CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P565

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

P	ARTI-TO BE COMPLETED BY THE	E STATE SURVEY AGENCY	Facility ID: 00913
MEDICARE/MEDICAID PROVIDER NO. (L1) 245295 2.STATE VENDOR OR MEDICAID NO. (L2) 493226900	3. NAME AND ADDRESS OF FACILITY (L3) BETHEL CARE CENTER (L4) 420 MARSHALL AVENUE (L5) SAINT PAUL, MN	(L6) 55102	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGORY	02 (L7) 9 ESRD 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 08/20/2015 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited	03 SNF/NF/Distinct 07 X-Ray 1	0 NF 14 CORF 1 ICF/IID 15 ASC 2 RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 131 (L1 13. Total Certified Beds 131 (L1	D. M.C. C. T. M.D.	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF 5. Life Safety Code vers: * Code: A*	6. Scope of Services Limit7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 S 131 (L37) (L38) (L38)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
STATE SURVEY AGENCY REMARKS (IF APPLICA SURVEYOR SIGNATURE	BLE SHOW LTC CANCELLATION DATE): Date :	18. STATE SURVEY AGENCY AI	PPROVAL Date:
Susan Miller, HFE NE I		Kate JohnsTon, Pr	
PART II -	TO BE COMPLETED BY HCFA REG	` '	
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate 2. Facility is not Eligible (L.2)	20. COMPLIANCE WITH CIVI RIGHTS ACT:		Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGR OF PARTICIPATION BEGINN 12/01/1985 (L24) (L41)	EEMENT 24. LTC AGREEMENT IING DATE ENDING DATE (L25)	VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
A. Suspe	ATIVE SANCTIONS nsion of Admissions: (L44) d Suspension Date: (L45)	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE: (L28)	29. INTERMEDIARY/CARRIER NO. 03001	30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE 08/07/2015	(L33) DETERMINATION APPRO)VAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245295

September 25, 2015

Ms. Jennifer Schoenecker, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, Minnesota 55102

Dear Ms. Schoenecker:

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 August 4, 2015 the above facility is certified for or recommended for:

131 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 131 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

Health Regulation Division kate.johnston@state.mn.us

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 September 17, 2015

Ms. Jennifer Schoenecker, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, Minnesota 55102

RE: Project Number S5295024

Dear Ms. Schoenecker:

On September 4, 2015, we informed you that the following enforcement remedy was being imposed:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 25, 2015. (42 CFR 488.417 (b))

Also, we notified you in our letter of September 4, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 25, 2015.

This was based on the deficiencies cited by this Department for a standard survey completed on June 25, 2015, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 3, 2015, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 4, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2015, as of August 4, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our

Bethel Care Center September 17, 2015 Page 2

letter of September 4, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective September 25, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 25, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 25, 2015, is to be rescinded.

In our letter of September 4, 2015, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 25, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 4, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR 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

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

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 245295	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/20/2015
Name	of Facility		Street Address, City, State, Zip Code	
BETHEL CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102	

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) I	Date
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix	F0253	_08/04/2015	ID Prefix	F0329		08/04/2015		ID Prefix	F0371		08/04/2015
-	483.15(h)(2)	_		483.25(I)					483.35(i)		_
LSC		_	LSC				<u> </u>	LSC			_
		0				0					0
		Correction				Correction					Correction Completed
ID Prefix	F0465	Completed 08/04/2015	ID Prefix	F0467		Completed 08/04/2015		ID Prefix			Completed
Reg. #	483.70(h)		Reg. #	483.70(h)(2)				Reg. #			
LSC			LSC					-			<i>-</i> -
		Correction				Correction					Correction
ID Prefix		Completed	ID Prefix			Completed		ID Prefix			Completed
		_									_
Reg. #		_	Reg. #					Reg. #			_
			130				+-				_
		Correction				Correction					Correction
		Completed				Completed					Completed
ID Prefix		_	ID Prefix					ID Prefix			_
Reg. #			Reg. #					Reg. #			
LSC		- -	LSC					LSC			-
		Competion				Competion					Composition
		Correction Completed				Correction Completed					Correction Completed
ID Prefix			ID Prefix			Completed		ID Prefix			Completed
Reg. #			Reg. #			•		Reg. #			_
LSC		_									_
Reviewed By	Reviewed	Ву	Date:	Signature of S	Surve	yor:				Date:	
State Agency	SR/1	ΧJ	09/04/20		•	3298	4			08/	20/2015
Reviewed By		,	Date:	Signature of S	Surve					Date:	
CMS RO											
Followup to	Survey Completed on:			Check fo	r any	Uncorrected I	Defici	encies. Was	a Summary of		
	6/25/2015			Uncor	rrected	d Deficiencies	(CMS	3-2567) 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 245295	(Y2) Multiple Construction A. Building B. Wing 01 - MAII	N BUILDING 01	(Y3) Date of Revisit 9/3/2015	
Name	of Facility		Street Address, City, State, Zip Code		
BE	THEL CARE CENTER		420 MARSHALL AVENUE		
			SAINT PAUL, MN 55102		

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
			Correction					Correction					Correction
10.0 %			Completed		ID D . C			Completed		ID D . C			Completed
ID Prefix			07/07/2015					08/04/2015					08/04/2015
•	NFPA 101				-	NFPA 101				•	NFPA 101		_
	K0029			_	LSC	K0052			_	LSC	K0054		
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			08/04/2015		ID Prefix			08/04/2015		ID Prefix			07/10/2015
Reg. #	NFPA 101				Reg. #	NFPA 101				Reg. #	NFPA 101		_
LSC	K0062				LSC	K0067				LSC	K0130		_
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg.#								•					_
					LSC					LSC			_
									+				
			Correction					Correction					Correction
ID Deefin			Completed		ID Danfin			Completed		ID Danfin			Completed
													_
Reg. #					Reg. #					Reg. #			_
				-					+		-		_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix					ID Prefix					ID Prefix			_
Reg.#					Reg. #					Reg. #			_
LSC					LSC					LSC			_
Reviewed By	Rev	viewed E	Зу	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	1	GS	/KJ	09	/17/20	15		124	124			09/	03/2015
Reviewed By	Rev	viewed E	Ву	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed	on:					-				a Summary of	·	
	6/29/201	5				Unco	rrecte	d Deficiencies	(CN	IS-2567) Sent	to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 4, 2015

Ms. Jennifer Schoenecker, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, Minnesota 55102

Re: Reinspection Results - Project Number H5295112

Dear Ms. Schoenecker:

On August 20, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 25, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Licensing and Certification Program

Health Regulation Division kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

Y4) Item	(Y5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y:	5) D	ate
ID Prefix	21015	Correction Completed 08/04/2015	ID Prefix	21535	Correction Completed 08/04/2015		ID Prefix	21695		Correction Completed 08/04/2015
	MN Rule 4658.0610 Subp			MN Rule4658.1315 Subp.1			-	MN Rule 4658.141		
LSC		_	LSC				LSC			
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	23240	08/04/2015								-
•	MN Rule 4658.5405	_	Reg. #				Reg. #			-
		_	100							
		Correction			Correction					Correction
ID Profiv		Completed	ID Profix		Completed		ID Prefix			Completed
		_								-
Reg. # LSC		_	Reg. #				Reg. # LSC			-
		_				+-				•
		Correction			Correction					Correction
ID Profiv		Completed	ID Profiv		Completed		ID Profiv			Completed
Reg. #		_	Reg. #							-
		_ _					LSC			-
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix				ID Prefix			-
Reg. #		_	Reg. #				Reg. #			
		_	LSC				LSC			
Reviewed By	Reviewed	Ву	Date:	Signature of Surve	yor:			[Date:	
State Agency	,	SR/KJ	09/01/20	015		32984	1		08/20	0/2015
Reviewed By CMS RO	Reviewed	Ву	Date:	Signature of Surve	yor:				Date:	
Followup to Survey Completed on:			_				a Summary of to the Facility?	VEC	NO	
	6/25/2015	5/00)		Page 1 of 1		•			YES 6512	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: P565

