel and discard towel in proper container. Use a dry towel to turn off water faucet. Discard towel.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the facility was free of urine odors for 2 of 2 resident rooms (R59, R82) whose room had a strong odor of urine. Findings include: On 8/2/16, at 9:08 a.m. R59's room had a very strong odor of urine. On 8/2/16, at 1:29 p.m. R59's room was very warm and had a strong urine odor. R59 was sitting in his wheelchair and a catheter bag was observed to be attached to his leg. On 8/2/16, at 1:46 a.m. nursing assistant (NA)-C stated R59 had a foley catheter. NA-C stated his room did have odors and he often refused to let	F 465	Corrective Action For Residents Affected By Deficient Practice: Resident # 59 had his indwelling catheter removed on August 10, 2016. Resident #82 continues to have his indwelling catheter. Facility has new protocol in place for Resident #82 that we use 2 catheter leg bags, alternating wearing it every other day to eliminate odors. Facility will continue to do floor care in resident's room weekly and PRN. Facility will use of charcoal within resident's room to help absorb the odor. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: Facility audit completed to note any resident with an odor issue.	9/12/16

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F 465	Continued From page 27 the staff clean him up. NA-C stated "sometimes we open his window just to air his room out." On 8/2/16, at 3:39 p.m. interview with NA-B stated it was really hot in R59's room and they have noticed an odor in his room. NA-B stated once in awhile his catheter would leak urine if his drainage bag didn't get closed all they way. She further indicated R59 had a room deodorizer with charcoal in it to absorb the odors and they had maintenance shampoo the carpet in his room. On 8/3/16, at 7:02 a.m. licensed practical nurse (LPN)-B stated R59 had a catheter and the staff removed his leg bag in the evening and placed a larger bag at night. LPN-B indicated the staff was supposed to be cleaning the bags out when they switched them out. LPN-B stated she was not sure if the urine odor was from the bag leaking or overflowing. On 8/3/16, at 7:07 a.m. housekeeper (H)-A stated she smelled the odor in R59's room. The nurses put a thing in his room that absorbs the odor. She cleaned his room daily and sprayed air freshener. H-A further stated they stripped his bed weekly and that his chair was plastic so staff could wipe it down. A strong odor of urine was noted in the bathroom. H-A stated she knew his bag leaked because she had to clean the urine in the dining room. During interview 08/03/16, at 7:20 a.m. maintenance (M)-A stated he shampoo's R59's carpets and he did R59's a least weekly. M-A stated it was so hard to keep these rooms clean when they were carpeted. On 8/2/16 at 3:31 p.m. there was a strong odor of urine in R82's room. R82 stated that a new	F 465	Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur:Training and re-education will be provided to nursing staff starting on August 31, 2016 regarding catheter care and the disinfection of indwelling catheter bags. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will do random audits to confirm compliance of the cleaning/care of catheter. 2 random audits will be done monthly x 4 months or until the building is closed. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 465	Continued From page 28	F 465		

urinary drainage bag was applied today and there would also be a new closed system applied that evening.
On 8/3/16 at 6:55 a.m., a strong odor of urine was present in R82's room.
On 8/3/16, at 12:00 p.m. R82 was observed in the dining room. R82 was neat and well groomed in appearance, with no odor of urine noted.
On 8/2/16 at 3:28 p.m. nursing assistant (NA)-E stated that R82 received assistance to mange catheter use. NA-E stated that aides provided R82 with assistance to change the catheter drainage system from the bed bag to the leg bag. However, NA-E was unsure of any special process to complete this task.
On 8/3/16 at 12:01 p.m. housekeeper (H)-A stated "sometimes there is the smell of urine" in R82's room and indicated there had been multiple interventions in place to eliminate the odor, including placement of a charcoal odor absorbing product, cleaning the room, and shampooing the carpet. H-A stated she has notified maintenance (M)-A if spots were noted on the carpet and/or if there was an odor in the room. H-A stated that the carpet in the room was shampooed weekly or more. H-A stated that R78 had expressed concerns regarding the odor of urine present in the hallway, drifting into his room.
On 8/3/16 at 12:10 p.m., M-A stated that he had shampooed the carpet in R82's room on 8/2/16 and again 8/3/16. M-A stated R82's catheter bag had leaked and R82 informed M-A that the carpet would need to be cleaned. M-A stated carpet cleaning was done in R82's room on a weekly basis, and may be done up to three to four times per week, depending on the need.
On 8/3/16, at 12:17 p.m. R82 stated M-A had recently cleaned the carpet. R82 stated a new urinary drainage bag was applied last night and

