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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P565

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00913

1. 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**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/20/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **131** (L18)

13.Total Certified Beds **131** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	131			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susan Miller, HFE NE II — 08/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/07/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245295	A. Building B. Wing	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) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **08/04/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/04/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/04/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/04/2015**	ID Prefix **F0467** Reg. # **483.70(h)(2)** LSC	Correction Completed **08/04/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	09/04/2015	32984	08/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/25/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245295	A. Building B. Wing **01 - MAIN BUILDING 01**	9/3/2015

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) Date
ID Prefix	Correction Completed 07/07/2015	ID Prefix	Correction Completed 08/04/2015	ID Prefix	Correction Completed 08/04/2015
Reg. # NFPA 101		Reg. # NFPA 101		Reg. # NFPA 101	
LSC K0029		LSC K0052		LSC K0054	
ID Prefix	Correction Completed 08/04/2015	ID Prefix	Correction Completed 08/04/2015	ID Prefix	Correction Completed 07/10/2015
Reg. # NFPA 101		Reg. # NFPA 101		Reg. # NFPA 101	
LSC K0062		LSC K0067		LSC K0130	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/KJ	09/17/2015	12424	09/03/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/29/2015

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00913	A. Building B. Wing	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 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	(Y5) Date
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp. 7** LSC	Correction Completed **08/04/2015**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 ABC** LSC	Correction Completed **08/04/2015**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **08/04/2015**
ID Prefix **23240** Reg. # **MN Rule 4658.5405** LSC	Correction Completed **08/04/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KJ	09/01/2015	32984	08/20/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/25/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P565

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00913

1. 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: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/25/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **131** (L18)

13.Total Certified Beds **131** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	131			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Vidya Tomar, HFE NE II 07/17/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/06/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

<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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	06/25/2015

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation was also completed at the time of the standard survey. An investigation of complaint [H5295113] was completed. The complaint was unsubstantiated.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility did not maintain a sanitary and comfortable room environment for 1 of 3 residents (R60) reviewed for urinary catheter use. Findings include:	F 253	Immediate corrective action: On 6/24/15, R60's mattress was replaced, floor mats were removed from the room, floor was cleaned with a disinfecting solution and wheelchair was cleaned. Corrective Action as it applies to others: All resident rooms will be audited for urine	8/4/15

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

Electronically Signed | 07/16/2015

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F 253	Continued From page 1 During observation on 6/23/15, at 9:48 a.m. there was a strong odor of urine near and around the bed of R60. The resident, resident's clothing, and resident's bedding were all clean and dry. The resident's catheter system was intact. The resident did not respond to any questions or open his eyes when an interview was attempted by a surveyor. The odor near this resident's bed continued on 6/24/15 at 2:05 p.m. Record review revealed a quarterly Minimum Data Set, dated 3/31/15, that described the resident as severely cognitively impaired, not interviewable, and without speech. When interviewed on 6/24/15 at 2:06 p.m., registered nurse (RN)-B, the nurse manager for this unit, acknowledged the odor in the room and stated that he did not know where the odor was coming from. He stated that this resident had experienced urine leakage in the past, but none was present at this time. When interviewed on 6/24/15 at 2:07 p.m., nursing assistant (NA)-A stated that the resident experienced a significant leakage of urine from his catheter system a few weeks ago and the urine pooled on the floor near the resident's bed. NA-A wondered if some of that urine had been retained by the floor surface or the mats on the floor next to the resident's bed. On 6/25/15 at 9:52 a.m. the resident's room was observed again and there was no urine odor. The nurse manager was again interviewed at that time and he stated that he had removed the mats from the resident's floor and replaced the	F 253	odor to identify other residents that may be affected. Housekeeping staff will be educated on the Policy "Cleaning and Disinfecting of Environmental Surfaces". The correction will be completed by: August 4, 2015 Recurrence will be prevented by: Random weekly audits will be completed for a period of 90 days to ensure resident rooms are free of odors. Audit results will be shared with the QA committee for recommendations for further monitoring. The correction will be monitored by: Administrator/Designee	