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

		PAKI	1 - 10 BE COM	LTETED BA 1	HE STAT	E SURVEY AGENCY	Facility ID: 00913	
(L1) 245295 2.STATE VENDOR OR MEDIC	STATE VENDOR OR MEDICAID NO.			DRESS OF FACILIT RE CENTER ALL AVENUE	ГҮ	(L6) 55102	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint	
5. EFFECTIVE DATE CHANG (L9)	E OF OWNERSHIP		7. PROVIDER/SUP		Y 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
6. DATE OF SURVEY 8. ACCREDITATION STATUS: 0 Unaccredited 2 AOA	06/25/2015	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31	
11LTC PERIOD OF CERTIFICATION (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	131 131	, ,	X B. Not in Comp	ce With quirements		And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: B*	Following Requirements:	
	AKDOWN 8/19 SNF 131 (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	_
16. STATE SURVEY AGENCY17. SURVEYOR SIGNATURE	REMARKS (IF APP	LICABLE S	HOW LTC CANCELL Date:	ATION DATE):		18. STATE SURVEY AGENCY AP	PROVAL Date:	_
Vidya Tor	mar, HFE N	IE II		07/17/2015	(L19)	Kate JohnsTon, Pr	ogram Specialist 08/06/2015	.0)
	PART	TII - TO	BE COMPLETE	D BY HCFA RE	EGIONAL	OFFICE OR SINGLE STAT	E AGENCY	
DETERMINATION OF ELI	gible to Participate	(L21)		IPLIANCE WITH C	IVIL	1. Statement of Financi 2. Ownership/Control I 3. Both of the Above :	al Solvency (HCFA-2572) nterest Disclosure Stmt (HCFA-1513)	
22. ORIGINAL DATE OF PARTICIPATION 12/01/1985 (L24)	BE	CAGREEMI EGINNING 41)		4. LTC AGREEME ENDING DATE (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety	
25. LTC EXTENSION DATE:	A.	Suspension	E SANCTIONS of Admissions: pension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS		_
			03001					
	(L28))	03001		(L31)			
31. RO RECEIPT OF CMS-1539		32	. DETERMINATION C	DF APPROVAL DAT	TE			
	(L32)				(L33)	DETERMINATION APPRO	VAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered July 8, 2015

Ms. Jennifer Schoenecker, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, Minnesota 55102

RE: Project Number S5295024

Dear Ms. Schoenecker:

On June 25, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. 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. In addition, at the time of the June 25, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number H5295113 that was found to be unsubstantiated.

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

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

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

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

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

Potential Consequences - 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:

Susanne Reuss, Unit Supervisor Minnesota Department of Health Licensing and Certification Program Health Regulations Division P.O. Box 64900 85 East Seventh Place, Suite 220 St. Paul, Minnesota 55164-0900 Telephone: (651) 201-3793

Fax: 651-215-9697

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 August 4, 2015, 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.

Bethel Care Center July 8, 2015 Page 4

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 September 25, 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 December 25, 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

Bethel Care Center July 8, 2015 Page 5

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 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.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

PRINTED: 07/16/2015 FORM APPROVED OMB NO. 0938-0391

	DI AN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		245295	B. WING		06/25/2015		
	PROVIDER OR SUPPLIER CARE CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 20 MARSHALL AVENUE SAINT PAUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 000	INITIAL COMMENT	-S	F 000				
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve from the otance. Because you are four signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with					
		vey was conducted and tion was also completed at the survey.					
F 253 SS=D	completed. The cor		F 253		8/4/15		
	maintenance service	ovide housekeeping and ees necessary to maintain a ed comfortable interior.					
	by: Based on observatinterview, the facility and comfortable rooresidents (R60) rev Findings include:	NT is not met as evidenced ion, record review, and y did not maintain a sanitary om environment for 1 of 3 iewed for urinary catheter use.		Immediate corrective action: On 6/24/15, R60's mattress was repl floor mats were removed from the ro floor was cleaned with a disinfecting solution and wheelchair was cleaned Corrective Action as it applies to othe All resident rooms will be audited for	om, . ers: urine		
_ABORATOR\	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE		

