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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NYDE
Facility ID: 00792

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA NH PLEASANTVIEW**
(L4) **901 SOUTHEAST WILLMAR**
(L5) **AVENUE 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 **11/15/2014** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

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

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 11/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 11/20/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS
Posted 12/02/2014 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245427
Electronically delivered
November 20, 2014

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

Dear Mr. Pietsch:

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

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

Effective October 27, 2014 the above facility is certified for or recommended for:

123 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 20, 2014

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

RE: Project Number S5427025

Dear Mr. Pietsch:

On October 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 2, 2014. 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 November 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 27, 2014 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 October 2, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 27, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 2, 2014, effective October 27, 2014 and therefore remedies outlined in our letter to you dated October 16, 2014, 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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245427	A. Building B. Wing	11/15/2014

Name of Facility	Street Address, City, State, Zip Code
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	10/24/2014	ID Prefix F0241 Reg. # 483.15(a) LSC	10/24/2014	ID Prefix F0242 Reg. # 483.15(b) LSC	10/24/2014
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	10/24/2014	ID Prefix F0312 Reg. # 483.25(a)(3) LSC	10/24/2014	ID Prefix F0314 Reg. # 483.25(c) LSC	10/24/2014
ID Prefix F0315 Reg. # 483.25(d) LSC	10/24/2014	ID Prefix F0441 Reg. # 483.65 LSC	10/24/2014	ID Prefix F0465 Reg. # 483.70(h) LSC	10/24/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	11/20/2014	10562	11/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/2/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245427	A. Building 01 - MAIN BUILDING 01 B. Wing	10/27/2014

Name of Facility	Street Address, City, State, Zip Code
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0141	Correction Completed 10/27/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	11/20/2014	10562	10/27/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/30/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NYDE
Facility ID: 00792

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY 10/02/2014 (L34)

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

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

FISCAL YEAR ENDING DATE: (L35) 09/30

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

12. Total Facility Beds 123 (L18)

13. Total Certified Beds 123 (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: B* (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 10/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 11/19/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 11/24/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

October 16, 2014

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

RE: Project Number S5427025

Dear Mr. Pietsch:

On October 2, 2014, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> <u>Opportunity to Correct</u> **- the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Electronic Plan of Correction</u> **- when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> **- the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> <u>Potential Consequences</u> **- the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Supervisor
St. Cloud Survey Team A
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: brenda.fischer@state.mn.us

Phone: (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 October 12, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 January 2, 2015 (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 April 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance.

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

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

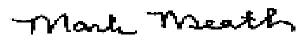
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File 5427s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		10/24/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/24/2014

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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	245427	A. BUILDING ______ B. WING ______	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide the appropriate non-coverage notice for 1 of 3 residents (R38) who remained in the facility after Medicare coverage had ended, whom was reviewed for liability notices. Findings include: R38's progress note, dated 7/22/14, indicated R38 admitted to the facility for a COPD (Chronic Obstructive Pulmonary Disease) exacerbation which required hospitalization. An additional progress note, dated 7/31/14, indicated R38 was provided a notice of Medicare non-coverage with his last covered day being 8/1/14. R38 planned to	F 156	F156 Notice of Rights, Rules, Services, Charges Corrective Action For Residents Affected By Deficient Practice: R38 discharged from the facility on August 20, 2014. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: An audit was completed on all residents who were covered under Medicare whose coverage ended on or after October 2, 2014 to determine if they received the appropriate non-coverage notice after Medicare coverage ended. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility policy was developed for	

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F 156	Continued From page 3 remain in the facility until additional placement could be found, or home health could arrange routine visits. A subsequent progress note, dated 8/20/14, indicated R38 dismissed the facility to a different nursing home. R38 dismissed the facility 19 days after Medicare coverage had ended. R38's was given the Notice of Medicare Non-Coverage (CMS 10123), dated 7/29/14, identifying Medicare coverage would end on 8/1/14, being signed by R38 on 7/29/14. However, the facility did not give R38 a Skilled Nursing Facility Advance Beneficiary Notice (SNFABN), or any of the five denial letters from Medicare, that identified how R38 would be paying for services when discharged from Medicare on 8/1/14, and remained in the facility. During interview on 10/2/14, at 9:37 a.m., licensed social worker (LSW)-A stated the county case manager (for R38) was trying to get home health services ready for R38, however was not able to do so in time before R38 was set to dismiss from the facility. Further, LSW-A stated R38 should have been given the SNFABN as he remained in the facility after Medicare coverage had ended. When interviewed on 10/2/14, at 9:46 a.m., the director of nursing (DON) stated resident should be given adequate notice before Medicare coverage ends. R38 should have been given the SNFABN by social services since she remained in the facility after Medicare coverage had ended. A policy on liability notices was requested, however on 10/2/14 at 10:20 a.m., the DON stated they did not have one, and were to be following the CMS (Centers for Medicare and	F 156	Medicare A Determination. Social service staff was in-serviced on the Medicare A Determination policy and re-trained on the non-coverage notice requirements that residents are to receive when Medicare coverage has ended on October 27, 2014. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: A monthly audit will be completed by the Director of Social Services to verify that the appropriate non-coverage notice was issued to residents whose Medicare coverage has ended. The audit will be presented to the facility Quality Assurance committee for a period of three months to verify that compliance has been attained. Completion Date: November 7, 2014	