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F 253	Continued From page 2 mattress on the resident's bed.	F 253		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, 1 of 5 residents (R165), reviewed for unnecessary medications, exceeded the physicians orders for the prescribed medication dose. Findings include:	F 329	Immediate corrective action: The MD was notified for R165 and orders were received to discontinue the PRN Acetaminophen. The Nurse who administered the Acetaminophen was re-educated.	8/4/15

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F 329	Continued From page 3 Review of R165's physician order summary report, dated June 9, 2015, R165 had an order for "Acetaminophen Tablet Give 500 mg by mouth every 6 hours as needed for pain-document on pain index before and 30 minutes after administration- do not exceed 3000 mg(milligrams)/24 hours. change to 1000 mg TID [three times a day]" Review of R165's Medication Administration Record (MAR) dated 6/1/15 - 6/30/15, identified an order for the following: "Acetaminophen Tablet Give 1000 mg by mouth three times a day for pain Not to exceed 3 grams of Acetaminophen in 24 hours Start date 6/10/2015 1400." Review of the MAR indicated R165 had received the medication three times a day since admission on 6/9/15. Review of the MAR indicated R165 had received an additional dose of Acetaminophen 650 mg on 6/22/15 at 2322, which exceeded the physician order for 3000 mg in 24 hours. When interviewed on 6/25/15 at 12:15 p.m., registered nurse (RN)-A stated the nurse who administered 650 mg of Acetaminophen to R165 had taken the "as needed" order from the standing orders. RN-A acknoweldged the current physician's order and stated the nurse should have called the on-call physician before administering the additional Acetaminophen. RN-A verified that no call had been made to the MD and that the additional medication dose given to R165 was a medication error.	F 329	Corrective Action as it applies to others: A review of residents who receive Acetaminophen will be completed to ensure the medication is administered in accordance with MD orders. The policy and procedure for Medication Administration was reviewed and remains current. Licensed nursing staff will be re-educated on 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 completed on each nursing unit for a period of 90 days to ensure residents receive Tylenol in accordance with MD orders. Audit results will be shared with the QA committee for recommendations for further monitoring. The correction will be monitored by: The Director of Nursing or designee.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		8/4/15

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F 371	Continued From page 4 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain sanitation in the kitchen. This had the potential to affect approximately 60 of the 90 residents in the facility. Findings include: An inspection of the kitchen was completed on 6/22/15 at 12:00 p.m. The food service director (FSD) was present during the inspection. The following issues were found: A manual can opener was heavily soiled with dried on food debris around the entire blade edged, cutting mechanism and down the shaft. The base attached to the counter holding the opener was also soiled around the edges. The FSD verified the state of the can opener and that the mechanism had not been routinely dismantled for cleaning. The can opener was taken out of operation and replaced with a new manual opener and base. According to the posted kitchen cleaning schedule the can opener was to be cleaned weekly. The dirty end of the dish room was observed with dark build up on the counter that could be	F 371	Immediate corrective action: The manual can opener was replaced with a new manual can opener and base. The counter at the dirty end of the dish room was cleaned. The wall behind that pot and pan sink was cleaned. The stainless steel piece along the back of the sink was caulked. The serving utensil drawer by the stove was cleaned. The dishwasher interior walls, ceiling and top of spray arms was cleaned. The contracted vendor that services the dishwasher evaluated the dishwasher on 7/2/15 and determined that the motor for the disinfecting spray arms was in need of repair. The dishwasher is scheduled for repair on 7/21/15. The dishwasher water temps were reviewed and are in acceptable range. Corrective Action as it applies to others: Dietary staff will be educated on the kitchen "Sanitization" policy. The kitchen cleaning schedule was revised to include cleaning of the wall behind the pot and pan sink, to scour the dishwashing area and to check the interior of the dishwasher. Temps will continue to be audited daily.	