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

Electronically Signed

07/16/2015

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		E SURVEY IPLETED			
		245295	B. WING		06/	25/2015			
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102	REET ADDRESS, CITY, STATE, ZIP CODE 0 MARSHALL AVENUE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
F 253	During observation was a strong odor bed of R60. The resident's bedding resident's catheter resident did not reshis eyes when an i surveyor. The odor near this 6/24/15 at 2:05 p.n. Record review reve Data Set, dated 3/3 resident as severe interviewable, and When interviewed registered nurse (Fthis unit, acknowle stated that he did recoming from. He sexperienced urine was present at this When interviewed nursing assistant (experienced a sign his catheter system urine pooled on the NA-A wondered if sertained by the floor floor next to the resulting and he stated that he stated that he did resperienced a sign his catheter system urine pooled on the NA-A wondered if sertained by the floor floor next to the resulting and he stated that he stated that he did resperienced a sign his catheter system urine pooled on the NA-A wondered if sertained by the floor floor next to the resulting and he stated that he stated that he did respectively.	on 6/23/15, at 9:48 a.m. there of urine near and around the esident, resident's clothing, and were all clean and dry. The system was intact. The spond to any questions or open nterview was attempted by a seresident's bed continued on an an area of the ly cognitively impaired, not without speech. on 6/24/15 at 2:06 p.m., RN)-B, the nurse manager for dged the odor in the room and not know where the odor was stated that this resident had leakage in the past, but none is time. on 6/24/15 at 2:07 p.m., NA)-A stated that the resident had leakage of urine from a few weeks ago and the effloor near the resident's bed. some of that urine had been or surface or the mats on the	F 253	odor to identify other residents be affected. Housekeeping staff will be eduthe Policy "Cleaning and Disin Environmental Surfaces". The correction will be complete August 4, 2015 Recurrence will be prevented to Random weekly audits will be for a period of 90 days to ensurooms are free of odors. Audit be shared with the QA committ recommendations for further mathematical The correction will be monitored Administrator/Designee.	cated on fecting of ed by: by: completed re resident results will the formonitoring.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		245295	B. WING		06/2	25/2015
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102	, ,	, = 0.10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 253 F 329	Continued From pa	_	F 25			8/4/15
SS=D	UNNECESSARY D Each resident's dru unnecessary drugs	RUGS g regimen must be free from . An unnecessary drug is any	1 32			0/4/13
	duplicate therapy); without adequate m indications for its us adverse consequer	excessive dose (including or for excessive duration; or monitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any e reasons above.				
	resident, the facility who have not used given these drugs therapy is necessal as diagnosed and crecord; and resider drugs receive gradibehavioral interven	chensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug by to treat a specific condition documented in the clinical that who use antipsychotic unal dose reductions, and tions, unless clinically an effort to discontinue these				
	by: Based on interview residents (R165), re	NT is not met as evidenced and document review, 1 of 5 eviewed for unnecessary ded the physicians orders for ication dose.		Immediate corrective action: The MD was notified for R165 and were received to discontinue the Acetaminophen. The Nurse who administered the Acetaminophen was re-educated	PRN	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		245295	B. WING		06/2	25/2015
	PROVIDER OR SUPPLIER CARE CENTER		4:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 MARSHALL AVENUE AINT PAUL, MN 55102	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371 SS=E	report, dated June 9 "Acetaminophen Talevery 6 hours as no pain index before a administration- do no mg(milligrams)/24 http://discourse.com/di	hysician order summary 29, 2015, R165 had an order for blet Give 500 mg by mouth reded for pain-document on and 30 minutes after not exceed 3000 hours. change to 1000 mg day]" Review of R165's tration Record (MAR) dated entified an order for the nophen Tablet Give 1000 mg as a day for pain Not to Acetaminophen in 24 hours 5 1400." Review of the MAR received the medication three dmission on 6/9/15. Review at R165 had received an Acetaminophen 650 mg on hich exceeded the physician in 24 hours. On 6/25/15 at 12:15 p.m., N)-A stated the nurse who ag of Acetaminophen to R165 heeded" order from the N-A acknoweldged the current and stated the nurse should call physician before dditional Acetaminophen. The call had been made to the ditional medication dose given ication error.	F 371	Corrective Action as it applies to of A review of residents who receive Acetaminophen will be completed ensure the medication is administed accordance with MD orders. The policy and procedure for Medical Administration was reviewed and recurrent. Licensed nursing staff will be re-ection the policy by August 4, 2015. The Correction will be completed by August 4, 2015. Recurrence will be prevented by: Random weekly audits will be component of the component of the policy by August 4, 2015. Recurrence will be prevented by: Random weekly audits will be component of the component of the policy of the prevented by the component of the policy of the prevented by t	to ered in cation emains ducated by: pleted f 90 ylenol dit or	8/4/15
		om sources approved or				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245295	B. WING		06/	25/2015
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	authorities; and (2) Store, prepare, under sanitary cond	distribute and serve food	F 3	71		
	review, the facility f the kitchen. This has approximately 60 of facility. Findings include: An inspection of the 6/22/15 at 12:00 p.i (FSD) was present following issues we A manual can open dried on food debrisedged, cutting med the base attached opener was also so FSD verified the state mechanism has for cleaning. The coperation and replacement and base. A cleaning schedule to cleaned weekly. The dirty end of the	tion, interview and document ailed to maintain sanitation in ad the potential to affect if the 90 residents in the ekitchen was completed on m. The food service director during the inspection. The re found: er was heavily soiled with a round the entire blade hanism and down the shaft. To the counter holding the siled around the edges. The late of the can opener and that if not been routinely dismantled an opener was taken out of according to the posted kitchen the can opener was to be		Immediate corrective action The manual can opener was with a new manual can open The counter at the dirty end room was cleaned. The wal pot and pan sink was cleaned stainless steel piece along the sink was caulked. The serving drawer by the stove was cleaned dishwasher interior walls, ce of spray arms was cleaned. contracted vendor that serving dishwasher evaluated the distribution of the disinfecting spray arms was repair. The dishwasher is so repair on 7/21/15. The dish temps were reviewed and an acceptable range. Corrective Action as it applied Dietary staff will be educated kitchen "Sanitization" policy. cleaning schedule was revisicleaning of the wall behind the pan sink, to scour the dishwasher. Temps will consulted daily.	s replaced her and base. of the dish II behind that ed. The he back of the ing utensil aned. The ciling and top The ces the shwasher on the motor for was in need of cheduled for the washer water re in es to others: d on the The kitchen ed to include he pot and ashing area he	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY MPLETED
		245295	B. WING		06/	25/2015
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	away but had not so The wall behind the and splatters. A state back of the sink, dedripping down the leavest wall and was loose along the wall behindrawer by the stove According to the pocook's area was to schedule lacked did the pot and pan sin area. On 6/22/15 at 5:30 observation, an unial a glass to show the inspected and foun resident complained are often dirty. A become debris aroun "I don't want to eat knows what else is I leap." Another renapkin to wipe out On 6/25/15 at 11:00 observed. The was 125 degrees Fahrer reached a temperature log incompliant of the sanit million for the sanit	FSD said they clean with lime coured the counter. In pot and pan sink had stains atinless steel piece along the esigned to keep water from back, was not caulked to the allowing wash water to spill and the sink. A serving utensile had sticky build up. Dested cleaning schedule the be cleaned daily. The cleaning rection to clean the wall behind ask or to scour the dishwashing. In p.m., during the supper meal identified resident handed over at it was dirty. The cup was and to have dried on debris. The dishes and silverware owl containing beets also had did the edge. The resident said, [my beets] anymore, who in there. I always look before sident was observed using his his cup before use. O a.m., the dishwasher was sh water reached a temp of enheit (F) and the rinse atture of 130 degrees F. The dicated wash temperature to be a rinse to be at 50-100 parts per	F 371	The Correction will be complete August 4, 2015 Recurrence will be prevented be Random weekly audits will be of for a period of 90 days to ensure compliance with the kitchen Sapolicy. Audit results will be shat the QA committee for recommend for further monitoring. The correction will be monitored The Administrator/Designee	oy: completed re unitization ared with endations	
	on the interior walls the spray arms. Bi	s, ceiling and along the top of ts of small foil wrappers had four of the sprays arm jets.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED	
		245295	B. WING		06/	25/2015	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102	REET ADDRESS, CITY, STATE, ZIP CODE MARSHALL AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 371	interior. The FSD de-limed on a regunot been used to obuild up. Also the cleaned on a regunobserved and four debris dried on. Trepresentative was verified that the was be adequate. The sales represe 7/1/15 at 3:30 p.m most likely from st stated the spray an inspected daily as from re-circulating He explained the scleaned off using a verified the wash to be a regular to the state of the sales represe 7/1/15 at 3:30 p.m.	he condition of the dishwasher stated the machine was ular basis, but detergent had clean out the greasy food debris spray arms had not been lar basis. Clean cups were not to have small bits of food he chemical sales is called at 11:30 a.m. and ash temperature of 120 would intative was called again on . He verified the build up was arches from food debris. He rms should be removed and they can become dirty inside water and can get plugged. Starchy build up could be a strong detergent. He again emperature could be at least herature of at least 139 F is	F 371				
	reports for the dish 6/1/15, were review recommendations interior of the mac schedule was revied ishwasher was to basis. The schedule and clean the interior A facility policy (un Department Sanita sanitation was to be equipment. Also, the schedule of the	ne preventive maintenance nwasher, dated 4/2/15 and wed. There were no on the reports for cleaning the hine. The kitchen cleaning ewed (no date). The be de-limed on a weekly ale lacked instructions to check rior or the spray arms. Idated) titled Foodservice ation Monitoring indicated be maintained, including here was to be "a stem for on-going sanitation					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		245295	B. WING		06/25/2015
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION
F 371 F 465 SS=E	service department temperature of the than 150 F for low to the machine was to least once per day manufacturer's received 483.70(h) SAFE/FUNCTIONALE ENVIRON The facility must pr	work environment in the food a." The policy indicated a wash water shall not be less temperature machines, and be thoroughly cleaned at in accordance with the commendation. AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 37		8/4/15
	by: Based on observareview, the facility from the facility floor, 1 from the facility floor, 1 from with splintere flooring, 3 of 3 residents on 2 not chair for bathing. Findings include: On 6/22/15 at 1:30 observed to have a on the south wing of the facility floor.	NT is not met as evidenced tion, interview and document ailed to provide a comfortable, ving condition for 5 of 6 48, R63, R96 and R21) who prooms that were not clean, 2 residents residing in a room of 1 resident (R5) residing in a docupboards and worn dents (R25, R13 and R39) with doors that did not shut, and if floor who utilized a shower p.m., the 3rd floor unit was heavy musty odor particularly of resident rooms.		R24, R63 and R21's (there was no resident listed for R148 and R96, be corrective action as it applies to oth has ensured that their bathroom ha addressed) bathrooms were cleane toilet was scrubbed, the floor was scrubbed and the peeling paint on toilet base was removed. The floor R63 and R65 was top scrubbed. The cabinet door, drawer and vinyl floor covering in R5's room was repaired R25's door was repaired to close fur R13's bed was adjusted so that the to the room of R13 and R39 can ful close. The shower chair in the show area on 2nd floor was cleaned immediately. Corrective Action as it applies to oth All resident bathrooms will be deep cleaned to include toilet surfaces, floor	ut the ers s been ed; the he for he ! !!ly. door ly wer