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F 156	Continued From page 4 Medicaid) guidelines.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete timely grooming to promote dignity for 1 of 3 residents (R63), who were dependent upon staff for activities of daily living and grooming. Findings include: R63's quarterly Minimum Data Set (MDS), dated 8/1/14, indicated R63 had severe cognitive impairment, and required extensive assistance from staff to complete personal hygiene and grooming. R63's care plan, dated 10/2014, indicated R63 had self care deficits related to impaired mobility, and cognitive impairment. R63 required extensive assistance to complete her activities of daily living (ADL's), including personal hygiene. During observation on 9/30/14, at 12:10 p.m., R63 was seated at a dining room table eating her noon meal. She had long visible facial hair on her upper lip and chin. Later that evening at 6:53	F 241	F241 Dignity and Respect of Individuality Corrective Action For Residents Affected By Deficient Practice: R63 s family was contacted to verify resident/family preference for facial hair grooming. Facial hair was removed per family preference. Care plan was updated to reflect preference. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: An audit was completed to identify residents who are dependent on staff for activities of daily living for grooming. The audit reflects those residents who need assistance with facial hair removal as part of their grooming regimen. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility policy was developed on Resident Dignity and the facility policy for Shaving a Resident was revised. All nursing staff was in-serviced on the	10/24/14

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F 241	Continued From page 5 p.m., she continued to have long visible facial hair. When observed the following day, 10/1/14 at 9:11 a.m., R63 was seated in the commons area of the unit with other residents and continued to have her long visible facial hair. When interviewed on 10/1/14, at 1:04 p.m., R63's family member (FM)-A stated R63 needed staff assistance to complete shaving. R63 was always a well-kept person in her past, and being seen by others with facial hair would be upsetting to her, "She doesn't like to have that on her face." During interview on 10/1/14, at 1:19 p.m., nursing assistant (NA)-A stated R63 had fast growing facial hair and it should be trimmed and removed regularly, "It's really long now." NA-A stated R63's facial hair should have been removed before getting so long. During interview on 10/1/14, at 2:27 p.m., registered nurse (RN)-A stated R63 required physical assistance from staff for her personal care and grooming. R63 had no identified preference to have facial hair, and it should have been removed during daily cares. When interviewed on 10/2/14, at 9:52 a.m., the director of nursing (DON) stated R63 should have had her facial hair removed promptly when it was noticed. Further, the DON stated having long facial hair would be an un-dignified appearance concern for R63, "It could be for anybody." A facility policy on dignity was requested, but none was provided.	F 241	Resident Dignity policy and the revised Shaving a Resident policy on October 27, 2014. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: A weekly audit will be completed by the Director of Nursing or designee to verify that each resident who is dependent on staff for activities of daily living and grooming had personal grooming completed timely. The audit will be presented to the facility Quality Assurance committee for a period of three months to verify that compliance has been attained. Completion Date: November 7, 2014	

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F 242	Continued From page 6	F 242		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to follow bathing preference for 1 of 3 residents (R1) who wanted a bath. Findings include: R1's quarterly Minimum Data Set (MDS), dated 7/4/14, indicated R1 had intact cognition, required physical assistance to complete bathing. R1's annual MDS, dated 4/4/14, indicated it was somewhat important for R1 to be able to choose between a tub bath, shower, bed bath, or sponge bath. During interview on 9/29/14, at 2:27 p.m., R1 stated she mostly takes a shower, however it would be nice to take a bath once in a while too but staff did not offer a choice of taking a shower or having a tub bath. During a subsequent interview with R1, on 9/30/14 at 7:14 p.m., R1 stated she was scheduled to receive a shower that same evening, but would ask staff for a tub bath instead.	F 242	F242 Self-Determination-Right to Make Choices Corrective Action For Residents Affected By Deficient Practice: The Care Plan for R1 was updated to reflect the resident preference for an occasional bath instead of a shower. The Care Plan indicates that staff is to ask R1 prior to each scheduled bathing for individual preference of shower or tub bath. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to verify that each Resident Care Plan addresses bathing preferences. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: A facility policy was developed for Resident Choices. All nursing staff was in-serviced on the Resident Choices policy on October 27, 2014. How The Facility Will Monitor	10/24/14

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F 242	Continued From page 7 When interviewed on 10/1/14, at 6:52 a.m., R1 stated she requested a tub bath the other evening instead of a shower, however was given a shower by staff. Staff did not tell me why I would not have a tub bath. R1 further stated she likes to have a tub bath once in awhile as she enjoys just being able to sit in a warm tub and soak sometimes. An undated copy of the bathing schedule indicated R1 was scheduled for bathing on Tuesday evening, and Friday morning. The schedule did not identify resident preference of a shower or tub bath. R1's care plan, dated 10/2014, indicated R1 required extensive assistance with bathing, and preferred no male caregivers assist her with bathing. The care plan did not address any preference for bathing for R1. Review of R1's progress note, dated 10/1/14, indicated R1 was assisted with a shower by staff (on 9/30/14, the same date she requested to have a tub bath instead of a shower). The nursing assistant (NA)-M assigned to complete R1's bath on 9/30/14 was contacted several times, but did not return the call. During interview on 10/1/14, at 12:49 p.m., NA-A stated she typically never gave R1 an option when completing her bathing, the resident should be given a choice for bathing preference. When interviewed on 10/2/14, at 8:30 a.m., licensed social worker (LSW)-B stated R1 was cognitively able to make choices for her bathing.	F 242	Performance To Make Sure That Solutions Are Sustained: A monthly audit will be completed by the Director of Nursing or designee to verify that each resident s preferences for bathing are indicated on the Resident Care Plan. The audit will include monthly interviews of forty residents regarding whether or not staff have honored their bathing preferences. The audit will be presented to the facility Quality Assurance committee for a period of three months to verify that compliance has been attained. Completion Date: November 7, 2014	