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F 371	Continued From page 5 scratched off. The FSD said they clean with lime away but had not scoured the counter. The wall behind the pot and pan sink had stains and splatters. A stainless steel piece along the back of the sink, designed to keep water from dripping down the back, was not caulked to the wall and was loose allowing wash water to spill along the wall behind the sink. A serving utensil drawer by the stove had sticky build up. According to the posted cleaning schedule the cook's area was to be cleaned daily. The cleaning schedule lacked direction to clean the wall behind the pot and pan sink or to scour the dishwashing area. On 6/22/15 at 5:30 p.m., during the supper meal observation, an unidentified resident handed over a glass to show that it was dirty. The cup was inspected and found to have dried on debris. The resident complained the dishes and silverware are often dirty. A bowl containing beets also had some debris around the edge. The resident said, "I don't want to eat [my beets] anymore, who knows what else is in there. I always look before I leap." Another resident was observed using his napkin to wipe out his cup before use. On 6/25/15 at 11:00 a.m., the dishwasher was observed. The wash water reached a temp of 125 degrees Fahrenheit (F) and the rinse reached a temperature of 130 degrees F. The temperature log indicated wash temperature to be 120 degrees F and rinse to be at 50-100 parts per million for the sanitizing rinse agent. The dishwasher had a thick dark greasy build up on the interior walls, ceiling and along the top of the spray arms. Bits of small foil wrappers had become lodged in four of the sprays arm jets.	F 371	The Correction will be completed by: August 4, 2015 Recurrence will be prevented by: Random weekly audits will be completed for a period of 90 days to ensure compliance with the kitchen Sanitization policy. Audit results will be shared with the QA committee for recommendations for further monitoring. The correction will be monitored by: The Administrator/Designee	

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F 371	Continued From page 6	F 371		

The FSD verified the condition of the dishwasher interior. The FSD stated the machine was de-limed on a regular basis, but detergent had not been used to clean out the greasy food debris build up. Also the spray arms had not been cleaned on a regular basis. Clean cups were observed and found to have small bits of food debris dried on. The chemical sales representative was called at 11:30 a.m. and verified that the wash temperature of 120 would be adequate.

The sales representative was called again on 7/1/15 at 3:30 p.m. He verified the build up was most likely from starches from food debris. He stated the spray arms should be removed and inspected daily as they can become dirty inside from re-circulating water and can get plugged. He explained the starchy build up could be cleaned off using a strong detergent. He again verified the wash temperature could be at least 120 F, but, a temperature of at least 139 F is better to dissolve animal fats.

The monthly routine preventive maintenance reports for the dishwasher, dated 4/2/15 and 6/1/15, were reviewed. There were no recommendations on the reports for cleaning the interior of the machine. The kitchen cleaning schedule was reviewed (no date). The dishwasher was to be de-limed on a weekly basis. The schedule lacked instructions to check and clean the interior or the spray arms.

A facility policy (undated) titled Foodservice Department Sanitation Monitoring indicated sanitation was to be maintained, including equipment. Also, there was to be "a comprehensive system for on-going sanitation

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F 371	Continued From page 7 inspections of the work environment in the food service department." The policy indicated a temperature of the wash water shall not be less than 150 F for low temperature machines, and the machine was to be thoroughly cleaned at least once per day in accordance with the manufacturer's recommendation.	F 371		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a comfortable, safe and sanitary living condition for 5 of 6 residents (R 24, R148, R63, R96 and R21) who utilized shared bathrooms that were not clean, 2 of 2 (R65 and R63) residents residing in a room with a dirty floor, 1 of 1 resident (R5) residing in a room with splintered cupboards and worn flooring, 3 of 3 residents (R25, R13 and R39) residing in rooms with doors that did not shut, and all residents on 2nd floor who utilized a shower chair for bathing. Findings include: On 6/22/15 at 1:30 p.m., the 3rd floor unit was observed to have a heavy musty odor particularly on the south wing of resident rooms. On 6/24/15 between 10:30 a.m. and 12:00 p.m. a	F 465	R24, R63 and R21's (there was not a resident listed for R148 and R96, but the corrective action as it applies to others has ensured that their bathroom has been addressed) bathrooms were cleaned ; the toilet was scrubbed, the floor was scrubbed and the peeling paint on the toilet base was removed. The floor for 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 fully. R13's bed was adjusted so that the door to the room of R13 and R39 can fully close. The shower chair in the shower area on 2nd floor was cleaned immediately. Corrective Action as it applies to others: All resident bathrooms will be deep cleaned to include toilet surfaces, floor	8/4/15