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245295	B. WING			06/:	25/2015
	PROVIDER OR SUPPLIER CARE CENTER	,		42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	facility environment administrator and represent during the any stale environment administrator ment who had programs the tour two bathrosobserved to have a were dirty on the comment to These findings were director and adminion on 6/25/15 at 10:3 director was intervinew to the position odors and dirty bat working on a plant the resident bathrowas "difficult to kee had poor hygiene wodors. Deep Clean Calent for the months of Nowas no schedule you March and April so question to be deep crossed off to indicate accomplished. During the environment of R63 and Formanufactured divorsity with dark soil. The manufactured divorsity with dark soil. The multiple rooms through the street of the month of the manufactured divorsity of the manufactured divorsi	tal tour was conducted. The maintenance director were tour. They denied detecting ental odors, although the ioned there were residents to improve hygiene. During oms on 3rd floor were stale urine odors, toilets that uter surfaces, peeling paint ilet base and unclean floors. The verified by the maintenance istrator. O a.m., the housekeeping ewed. He explained he was but had recognized the stale hrooms on 3rd floor and was complete deep cleaning of oms. He explained 3rd floor to pup with as some residents which also contributed to the dar schedules were provided flarch and April, 2015. There exist for June. Although the hedules listed the bathrooms in the cleaned, they were not attended to the deep cleaning had been mental tour, the floor in the less was verified as looking vinyl floor covering had that had become filled in same vinyl was also in use in oughout the facility. At 1:30 attor reported the floor had been	F4	.65	and toilet base. All resident cabine drawers will be audited to ensure vis not loose and drawers can shut completely. All resident room door be audited to ensure doors close completely. Housekeeping staff will be educate bathroom cleaning. Maintenance veducated on ongoing maintenance cabinets, drawers and doors. Nursistaff will be educated on cleaning schairs after each use. The Correction will be completed by August 4, 2015. Recurrence will be prevented by: Random weekly audits will be comfor a period of 90 days to ensure compliance. Audit results will be similar the QA committee for recommendations for further monit. The correction will be monitored by The Administrator/Designee.	eneer s will ed on will be of sing shower y: pleted hared oring.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245295	B. WING		····	06/2	25/2015
	PROVIDER OR SUPPLIER CARE CENTER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 MARSHALL AVENUE 6AINT PAUL, MN 55102	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	have a cabinet door splintered veneer a to close. The loose posing a safety issue covering along the missing in places of these findings were director and the adravailable for intervier. The door to the rooduring the tour was The door would not preventing it from ladirector examined to believed the plastic edge of the door maclosing and stated head or was unable to the tour was unable to the tour was unable to the first and the room of resident R13 stuck out into the door from shutting a pulled around the emaintenance direct being un-aware of the stated R13 had record the maintenance of the space and not op.m. on 6/24/15, the piece had been remainter the room.	s observed during the tour to r under the sink with loose and and a drawer that was difficult veneer had sharp edges are. Also, the vinyl floor threshold to the bathroom was exposing the under flooring. The verified by the maintenance ministrator. R5 was not ew at the time of the tour. In of R25 was observed unable to be closed properly. It is that in the door frame, atching. The maintenance he door and stated he covering along the inside any be preventing the door from the had no prior knowledge the	F 4	·65			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		SURVEY PLETED
		245295	B. WING		06/2	25/2015
	PROVIDER OR SUPPLIER CARE CENTER		4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	during the tour. As the shower area. The bottom frame ocushion. A houseked determine if the state housekeeper was a rag and cleaning stated the policy was use. A policy from the codated 1/1/2001, indicated the shower area.	ge 10 shower chair was in place in There were brown stains along if the chair and on the seat epper was called in to ins could be wiped clean. The able to wipe off the stains with spray. The administrator as to clean the equipment after ontracted cleaning company, icated a guiding principle "To (resident, families, visitiors and	F 465			
F 467 SS=E	employees) with the concentration on consystems operations 483.70(h)(2) ADEC VENTILATION-WINTHE facility must haventilation by mean	e best service possible with a possible mith a possible mith a control and s." BUATE OUTSIDE	F 467			8/4/15
	by: Based on observatifailed to provide probathrooms. This haresidents (R9, R12, R144) who utilized 90 residents who refindings include: On 6/24/15 at 10:30 tour was conducted.	NT is not met as evidenced tion and interview, the facility oper ventilation in 3 ad the potential to affect 7, R71, R94, R107, R117 and the shared bathrooms of the esided in the facility. O a.m., a facility environmental d. The administrator and or were present during the		Immediate corrective action: The rooftop motor was repaired on 6/24/15 so the vents in all three bathrooms are now taking air in an functioning properly. Corrective Action as it applies to ot All resident bathrooms will be audit ensure the vents are working proper Maintenance will be educated on ventilation requirements. Bathroom ventilation will be added to the preventative maintenance system.	d hers: ted to erly.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		245295	B. WING			06/25/2015
	PROVIDER OR SUPPLIER CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 420 MARSHALL AVENUE SAINT PAUL, MN 55102	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 467	bathroom vents to on There were no vent areas to draw air out areas to draw and the roof to draw one stack were obscovered over with one of the preventing any air for the maintenance of the drawing out. The explained that the four the the wrong direction the had not been away covered and thought areas to draw are and thought areas to draw air out areas to draw	entilation system utilized draw air out of the facility. s in the hallways or common	F 4	The Correction will be completed August 4, 2015 Recurrence will be prevented Random weekly audits will be for a period of 90 days to enscompliance. Audit results with the QA committee for recommendations for further The correction will be monited The Administrator/Designee	d by: e complet sure Il be shar	ed

PRINTED: 07/21/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 06/29/2015 245295 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **420 MARSHALL AVENUE BETHEL CARE CENTER** SAINT PAUL, MN 55102 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Bethel Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS** STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: (X6) DATE

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

TITLE

Electronically Signed

07/16/2015

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.