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F 242	Continued From page 8 During interview on 10/2/14, at 8:23 a.m., registered nurse (RN)-A stated residents should be bathed according to their preference and R1 could make a choice in her bathing preferences. When interviewed on 10/2/14, at 9:48 a.m., the director of nursing (DON) stated R1 should have been given a tub bath instead of a shower when she asked staff for one. A facility policy on choices was requested, but none was provided.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care and provide timely repositioning, and toileting, for 1 of 1 residents (R74) reviewed for urinary incontinence, and at risk for development of pressure ulcer development. Findings include: R74's diagnoses, identified from a physician's progress note dated 9/17/2014, included Alzheimer's dementia, atrial fibrillation and osteoporosis. R74's quarterly Minimum Data Set	F 282	F282 Services by Qualified Persons/Per Care Plan Corrective Action For Residents Affected By Deficient Practice: A new skin assessment, tissue tolerance testing, and toileting assessment were completed for R74. Care plan for R74 was updated to reflect the updated skin assessments and toileting assessment findings. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to identify residents who experience urinary	10/24/14

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F 282 Continued From page 9

(MDS), dated 7/11/2014, indicated impaired cognition,required extensive assistance from staff to complete activities of daily living (ADLs), including bed mobility, transferring, toileting and personal hygiene.

R74's care plan (CP), dated 10/2014, identified vulnerabilities for skin breakdown and ADL self-care deficits. The CP directed staff to assist R74 to turn and reposition every 1 and 1/2 hours when in her wheel chair, every 2 hours when in bed, and as needed. Further, the CP directed staff to toilet R74 every 2 hours while awake.

During continuous observation on 10/1/2014, from 7:16 a.m. to 9:40 a.m. (2 hours and 24 minutes,) R74 was dressed, and seated in her wheel chair in her room. At 8:41 a.m., dietary aide (DA)-A brought R74's breakfast into the room and placed the breakfast in front of R74 and left the room. R72 looked at the food, and occasionally glanced out her window, until nursing assistant (NA)-A and registered nurse (RN)-C came into the room at 9:40 a.m. to assist R74 with toileting and repositioning. R74 was assisted from the wheel chair to the bed with use of a mechanical lift. NA-A checked R74's incontinent pad, which was dry. At 9:46 a.m., R74 was lifted from her bed and repositioned back into her wheel chair. R74 did not request nor did staff offer R74 to be repositioned or toileted from 7:16 a.m. until 9:40 a.m., 2 hours and 24 minutes later.

In an interview on 10/1/2014 at 9:50 a.m., NA-C acknowledged R74 had not been toileted or repositioned while in her wheel chair "... since seven this morning [2 hours and 40 minutes]." NA-C stated R74 was "To be moved no later than

F 282

incontinence and who are at risk for development of pressure ulcers.

Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Staff were in-serviced on October 27, 2014 in regard to following specified time frames for toileting and repositioning care plans to reduce the risk for development of pressure ulcers.

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: A monthly audit will be completed by the Director of Nursing or designee for forty residents at varying times of the day to assure that timely repositioning and toileting has occurred. The audit will be presented to the facility Quality Assurance committee for a period of three months to verify that compliance has been attained.

Completion Date: November 7, 2014

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F 282	Continued From page 10 one and one-half hours, when she's sitting in her wheel chair." During an interview on 10/2/2014, at 10:48 a.m., RN-C said it was a goal that R74 "Maintain her continence, as best she is able, and have no skin breakdown." RN-C agreed R74's incontinence increased her risk to maintain intact skin, and therefore was necessary to follow a schedule, especially because of R74's dependence upon staff for mobility. RN-C said [R74's] assessment included "to be toileted every 2 hours while awake." RN-C also stated R74 "was to be turned and repositioned "every 2 hours while in bed," and "every 1 1/2 hours, when [R74] was up in her wheel chair." RN-C stated she "would expect" that turning, walking, repositioning and toileting "are completed for the residents as care planned." In an interview on 10/2/2014 at 11:22 a.m., the director of nursing, (DON) stated residents needed to be toileted, turned and repositioned timely. The DON said, "I would expect the care plan to be followed." A facility policy entitled "Resident Care Plans", revised 8/2013, indicated that a comprehensive care plan was designed "...to incorporate identified problem areas" and "...aid in preventing or reducing declines in the resident's functional levels."	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	F 312		10/24/14