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the drain was left open. R82 stated "I have to remind them that the drain is open, and I forgot to remind them that the drain wasn't closed. I don't blame them, I blame management for not training them properly." R82 stated when new employees started to work and provide assistance they have not been trained to perform his cares. "I can tell by the questions they ask that they haven't been trained. " R82 stated he has had problems with catheter leakage "quite regularly." R82 stated that when he got up this morning, there was a large spot on the rug, so he called M-A so the carpet could be cleaned.
On 8/3/16, at 12:40 p.m., R78 stated he has noticed an odor of urine in his room from the hallway. R78 stated that his family had brought in air freshener to make his room smell more pleasant. R78 resided next to R82.
On 8/4/16, at 8:59 a.m., registered nurse (RN)-C stated they shampoo the carpet in R82's room more often than others. RN-A stated the charcoal absorbing unit was placed on his wardrobe to address the odors. RN-A stated at times the bag or connection would leak. RN-C stated that once in a while the drainage port it was not closed all the way or that there is faulty valve or bag. RN-C stated that nursing assistants are trained regarding catheter cares with general orientation, and while training with existing staff.

The policy, Urinary Collection Device Policy and Procedure, dated 3/2/12 was noted to include directions for connection of a leg bag to indwelling catheter, cleaning of a urinary collection bag, and connection of a standard collection device (Foley bag) to an indwelling catheter. Although the policy specifically identified the need to close the valve to clean the urine collection bag, it did not address the need to

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F 465	Continued From page 30 close collection bags upon transition from one device to the other.	F 465		

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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, Fire Marshal Division. At the time of this survey, Bethesda Heritage Center 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. 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	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/26/2016

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 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 Bethesda Heritage Center is a 4-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1999, additions were added to the east and west which were determined to be of Type II(222)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.	K 000		

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K 000	Continued From page 2 The facility has a licensed capacity of 125 beds and had a census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview::A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire ala rm system wiring or other transmission paths are monitored for integrity.	K 051	The Fire Alarm Panel will be moved to the 2nd floor so it can be in a location that is monitored at all times.	9/12/16

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K 051	Continued From page 3 Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 Findings include: On facility tour between 07:30 AM to 12:30 PM on 08/02/2016, observations and interview revealed: 1) Fire Alarm Panel was not located in a monitored location. This deficient condition was verified by Maintenance Director (RB).	K 051		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1,	K 056		9/12/16

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BETHESDA HERITAGE CENTER	**1012 EAST THIRD STREET WILLMAR, MN 56201**

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K 056	Continued From page 4 NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility faille to ensure that the automatic sprinkler system is installed in accordance with the NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.5.1 and the NFPA 13 "The Standard for the Installation of Sprinkler Systems" 1999 edition sections 5-4 and 5-5. Findings include: On facility tour between 07:30 AM to 12:30 PM on 08/02/2016, observations and interview revealed: 1) Under the air handler there is no sprinkler coverage. This deficient condition was verified by Maintenance Director (RB).	K 056	A sprinkler will be installed below the air handler.	
K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on reord review and interview, generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) Findings include: During facility record review and staff interview between 07:30 AM to 12:30 PM on 08/02/2016, it was revealed:	K 144	The cool down time for the emergency generator will be documented. This was added to the emergency generator log sheet. Maintenance Director or designee will audit monthly x 4 months or until the building is closed to ensure compliance. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	9/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**08/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 5 1) The facility did not document the required cool down for the emergency generator. This deficient condition was verified by Maintenance Director (RB).	K 144		