CENTE	19 LOK MEDICAKE	& MEDICAID SERVICES		_		1	0930-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245295	B. WING			06/2	29/2015
	PROVIDER OR SUPPLIER CARE CENTER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIOI DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the deficit 2. The actual, or properties of the correct the deficit 3. The name and/oresponsible for correct a reoccurred bethel Care Center partial basement. To different times. To constructed in 1968 Type II(222) constructed in 1968 Type II(222) constructed to that was determined construction. Becauthe addition meet the addition meet the addition meet the for existing building one building. The facility is fully for a complete fire alared detection in the correction, that is modepartment notifical licensed capacity of 96 at the time of	tate.mn.us AND n@state.mn.us RRECTION FOR EACH TINCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. r title of the person rection and monitoring to ence of the deficiency. r is a 4-story building with a rhe building was constructed at the original building was and was determined to be of action. In 1982, an addition the East side of the building d to be of Type II(222) use the original building and the construction type allowed as, the facility was surveyed as are sprinkler protected and has are system with smoke ridors and spaces open to the nitored for automatic fire tion. The facility has a f 131 beds and had a census the survey.		0000			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245295	B. WING	_		06/2	29/2015
	PROVIDER OR SUPPLIER CARE CENTER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 120 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029 K 029 SS=D	One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved automoption is used, the other spaces by sm doors. Doors are sfield-applied protect.	retry code standard construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When hatic fire extinguishing system areas are separated from hoke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are)29)29			8/4/15
	Based on observatifailed to provide proaccordance with the -2000 edition, Section Findings include: On facility tour betton 06/29/2015, it with 1) 2nd floor Soiled did not fully close at 2) 1st floor Laundry not fully close and I This deficiency was	Utility Room door to corridor and latch when tested. y Room door to corridor did atch when tested. s verified by the facility Director			1. The 2nd floor Soiled Utility Room to corridor has been repaired so that fully closes and latches. The 1st flot Laundry Room door to corridor has repaired so that it fully closes and la 2. The completion date was July 7, 2 3. The Maintenance Director is responsible for correction and monit to prevent a re-occurrence.	t it or been tches. 2015.	
K 052 SS=C	at the time of disco NFPA 101 LIFE SA A fire alarm system	d Maintenance upervisor (JS) very FETY CODE STANDARD required for life safety is d maintained in accordance	K)52			8/4/15

PRINTED: 07/21/2015 FORM APPROVED OMB NO. 0938-0391

CLIVIL	12 LOK MEDICAKE	& MEDICAID SERVICES				10 110.	0930-038
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01		SURVEY PLETED
		245295	B. WING			06/2	29/2015
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE MARSHALL AVENUE		
BETHEL	CARE CENTER			SA	INT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 052	72. The system has and testing program	ge 3 nal Electrical Code and NFPA s an approved maintenance n complying with applicable PA 70 and 72. 9.6.1.4	КС	052			
K 054 SS=D	Based on review of interview,, it was do to properly maintain accordance with Ni deficient practice or including patients, so Findings include: On facility tour betwon 06/29/2015, it was alarm documentation tested on a monthly tests conducted du This deficiency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and at the time of disconsistency was of Nursing (SR) and the time of disconsistency was of Nursi	veen 12:30 PM and 04:30 PM as noted during review of fire on that the DACT has not been by basis. No documentation of ring 10 of the last 12 months. Is verified by the facility Director Maintenance upervisor (JS)	K		1. The Maintenance Director will er all required monthly testing is comp and will obtain all required documer including DACT testing, on a month basis when testing the fire alarm sy 2. The completion date will be Augu 2015. 3. The Maintenance Director is responsible for correction and monito prevent a re-occurrence.	leted ntation, ly stem. ist 4,	8/4/15

Event ID: P56521

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245295	B. WING			06/	29/2015
	PROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 054	Continued From pa	age 4	K)54			
K 062 SS=D	Based on record in detectors, including hold-open devices, inspected and teste manufacturer's specifindings include: On facility tour betwon 06/29/2015, it were without there we detector sensitivity This deficiency was of Nursing (SR) and at the time of disconsisted automatic continuously maint condition and are in	ween 12:30 PM and 04:30 PM ras revealed during record ras no documentation of smoke testing. s verified by the facility Director d Maintenance upervisor (JS)	K	062	1. The documented smoke detect sensitivity testing will be obtained contracted vendor that tests the fasmoke detectors. The required documentation will be obtained from contracted vendor on a monthly be 2. The completion date will be Aug 2015. 3. The Maintenance Director is responsible for correction and moto prevent a re-occurrence.	from the acility's om the asis. gust 4,	8/4/15
	Based on observa interview the comp system is not being with NFPA 25(99) S practice could effect if the system were Findings include:	s not met as evidenced by: tion, record review and lete automatic fire sprinkler maintained in accordance Section 9.2.7. This deficient all occupants of the building to fail under fire conditions. veen 12:30 PM and 04:30 PM			The documented sprinkler flow will be obtained from the contracted vendor that tests the facility's autofire sprinkler system. The required documentation will be obtained from the wires strapped to the sprinkle in 4th floor central area and 2nd floroom 210 will be removed.	ed matic d om the asis. r piping	

PRINTED: 07/21/2015 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 245295 06/29/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **420 MARSHALL AVENUE BETHEL CARE CENTER** SAINT PAUL, MN 55102 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 062 | Continued From page 5 K 062 2. The completion date will be August 4, on 06/29/2015, it was observed and revealed during review of available fire sprinkler records 2015. 3. The Maintenance Director is that: responsible for correction and monitoring 1) There was no documentation for quarterly sprinkler flow testing in the last 12 months. to prevent a re-occurrence. 2) Wires are strapped to the sprinkler piping in the following areas: A) 4th floor central area. B) 2nd floor room 210. This deficiency was verified by the facility Director of Nursing (SR) and Maintenance upervisor (JS) at the time of discovery NFPA 101 LIFE SAFETY CODE STANDARD K 067 K 067 8/4/15 SS=C Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1. 9.2. NFPA 90A. 19.5.2.2 This STANDARD is not met as evidenced by: Based on review of records and interview, the 1. The documented smoke/fire damper test and inspection will be obtained from facility failed to maintain the ventilation system in accordance with the provisions of section 9.2 and the contracted vendor that tests that facility's ventilation system. The required are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, documentation will be obtained from the NFPA 90A, 19.5.2.2. This deficient practice contracted vendor on a monthly basis. could affect the safety of all patients, staff and 2. The completion date will be August 4, 2015. visitors. 3. The Maintenance Director is responsible for correction and monitoring Findings include: On facility tour between 12:30 PM and 04:30 PM to prevent a re-occurrence. on 06/29/2015, based on review of available

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 07/21/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	G 01 - MAIN BUILDING 01	V /	IPLETED
		245295	B. WING _		06/	29/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETI DATE
K 067 K 130 SS=D	documentation that been tested and in This deficiency was of Nursing (SR) are at the time of disconstruction NFPA 101 MISCE	vas reveled that there was no at smoke/fire dampers had aspected every four years. s verified by the facility Director and Maintenance upervisor (JS) overy	K 06			8/4/15
	Medical equipmenthe wall electrical of Findings include: On facility tour beton 06/29/2015, it vequipment was cotap in resident roo This deficiency was	ween 12:30 PM and 04:30 PM vas observed that medical nnected to a relocatable power ms 204 & 227. s verified by the facility Director of Maintenance upervisor (JS)		1. Additional outlets were insta room 204 and 227. Medical eq no longer connected to a relocation power tap. 2. The completion date was July 3. The Maintenance Director is responsible for correction and not to prevent a re-occurrence.	uipment is table y 10, 2015.	