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F 312	Continued From page 11 and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine personal grooming for 2 of 3 residents (R74, R63) who were dependent upon staff for activities of daily living. Findings include: R74's quarterly Minimum Data Set (MDS) dated 7/11/2014, identified R74 had impaired cognition and required extensive assistance from staff to complete activities of daily living (ADLs). The care plan, dated 10/2014, identified R74's ADL self care deficit, and listed "extensive assist of one" as an intervention for personal hygiene. During observation on 9/29/2014, R74 was seated in her wheel chair in her room, her hands resting on a bedside table, and peering out the window. R74 had numerous visible facial hair on her chin and upper lip, approximately one-half inch in length. During an interview on 9/30/2014 at 7:25 p.m., family member (FM)-A said R74 had "...quite a few hairs on her face," and added, "She is due for a clip." FM-A said he did not feel R74's facial hair was "bothersome" to him, and also felt it would not bother R74. FM-A stated [R74]'s face "should be clean," and said he would mention it to staff, because "tomorrow is [R74]'s bath day."	F 312	F312 ADL Care Provided for Dependent Residents Corrective Action For Residents Affected By Deficient Practice: R63 s family and R74 s family were contacted to verify resident/family preference for facial hair grooming. Facial hair was removed on both residents per family preference. Care plans were both updated to reflect preference. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: An audit was completed to identify residents who are dependent on staff for activities of daily living and grooming. The audit reflects those residents who need assistance with facial hair removal as part of their grooming regimen. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: The facility policy for Shaving a Resident was revised. All nursing staff was in-serviced on revised policy on October 27, 2014. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: A weekly audit will be completed by the Director of Nursing or designee to verify that each	

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	245427	A. BUILDING ______ B. WING ______	10/02/2014

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In an interview on 10/1/2014 on 12:55 p.m., nursing assistant (NA)-C acknowledged R74 had facial hairs on her upper lip and chin. NA-C said R74 "Has a bath later today." NA-C stated the aides completed grooming for the resident, as R74 "was not able to do that for herself."

During observation on 10/2/2014 at 8:22 a.m., R74 was observed to be dressed, and seated in her wheel chair in her room. R74 was neatly groomed, and her facial hair on her lips or chin had been removed.

During an interview on 10/2/2014 at 9:33 a.m., licensed practical nurse (LPN)-B said a resident's appearance matters, and that is was "our responsibility" to make sure [grooming] was done for residents, especially if a resident was unable to do that for him or herself. LPN-B said she "would "expect facial grooming be completed" at least on bath days, and "as needed."

R63's quarterly Minimum Data Set (MDS), dated 8/1/14, indicated R63 had severe cognitive impairment, and required extensive assistance from staff to complete personal hygiene and grooming.

R63's Care Area Assessment Documentation Note, dated 2/7/14, indicated R63 required extensive assistance from staff to complete dressing, personal hygiene, and bathing.

R63's care plan, dated 10/2014, indicated R63 had self care deficits related to impaired mobility, and cognitive impairment. R63 required extensive assistance to complete her activities of

Provider's plan of correction (F 312):

resident who is dependent on staff for activities of daily living and grooming had personal grooming completed timely. The audit will be presented to the facility Quality Assurance committee for a period of three months to verify that compliance has been attained.

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F 312	Continued From page 13 daily living (ADL's), including personal hygiene. During observation on 9/30/14, at 12:10 p.m., R63 was seated at a dining room table eating her noon meal. She had long visible facial hair on her upper lip and chin. Later that evening at 6:53 p.m., she continued to have long visible facial hair. When observed the following day, 10/1/14 at 9:11 a.m., R63 was seated in the commons area of the unit with other residents and continued to have her long visible facial hair. During interview on 10/1/14, at 1:19 p.m., nursing assistant (NA)-A stated R63 facial hair should be trimmed and removed regularly, "It's really long now." When interviewed on 10/1/14, at 1:43 p.m., licensed practical nurse (LPN)-A stated R63's facial hair was approximately 0.5 cm (centimeters) in length when observed and should have been removed as she (R63) is dependent on staff for her grooming and personal care. During interview on 10/1/14, at 2:27 p.m., registered nurse (RN)-A stated R63 required physical assistance from staff for her personal care and grooming and had no identified preference to have facial hair, and it should have been removed during daily cares. When interviewed on 10/2/14, at 9:52 a.m., the director of nursing (DON) stated staff should be observing residents on a daily basis and completing grooming. R63 should have had her facial hair removed promptly when it was noticed.	F 312		

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F 312	Continued From page 14 A facility Shaving a Resident policy, dated 5/2011, indicated a policy, "To promote cleanliness and to provide skin care." The policy provided a procedure for how to complete shaving, but did not include parameters for how often shaving should be completed for residents.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a 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 provided timely repositioning for 1 of 1 residents (R74) reviewed at risk for pressure ulcers. Findings include: R74's diagnoses, identified from a physician's progress note dated 9/17/2014, included Alzheimer's dementia, atrial fibrillation and osteoporosis. R74's quarterly Minimum Data Set (MDS), dated 7/11/2014, indicated impaired cognition, and that R74 required extensive assistance to complete activities of daily living (ADLs), including bed mobility, transferring,	F 314	F314 Treatment/Svcs To Prevent/Heal Pressure Sores Corrective Action For Residents Affected By Deficient Practice: A new skin assessment and tissue tolerance testing was completed for R74. The care plan for R74 was updated to reflect the skin assessments findings. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to identify residents who are at risk for development of pressure ulcers.	10/24/14