(X2) MULTIPLE CONSTRUCTION

Event ID: P56521



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted July 8, 2015

Ms. Jennifer Schoenecker, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, Minnesota 55102

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5295024

Dear Ms. Schoenecker:

The above facility was surveyed on June 22, 2015 through June 25, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5295113 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Bethel Care Center July 8, 2015 Page 2

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist Licensing and Certification Program

Health Regulations Division

Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

Licensing and Certification File

PRINTED: 07/16/2015 FORM APPROVED

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00913	B. WING		06/2	5/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
BETHEL CARE CENTER 420 MARSHALL AVENUE SAINT PAUL, MN 55102						
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	N SHOULD BE COMPLETE	
2 000 Initial Comments			2 000			
	****ATTENTION*****					
	NH LICENSING CORRECTION ORDER					
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all rule provided at the tag ale number indicated below. In the items will be considered be the items will be considered be been been been been been been been				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. I to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

07/16/15 **Electronically Signed**

TITLE

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00913	B. WING		06/2	5/2015	
	PROVIDER OR SUPPLIER CARE CENTER	420 MARS	DRESS, CITY, S SHALL AVEN UL, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Department of Hea you electronically. Is necessary for State enter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department's provider and the fol issued. Please indicorrection that you and identify the date.	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the	2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of compl listed in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state safter the statement, "This Rule is ras evidence by." Following the sur findings are the Suggested Method Correction and Time period for Co PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES. A recertification survey was conduand complaint investigation was all completed at the time of the stand survey.	Fag." iance is of the "To order. ings statute not met veyors d of rrection. DING OF THIS ON FOR TATE cted so		
21015	Subp. 7. Sanitary oprocedures and cor	O Subp. 7 Dietary Staff nitary conditi conditions. Sanitary nditions must be maintained in dietary department at all	21015			8/4/15	

Minnesota Department of Health

STATE FORM P56511 If continuation sheet 2 of 14

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00913	B. WING		06/2	25/2015
	PROVIDER OR SUPPLIER	420 MARS	DRESS, CITY, S SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	This MN Requirements: Based on observation review, the facility for the kitchen. This has approximately 60 or facility. Findings include: An inspection of the 6/22/15 at 12:00 p.r (FSD) was present following issues we A manual can open dried on food debrised on food debrisedged, cutting mediated on food debrisedged, cutting mediated opener was also so FSD verified the state the mechanism had for cleaning. The coperation and replace opener and base. A cleaning schedule to cleaned weekly. The dirty end of the dark build up on the scratched off. The faway but had not so the wall behind the and splatters. A state back of the sink, ded dripping down the bewall and was loose along the wall behind the state of the state of the state of the sink, ded dripping down the bewall and was loose along the wall behind the state of the state of the state of the sink, ded dripping down the bewall and was loose along the wall behind the state of the state of the state of the sink, ded dripping down the bewall and was loose along the wall behind the state of the state of the state of the sink, ded dripping down the bewall and was loose along the wall behind the state of the state of the state of the sink, ded dripping down the state of the state of the sink, ded dripping down the state of the state o	ent is not met as evidenced on, interview and document ailed to maintain sanitation in ad the potential to affect if the 90 residents in the e kitchen was completed on m. The food service director during the inspection. The re found: er was heavily soiled with s around the entire blade hanism and down the shaft. to the counter holding the iled around the edges. The ate of the can opener and that if not been routinely dismantled an opener was taken out of ced with a new manual according to the posted kitchen he can opener was to be dish room was observed with e counter that could be ESD said they clean with lime	21015	corrected		

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00913	B. WING		06/2	25/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 3	21015			
	schedule lacked dir	be cleaned daily. The cleaning ection to clean the wall behind k or to scour the dishwashing				
	observation, an unical glass to show that inspected and found resident complained are often dirty. A bosome debris around "I don't want to eat knows what else is	p.m., during the supper meal dentified resident handed over tit was dirty. The cup was dito have dried on debris. The dithe dishes and silverware bull containing beets also had dithe edge. The resident said, [my beets] anymore, who in there. I always look before sident was observed using his his cup before use.				
	observed. The was 125 degrees Fahre reached a temperatemperature log ind	a.m., the dishwasher was sh water reached a temp of nheit (F) and the rinse ture of 130 degrees F. The licated wash temperature to be rinse to be at 50-100 parts per zing rinse agent.				
	on the interior walls the spray arms. Bit become lodged in for The FSD verified the interior. The FSD seed-limed on a regulation of the seed to cloud up. Also the seed cleaned on a regulation observed and found debris dried on. The representative was	d a thick dark greasy build up , ceiling and along the top of is of small foil wrappers had our of the sprays arm jets. The condition of the dishwasher stated the machine was ar basis, but detergent had ean out the greasy food debris spray arms had not been ar basis. Clean cups were do to have small bits of food the chemical sales called at 11:30 a.m. and sh temperature of 120 would				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00913	B. WING		06/2	5/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 30/2	0,2010
BETHEL	BETHEL CARE CENTER 420 MAR SAINT PA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21015	The sales represent 7/1/15 at 3:30 p.m. most likely from stated the spray arrinspected daily as the from re-circulating of the explained the state cleaned off using a verified the wash to the terminant of the monthly routing reports for the dishord of the machine was revied dishwasher was to basis. The schedule was revied dishwasher was to basis. The schedule and clean the interior of the machine was to be equipment. Also, the comprehensive system inspections of the washer was to be equipment of the than 150 F for low the machine was to least once per day in manufacturer's reconstruction.	tative was called again on He verified the build up was rches from food debris. He ms should be removed and hey can become dirty inside water and can get plugged. archy build up could be strong detergent. He again imperature could be at least erature of at least 139 F is animal fats. The preventive maintenance washer, dated 4/2/15 and red. There were no on the reports for cleaning the ine. The kitchen cleaning wed (no date). The be de-limed on a weekly e lacked instructions to check or or the spray arms. Idated) titled Foodservice cion Monitoring indicated e maintained, including ere was to be "a tem for on-going sanitation work environment in the food ." The policy indicated a wash water shall not be less emperature machines, and be thoroughly cleaned at in accordance with the commendation. THOD OF CORRECTION:	21015			
	The registered dieti	tian with the food service lop and implement cleaning				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00913	B. WING		06/2	25/2015
NAME OF PROV	IDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHEL CAF	RE CENTER		SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
prowa aud the	lls and surfaces. dits conducted. T quality committe	ine cleaning of equipment Staff could be educated and The results could be brought to	21015			
wh dis In par with Coo 483 Op Lor De He Thi ava sys sub	ug Usage; General bpart 1. General st be free from unecessary drug is A. in excessive rapy; B. for excessive. C. without adec D. in the prese ich indicate the continued. addition to the dat 4658.1310, the provisions in the decorations of Federal Respectations Manual neg-Term Care Fapartment of Heallath Care Finances standard is included in the Standard in the Standard is included in the Standard in the	al. A resident's drug regimen unnecessary drugs. An a sany drug when used: dose, including duplicate drug e duration; quate indications for its use; or nce of adverse consequences dose should be reduced or rug regimen review required in a nursing home must comply le Interpretive Guidelines for egulations, title 42, section Appendix P of the State, Guidance to Surveyors for acilities, published by the lith and Human Services, sing Administration, April 1992. Corporated by reference. It is ne Minitex interlibrary loan te Law Library. It is not	21535	corrected		8/4/15