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F 314	Continued From page 15 toileting and personal hygiene. The MDS also indicated R74 did not ambulate. A Braden Scale, (a measure for predicting pressure ulcer risk), dated 8/12/2014, indicated R74 was at high risk to develop pressure ulcers. A tissue perfusion assessment, dated 8/13/2014, indicated R74 could tolerate a 1 1/2 hour repositioning program while seated in a chair, and a 2 hour repositioning program when in bed. The care area assessment (CAA) for pressure ulcers, dated 4/17/2014, indicated R74 required extensive assist of one with bed mobility and other self care ADLs, and up to extensive assistance of two with transfers. R74's care plan (CP), dated 10/2014, identified a vulnerability for skin breakdown. The CP directed staff to assist R74 to turn and reposition every 1 and 1/2 hours when in her wheel chair, every 2 hours when in bed, and as needed. During continuous observation on 10/1/2014, from 7:16 a.m. to 9:40 a.m. (2 hours and 24 minutes,) R74 was dressed, and seated in her wheel chair in her room. At 8:41 a.m., dietary aide (DA)-A brought R74's breakfast into the room and placed the breakfast in front of R74 and left the room. R72 looked at the food, and occasionally glanced out her window, until nursing assistant (NA)-A and registered nurse (RN)-C came into the room at 9:40 a.m. to assist R74 with toileting and repositioning. R74 was assisted from the wheel chair to the bed with use of a mechanical lift. NA-A checked R74's incontinent pad, which was dry. At 9:46 a.m., R74 was lifted from her bed and repositioned back into her wheel chair. R74 did not request nor did staff offer R74 to be repositioned or toileted from 7:16 a.m. until 9:40 a.m., 2 hours and 24	F 314	Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Staff were in-serviced on October 27, 2014 in regard to following specified time frames for repositioning care plans to reduce the risk for development of pressure ulcers. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: A monthly audit will be completed by the Director of Nursing or designee on forty resident at varying times of the day to assure that timely repositioning has occurred. The audit will be presented to the facility Quality Assurance committee for a period of three months to verify that compliance has been attained. Completion Date: November 7, 2014	

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minutes later.

In an interview on 10/1/2014 at 9:50 a.m., NA-C acknowledged R74 had not been toileted or repositioned while in her wheel chair "... since seven this morning [2 hours and 40 minutes]." NA-C stated R74 was "To be moved no later than one and one-half hours, when she's sitting in her wheel chair."

A review of nursing progress notes from 7/9/2014 to 10/1/2014 indicated R74 did not have a pressure ulcer, nor did R74 develop a pressure ulcer during this time. The notes provided evidence of routine, weekly monitoring and assessment of R74's skin, which was currently intact.

During observation on 10/1/2014 at 12:52 p.m., NA-C and licensed practical nurse (LPN)-F assisted R74 from her wheel chair onto her bed with use of the mechanical lift. R74's incontinent pad revealed a minimal amount of urine, and a smearing of bowel movement. LPN-F inspected R74's bottom, which revealed no additional moisture. R74's skin was slightly pink in color and intact, with no sign of irritation, creasing or shearing.

In an interview on 10/2/2014 at 9:33 a.m., LPN-B stated "The aides and I are accountable for resident's toileting and turning schedules, would expect that [toileting and repositioning] get done." Further, LPN-B said, she would expect the aides "... to let me know if they can't get their work done, and how I can assist." LPN-B stated it was "... very important to maintain turning and toileting schedules" for the residents, to prevent pressure

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F 314	Continued From page 17 ulcers, and "...to keep their skin dry and intact." During an interview on 10/2/2014 at 10:48 a.m., RN-C said it was a goal that R74 "...maintain her continence, as best she is able, and have no skin breakdown." RN-C agreed R74's incontinence increased her risk for skin breakdown. RN-C said it was therefore was necessary to follow a schedule, especially because of R74's dependence upon staff for mobility. RN-C said [R74's] assessment included "...to be toileted every 2 hours while awake." RN-C also said R74 was to be turned and repositioned "...every 2 hours while in bed, and every 1 1/2 hours, when [R74] was up in her wheel chair." RN-C said she monitors the residents for repositioning, and stated "the staff a very good about communicating their needs for additional assistance" when necessary. RN-C stated she "would expect" that turning, walking, repositioning and toileting "...are completed for the residents as care planned." A review of a facility policy entitled "Pressure Ulcer Treatment Policy and Procedure", updated 2/23/2004, indicated the primary goal "is to prevent pressure ulcers from developing." The policy listed under "procedure" #6: Reposition every two hours or more frequently if indicated.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315		10/24/14

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F 315	Continued From page 18 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide toileting assistance for 1 of 1 residents (R74) reviewed for urinary incontinence. Findings include: R74's diagnoses, from a physician's progress note dated 9/17/2014, included Alzheimer's dementia, atrial fibrillation and osteoporosis. R74's quarterly Minimum Data Set (MDS), dated 7/11/2014, indicated impaired cognition, extensive assistance of staff to complete activities of daily living (ADLs), including transferring, toileting and personal hygiene. The CAA for urinary incontinence, dated 4/17/201, indicated R74 used incontinent pads, and that staff were to assist R74 to toilet every 2 hours and as needed while awake. R74's care plan (CP) dated 10/2014, directed two staff to assist with toileting when using a Hoyer lift [a mechanical lift], or one staff to assist, when R74 used the bedpan or required a change of incontinent pad. The CP further directed to toilet R74 every 2 hours, and as needed, when awake. During continuous observation on 10/1/2014, from 7:16 a.m. to 9:40 a.m. (2 hours and 24 minutes,) R74 was dressed, and seated in her	F 315	F315 No Catheter, prevent UTI, Restore Bladder Corrective Action For Residents Affected By Deficient Practice: A new toileting assessment was completed for R74. The care plan for R74 was updated to reflect the toileting assessment findings. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to identify residents who experience urinary incontinence. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Staff were in-serviced on October 27, 2014 with regard to following specified time frames for toileting care plans to prevent urinary tract infections and to promote continence. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: A monthly audit will be completed by the Director of Nursing or designee on forty residents at varying times of the day to assure that timely toileting has occurred. The audit will be presented to the facility Quality Assurance committee for a period of three	

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F 315	Continued From page 19 wheel chair in her room. At 8:41 a.m., dietary aide (DA)-A brought R74's breakfast into the room and placed the breakfast in front of R74 and left the room. R72 looked at the food, and occasionally glanced out her window, until nursing assistant (NA)-A and registered nurse (RN)-C came into the room at 9:40 a.m. to assist R74 with toileting. R74 was assisted from the wheel chair to the bed with use of a mechanical lift. NA-A checked R74's incontinent pad, which was dry. At 9:46 a.m., R74 was lifted from her bed and repositioned back into her wheel chair. R74 did not request nor did staff offer R74 to be toileted from 7:16 a.m. until 9:40 a.m., 2 hours and 24 minutes later. In an interview on 10/1/2014 at 9:50 a.m., NA-C acknowledged R74 had not been toileted, "since seven this morning [2 hours and 40 minutes]." NA-C stated R74 needed to "be checked and toileted every two hours" during the day. In an interview on 10/2/2014 at 9:33 a.m., LPN-B stated "The aides and I are accountable for resident's toileting schedules, she would expect the aides "... to let me know if they can't get their work done, and how I can assist." LPN-B stated it was "... very important to maintain toileting schedules for the residents, "to keep their skin dry and intact." During record review, a bowel and bladder assessment, dated, 7/9/2014, indicated R74 was frequently incontinent of bladder but at times could identify the need to void, use the call light, and ask to go the the toilet. During an interview on 10/2/2014 at 10:48 a.m.,	F 315	months to verify that compliance has been attained. Completion Date: November 7, 2014	

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F 315	Continued From page 20 RN-C acknowledged [R74] had urinary incontinence, and it was a goal that R74 "maintain her continence, " and R74's was dependent upon staff to meet her toileting needs. RN-C said R74 was assessed to be toileted every 2 hours while awake. RN-C stated she "would expect" that toileting "are completed for the residents as care planned." A facility toileting policy was requested, but not provided.	F 315		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a 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	F 441		10/24/14

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F 441	Continued From page 21 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 ensure the proper infection control measures were followed for handling of soiled linen in 1 of 4 observations of personal care which affected resident (R193). Findings include: On 10/01/14, at 11:45 a.m. resident assistant (RA)-A entered R132's room and removed soiled bed linen. RA-A gathered and rolled the bed linens, clutching them in her left arm next to her body and uniform with no gloves on , and walked down the hall to the soiled utility room and dropped the linen in a chute without washing her hands. RA-A then exited the room and walked down the G hall and the F hall and proceeded to the main dining room and wheeled R193 down to the hall to her room. RA-A placed her unwashed hand on top or R193's right hand and right arm. During interview on 10/01/14, at 10:55 a.m. RA-A acknowledged and admitted that she gathered	F 441	F441 Infection Control, Prevent Spread, Linens Corrective Action For Residents Affected By Deficient Practice: The linens for R193 s bed were properly changed on 10/1/14 after facility was made aware of deficient practice. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: All residents within the facility have the potential to be affected by this practice. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: All nursing staff were in-serviced on October 27, 2014 with regard to proper handling of soiled linens to prevent infections. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: The Director of	