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00913	B. WING		06/2	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 6	21535			
	residents (R165), reviewed for unnecessary medications, exceeded the physicians orders for the prescribed medication dose.					
	Findings include:					
	report, dated June 9 "Acetaminophen Talevery 6 hours as not pain index before a administration- do right mg(milligrams)/24 ht TID [three times a content of the Medication Adminis 6/1/15 - 6/30/15, idefollowing: "Acetamin by mouth three time exceed 3 grams of Start date 6/10/201 indicated R165 had times a day since a of the MAR indicate additional dose of America 18 for the MAR indicate additional dose of America 20 for the MAR indicate additional dose of America 20 for the MAR indicate additional dose of America 20 for the MAR indicate additional dose of America 20 for the MAR indicate additional dose of America 20 for the MAR indicate additional dose of America 20 for the MAR indicate additional dose of America 20 for the MAR indicate 20 f	nours. change to 1000 mg day]" Review of R165's tration Record (MAR) dated entified an order for the nophen Tablet Give 1000 mg es a day for pain Not to Acetaminophen in 24 hours 5 1400." Review of the MAR received the medication three dmission on 6/9/15. Review of R165 had received an Acetaminophen 650 mg on nich exceeded the physician				
	registered nurse (R administered 650 m had taken the "as n standing orders. Ri physician's order ar have called the on- administering the ar RN-A verified that i	on 6/25/15 at 12:15 p.m., N)-A stated the nurse who ng of Acetaminophen to R165 eeded" order from the N-A acknoweldged the current nd stated the nurse should call physician before dditional Acetaminophen. no call had been made to the ditional medication dose given ication error.				

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SUGGESTED METHOD OF CORRECTION:

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY LETED	
ANDILAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:		OCIVII	LLILD
		00913	B. WING		06/2	25/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21535	Continued From page 7		21535			
	work with the medic pharmacist to ensu for appropriate inter DON could ensure importance of moni medications. The D randomly audit resi	rsing (DON) or desigee could cal director and consultant re medications were reviewed rventions and monitoring. The the staff were educated on the toring for unnecessary OON or designee could dent records to ensure g and documentation was in				
	TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.					
21695	Subp. 4. Houseke provide housekeep necessary to maint comfortable interior	5 Subp. 4 Plant eration, & Maintenance eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, iixtures, equipment, lighting,	21695			8/4/15
	by: Based on observati interview, the facilit and comfortable ro- residents (R60) rev and failed to provid sanitary living cond R148, R63, R96 an bathrooms that wer R63) residents resi	ent is not met as evidenced on, record review, and y did not maintain a sanitary om environment for 1 of 3 iewed for urinary catheter use e a comfortable, safe and ition for 5 of 6 residents (R 24, d R21) who utilized shared te not clean, 2 of 2 (R65 and ding in a room with a dirty t (R5) residing in a room with		corrected		

Minnesota Department of Health

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00913	B. WING		06/2	25/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21695	splintered cupboard residents (R25, R13 with doors that did i	ge 8 ds and worn flooring, 3 of 3 ds and R39) residing in rooms not shut, and all residents on ed a shower chair for bathing.	21695			
	During observation was a strong odor of bed of R60. The re resident's bedding vesident's catheters resident did not res	on 6/23/15, at 9:48 a.m. there of urine near and around the sident, resident's clothing, and were all clean and dry. The system was intact. The pond to any questions or open aterview was attempted by a				
	6/24/15 at 2:05 p.m Record review reve Data Set, dated 3/3	aled a quarterly Minimum 1/15, that described the y cognitively impaired, not				
	registered nurse (R this unit, acknowled stated that he did no coming from. He si	on 6/24/15 at 2:06 p.m., N)-B, the nurse manager for liged the odor in the room and ot know where the odor was tated that this resident had eakage in the past, but none time.				
	nursing assistant (Nexperienced a signi his catheter system urine pooled on the NA-A wondered if s	on 6/24/15 at 2:07 p.m., IA)-A stated that the resident ficant leakage of urine from a few weeks ago and the floor near the resident's bed. ome of that urine had been r surface or the mats on the				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00913	B. WING		06/2	25/2015
	PROVIDER OR SUPPLIER	420 MARS	DRESS, CITY, S SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21695	floor next to the res On 6/25/15 at 9:52 observed again and The nurse manager time and he stated from the resident's mattress on the res On 6/22/15 at 1:30 observed to have a on the south wing of On 6/24/15 between facility environment administrator and in present during the tany stale environment administrator menti who had programs the tour two bathrood observed to have so were dirty on the out from the cement toi These findings were director and admini On 6/25/15 at 10:30 director was intervien new to the position, odors and dirty bath working on a plan to the resident bathrood was "difficult to kee had poor hygiene woodors. Deep Clean Calence Deep Clean Calence	ident's bed. a.m. the resident's room was a there was no urine odor. It was again interviewed at that that he had removed the mats floor and replaced the ident's bed. p.m., the 3rd floor unit was heavy musty odor particularly of resident rooms. In 10:30 a.m. and 12:00 p.m. a all tour was conducted. The naintenance director were four. They denied detecting tental odors, although the oned there were residents to improve hygiene. During oms on 3rd floor were tale urine odors, toilets that uter surfaces, peeling paint let base and unclean floors. It was a surfaced by the maintenance oder.	21695			

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Minnesota Department of Health