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F 441	Continued From page 22 the residents dirty linens and carried them with her arm next to her uniform. RA-A stated she should have placed them in a plastic bag. During interview 10/01/14 ,at 2:22 p.m. registered nurse (RN)-E stated the soiled linen should be placed in a plastic bag when carried down the hall and RA-A should not have had the used linen touching her uniform . During interview 10/01/14, at 3:00 p.m. the director of nursing (DON) stated linen should be bagged when carried down the hall according to their linen handling policy. The facilities Procedure For Linen Handling reviewed 1/2013 indicated "Because it is not always known which residents are infected or colonized with infectious microorganisms, soiled linen of all residents is handled the as if it is known to be contaminated. Therefore, all linen is treated the same way." The procedure indicated soiled linen is always handled with gloved hands. Soiled linen is placed in plastic bag while in the residents room. plastic bags will be available on small linen cart or in soiled utility rooms.	F 441	Nursing or designee will complete forty observations of bed linen handling monthly to assure that the linen was handled properly. The audit will be presented to the facility Quality Assurance committee for a period of three months to verify that compliance has been attained. Completion Date: November 7, 2014	
F 465 SS=C	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	F 465		10/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 23 review, the facility failed to maintain 4 of 6 appliances in the kitchen, which were used for food preparation, in a clean and sanitary manner. This had potential to affect all residents and visitors which had food prepared or served from the kitchen. Findings include: During the initial tour of the facility kitchen, on 9/29/14 at 9:19 a.m., three ovens (a single Blodgett, a stacked Rational, and a stacked Vulcan), along with a steamer were observed to be in use for food preparation. In addition, an open metal rack containing numerous steam table pans was positioned in-between the Blodgett and Vulcan ovens. All of the ovens, the steamer, and metal storage rack had copious amounts of a thick, dark colored sticky substance, along with thick amounts of clumping dust, debris and the remains of several hundred dead gnats, and numerous dead moths on top of the oven while they were in use. During interview on 9/29/14, at 11:09 a.m., the dietary manager (DM)-A stated the top of appliances, including ovens and steamer, are to be cleaned weekly by staff. The ovens and steamer should have been cleaned before which was supposed to be cleaned on the schedule on 9/22/14 (7 days ago). Review of the facility "EXTRA" Cleaning List, dated September 2014, indicated the outside of the Rational oven should have been cleaned once a week, and was initialed by staff to have been completed on 9/22/14. The Cleaning List	F 465	F465 Safe/Functional/Sanitary/Comfortable Environment Corrective Action For Residents Affected By Deficient Practice: No individual residents were identified to be affected by the deficient practice. The kitchen hood exterior filters which were dislodged during a wind event on September 28, 2014 were replaced and secured. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: All facility residents have the potential to be affected by the deficient practice. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: The weekly kitchen cleaning task list was revised to include all individual pieces of kitchen equipment. Manufacturer s directions for exterior cleaning were secured for each piece of equipment. Dietary staff was in-serviced on October 27, 2014 with regard to the equipment cleaning instructions per manufacturer. A weekly inspection form was initiated to verify that the exterior kitchen hood filters are securely in place. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: The weekly kitchen cleaning task list will be audited monthly by the Dietary Manager. The weekly maintenance filter inspection will be audited monthly by the Administrator. Results of each audit will be presented to the facility Quality Assurance committee	

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	245427	A. BUILDING _____ B. WING _____	10/02/2014

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F 465	Continued From page 24 did not indicate a cleaning schedule for the Vulcan or Blodgett oven, nor the metal storage rack containing pans and containers in between them. An additional tour of the kitchen, made on 9/30/14 at 2:57 p.m., found the Rational oven and steamer had been cleaned by staff. The Blodgett and Vulcan ovens continued to have copious dust, debris, and dead insect remains on top of them. In addition, the metal storage rack containing metallic pans for cooking and steaming, had clean pans sitting on top of the storage rack. Upon lifting the pans up, several more dead bugs were observed under the clean pans. When interviewed on 9/30/14 at 2:57 p.m., Cook (CK)-D stated the pans on the metal storage rack, which contained dead pests underneath, were used for cooking and should be cleaned. Further, CK-D stated the appliances were checked and cleaned of dust and debris on a monthly basis, and it had been well over a month since the tops of the appliances were last cleaned. During a subsequent interview on 9/30/14, at 6:34 p.m., the DM stated a filter on the roof was found to have been damaged by wind allowing debris and dust to collect on the appliances and shelving. DM was unsure how long it had been damaged, and it would be fixed promptly. When interviewed on 10/2/14, at 9:56 a.m., the director of nursing (DON) stated the kitchen and appliances should be clean to maintain good infection control practice, and set cleaning schedules should be followed accordingly.	F 465	for a period of three months to verify that compliance has been attained. Completion Date: November 7, 2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	10/02/2014

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F 465	Continued From page 25 During interview on 10/2/14, at 10:21 a.m., the registered dietician (RD)-A stated it was important to have clean surfaces which are free of dust, debris, and dead pests in the kitchen and the appliances should have been cleaned regularly, "Obviously that is not OK." An Installation and Operation Manual (for the Vulcan oven), dated 2009, indicated exterior stainless steel oven panels should be cleaned with a damp cloth. The other appliance manufacturers directions were requested, but not provided.	F 465		

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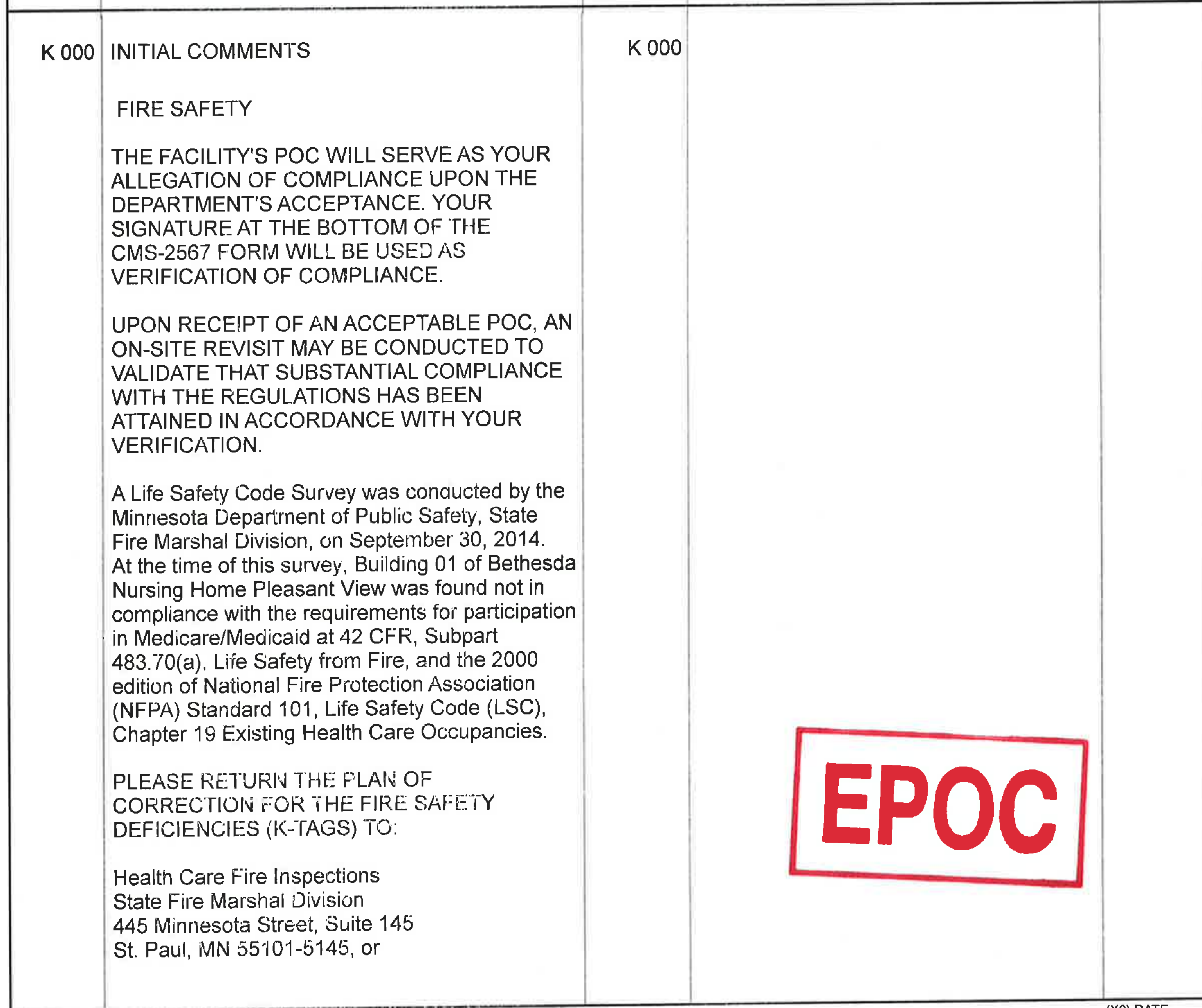
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5427024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 30, 2014. At the time of this survey, Building 01 of Bethesda Nursing Home Pleasant View was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, 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		10/24/2014

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	09/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Bethesda Nursing Home Pleasant View is a one-story building with full basement. The facility is fully fire sprinkler protected, and was constructed as follows: The original 1979 building was determined to be of Type V(111) construction; The 1994 building addition was determined to be of Type II(000) construction; The 1999 building addition was determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 124 beds and had a census of 111 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 141 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 141		10/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 141	Continued From page 2 Non-smoking and no smoking signs in areas where oxygen is used or stored are in accordance with 19.3.2.4, NFPA 99, 8.6.4.2. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide "No Smoking" signage at one or more medical gas storage locations. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.3.2.4 and NFPA 99 (1999 edition) Chapter 8, Section 8-3.1.11.3. FINDINGS INCLUDE: On 09/30/2014 between 11:00 AM and 2:00 PM, observation revealed Oxygen Storage rooms on the B-Wing and G-Wing corridors, and there were no "No Smoking" signs posted in the immediate vicinity of the rooms. These findings were confirmed with facility staff at the times of discovery.	K 141	K141□No Smoking Signs Corrective Action For Residents Affected By Deficient Practice: No residents were impacted by the deficient practice. No Smoking signs were placed at each medical gas storage location. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: All facility residents have the potential to be affected by the deficient practice. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: No Smoking signs were placed at each medical gas storage location. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: A monthly audit will be completed by the Maintenance Director to verify that the No Smoking Signs are in place at each medical gas storage location. The audit will be presented to the facility Quality Assurance Committee for a period of three months to verify that compliance has been maintained. Completion Date: November 7, 2014	

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	245427	A. BUILDING **02** B. WING ______	**09/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on September 30, 2014. At the time of this survey, Building 02 of Bethesda Nursing Home Pleasant View was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Bethesda Nursing Home Pleasant View consists of the 2005 and 2010 building additions. These additions are one-story in height, have a partial basement, are fully fire sprinkler protected, and were determined to be of Type II(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 124 beds and had a census of 111 at time of the survey.	K 000	EPOC	

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