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	00913	B. WING	·····	06/2	5/2015
PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
CARE CENTER					
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	LD BE	(X5) COMPLETE DATE
was no schedule yet March and April sch question to be deep crossed off to indica accomplished. During the environmon of R63 and Redarkly soiled. The manufactured divotwith dark soil. The multiple rooms thropm. the administratop scrubbed and lotter of the room of R5 was have a cabinet door splintered veneer at to close. The loose posing a safety issuctovering along the missing in places extracted from the door to the room of R5 was director and the adravailable for interview. The door to the room during the tour was The door would not preventing it from ladirector examined the believed the plastice edge of the door macclosing and stated in door was unable to A bed had been platter own of resident accomplished.	et for June. Although the nedules listed the bathrooms in cleaned, they were not ate deep cleaning had been mental tour, the floor in the 65 was verified as looking vinyl floor covering had as that had become filled in same vinyl was also in use in ughout the facility. At 1:30 tor reported the floor had been toked better. It is observed during the tour to runder the sink with loose and and a drawer that was difficult veneer had sharp edges are. Also, the vinyl floor chreshold to the bathroom was exposing the under flooring. The waintenance ministrator. R5 was not ew at the time of the tour. In of R25 was observed unable to be closed properly, fit shut in the door frame, atching. The maintenance he door and stated he covering along the inside and the properly. In of R25 was observed unable to be shut properly. In of R25 was observed unable to be closed properly. It is hut in the door frame, atching. The maintenance he door and stated he covering along the inside and the properly. In of R25 was observed unable to be shut properly. In of R25 was observed unable to be closed properly. In of R25 was observed unable to be closed properly. In of R25 was observed unable to be closed properly. In of R25 was observed unable to be closed properly. In of R25 was observed unable to be closed properly. In of R25 was observed unable to be closed properly. In of R25 was observed unable to be closed properly.	21695			
	PROVIDER OR SUPPLIER CARE CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa was no schedule ye March and April sch question to be deep crossed off to indica accomplished. During the environn room of R63 and Ri darkly soiled. The wanufactured divot with dark soil. The multiple rooms thro p.m. the administrat top scrubbed and lo The room of R5 wa have a cabinet door splintered veneer at to close. The loose posing a safety issu covering along the to missing in places ex These findings were director and the adr available for intervie The door to the roof during the tour was The door would not preventing it from la director examined to believed the plastic edge of the door ma closing and stated h door was unable to A bed had been pla the room of residen R13 stuck out into to	OF CORRECTION O0913 PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 was no schedule yet for June. Although the March and April schedules listed the bathrooms in question to be deep cleaned, they were not crossed off to indicate deep cleaning had been	PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 10 was no schedule yet for June. Although the March and April schedules listed the bathrooms in question to be deep cleaned, they were not crossed off to indicate deep cleaning had been accomplished. During the environmental tour, the floor in the room of R63 and R65 was verified as looking darkly soiled. The vinyl floor covering had manufactured divots that had become filled in with dark soil. The same vinyl was also in use in multiple rooms throughout the facility. At 1:30 p.m. the administrator reported the floor had been top scrubbed and looked better. The room of R5 was observed during the tour to have a cabinet door under the sink with loose and splintered veneer and a drawer that was difficult to close. The loose veneer had sharp edges posing a safety issue. Also, the vinyl floor covering along the threshold to the bathroom was missing in places exposing the under flooring. These findings were verified by the maintenance director and the administrator. R5 was not available for interview at the time of the tour. The door to the room of R25 was observed during the tour was unable to be closed properly. The door would not fit shut in the door frame, preventing it from latching. The maintenance director examined the door and stated he believed the plastic covering along the inside edge of the door may be preventing the door from closing and stated he had no prior knowledge the door was unable to be shut properly. A bed had been placed along the inside wall of the room of residents R13 and R39. The bed for R13 stuck out into the doorway preventing the	PROVIDER OR SUPPLIER CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 10 was no schedule yet for June. Although the March and April schedules listed the bathrooms in question to be deep cleaned, they were not crossed off to indicate deep cleaning had been accomplished. During the environmental tour, the floor in the room of R63 and R66 was verified as looking darkly soiled. The vinyl floor covering had manufactured divots that had become filled in with dark soil. The same vinyl was also in use in multiple rooms throughout the facility. At 1:30 p.m. the administrator reported the floor had been top scrubbed and looked better. The room of R5 was observed during the tour to have a cabinet door under the sink with loose and splintered veneer and a drawer that was difficult to close. The loose veneer had sharp edges posing a safety issue. Also, the vinyl floor covering along the theshold to the bathroom was missing in places exposing the under flooring. These findings were verified by the maintenance director and the administrator. R5 was not available for interview at the time of the tour. The door to the room of R25 was observed during the inside edge of the door may be preventing the door from closing and stated he had no prior knowledge the door was unable to be shut properly. A bed had been placed along the inside wall of the room of residents R13 and R39. The bed for R13 stuck out into the doorway preventing the	OPPORTECTION DUMBER: 00913 BUNDING: BUNDAG: BUNDAG:

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. Bolebiild.			
		00913	B. WING		06/2	5/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	pulled around the emaintenance direct being un-aware of t stated R13 had rec. The maintenance d determined an extrathe bed could be rethe space and not op.m. on 6/24/15, the piece had been renthe room. The shower room of during the tour. A sthe shower area. The bottom frame of cushion. A houseked determine if the stathousekeeper was a a rag and cleaning stated the policy was use. A policy from the condated 1/1/2001, indeprovide our clients employees) with the concentration on consystems operations. SUGGESTED MET The facility administreview and revise prelation to the facility staff could in factors for odors in residents who are used to the state of the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in residents who are used to the facility staff could in factors for odors in the facility staff could in factors for odors in the facility staff could in factors for odors in the facility staff could in factors for odors in the facility staff could in factors for odors in the facility staff could in factors for odors in the facility staff could in factors for odors in the facility staff could in factors for odors in the facility staff	nd of the bed for privacy. The or and administrator stated he issue. The administrator ently moved into the room. irector examined the bed and a bar protruding out the end of moved so the bed would fit in occlude the doorway. At 1:30 e administrator stated the noved and the bed now fit in the 2nd floor was observed shower chair was in place in there were brown stains along fithe chair and on the seat eper was called in to ins could be wiped clean. The able to wipe off the stains with spray. The administrator as to clean the equipment after ontracted cleaning company, icated a guiding principle "To (resident, families, visitiors and e best service possible with a onsistency, quality control and	21695			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00913	B. WING		06/2	5/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
BETHEL	BETHEL CARE CENTER 420 MAR SAINT P.						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21695	and/or cleaning soil pads, etc. The adn ensure proper venti administrator or desweekly/monthly aud TIME PERIOD FOR (21) Days.	and eliminated by removing ed bedding, flooring, floor ninistrator or designee could lation in all areas. The signee could could do	21695			8/4/15	
23240	Existing Constructor Existing facilities m ventilation in the kit collection room, soi areas, except if the semiprivate, and is ventilation. Ventilat according to part 46 This MN Requirement by: Based on observati failed to provide pro bathrooms. This have residents (R9, R12, R144) who utilized 90 residents who re Findings include: On 6/24/15 at 10:30 tour was conducted maintenance direct tour. The facility ve bathroom vents to consider the consideration of the co	ust have mechanical exhaust chen, laundry, soiled linen led utility rooms, and toilet toilet area is private or provided with window ion must be provided 658.4520. ent is not met as evidenced on and interview, the facility per ventilation in 3 ad the potential to affect 7 R71, R94, R107, R117 and the shared bathrooms of the	23240	corrected		8/4/15	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00913	B. WING		06/2	25/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
BETHEL CARE CENTER 420 MARSHALL AVENUE SAINT PAUL, MN 55102						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
23240	Continued From page 13		23240			
	areas to draw air ou	ut of the facility.				
	each other for the 3 Each stack of bathr on the roof to draw one stack were obs covered over with c preventing any air fremoved, the air wa The maintenance d be drawing out. The explained that the fa the wrong direction He had not been av covered and though	s were alligned directly above of floors of resident rooms. ooms utilized a separate fan air out. Three bathrooms in erved to have the vents ardboard and duct tape, low. When the covering was as observed to be blowing in irector verified the air should a maintenance director an on the roof must be turning and needed to be corrected. ware of the vents being at the vents may have been er to prevent cold outside air				
	director of environm review and revise p maintenance and m ventilation system. on these procedure The DES could more	THOD OF CORRECTION: The nental services (DES) could rocedures related to regular nonitoring of the exhaust The DES could train all staff s and how to report concerns. nitor for continued compliance. R CORRECTION: Twenty-one				

Minnesota Department of Health STATE FORM

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