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F 465	Continued From page 8 facility environmental tour was conducted. The administrator and maintenance director were present during the tour. They denied detecting any stale environmental odors, although the administrator mentioned there were residents who had programs to improve hygiene. During the tour two bathrooms on 3rd floor were observed to have stale urine odors, toilets that were dirty on the outer surfaces, peeling paint from the cement toilet base and unclean floors. These findings were verified by the maintenance director and administrator. On 6/25/15 at 10:30 a.m., the housekeeping director was interviewed. He explained he was new to the position, but had recognized the stale odors and dirty bathrooms on 3rd floor and was working on a plan to complete deep cleaning of the resident bathrooms. He explained 3rd floor was "difficult to keep up with" as some residents had poor hygiene which also contributed to the odors. Deep Clean Calendar schedules were provided for the months of March and April, 2015. There 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.	F 465	and toilet base. All resident cabinets and drawers will be audited to ensure veneer is not loose and drawers can shut completely. All resident room doors will be audited to ensure doors close completely. Housekeeping staff will be educated on bathroom cleaning. Maintenance will be educated on ongoing maintenance of cabinets, drawers and doors. Nursing staff will be educated on cleaning shower chairs after each use. The Correction will be completed by: August 4, 2015 Recurrence will be prevented by: Random weekly audits will be completed for a period of 90 days to ensure compliance. Audit results will be shared with the QA committee for recommendations for further monitoring. The correction will be monitored by: The Administrator/Designee	

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F 465	Continued From page 9	F 465		

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 door from shutting all the way. A curtain was pulled around the end of the bed for privacy. The maintenance director and administrator stated being un-aware of the issue. The administrator stated R13 had recently moved into the room. The maintenance director examined the bed and determined an extra bar protruding out the end of the bed could be removed so the bed would fit in the space and not occlude the doorway. At 1:30 p.m. on 6/24/15, the administrator stated the piece had been removed and the bed now fit in the room.

The shower room on the 2nd floor was observed

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F 465	Continued From page 10 during the tour. A shower chair was in place in the shower area. There were brown stains along the bottom frame of the chair and on the seat cushion. A housekeeper was called in to determine if the stains could be wiped clean. The housekeeper was able to wipe off the stains with a rag and cleaning spray. The administrator stated the policy was to clean the equipment after use. A policy from the contracted cleaning company, dated 1/1/2001, indicated a guiding principle "To provide our clients (resident, families, visitiors and employees) with the best service possible with a concentration on consistency, quality control and systems operations."	F 465		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide proper ventilation in 3 bathrooms. This had the potential to affect 7 residents (R9, R12, R71, R94, R107, R117 and R144) who utilized the shared bathrooms of the 90 residents who resided in the facility. Findings include: On 6/24/15 at 10:30 a.m., a facility environmental tour was conducted. The administrator and maintenance director were present during the	F 467	Immediate corrective action: The rooftop motor was repaired on 6/24/15 so the vents in all three bathrooms are now taking air in and functioning properly. Corrective Action as it applies to others: All resident bathrooms will be audited to ensure the vents are working properly. Maintenance will be educated on ventilation requirements. Bathroom ventilation will be added to the preventative maintenance system.	8/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

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F 467	Continued From page 11 tour. The facility ventilation system utilized bathroom vents to draw air out of the facility. There were no vents in the hallways or common areas to draw air out of the facility. Resident bathrooms were alligned directly above each other for the 3 floors of resident rooms. Each stack of bathrooms utilized a separate fan on the roof to draw air out. Three bathrooms in one stack were observed to have the vents covered over with cardboard and duct tape, preventing any air flow. When the covering was removed, the air was observed to be blowing in. The maintenance director verified the air should be drawing out. The maintenance director explained that the fan on the roof must be turning the wrong direction and needed to be corrected. He had not been aware of the vents being covered and thought the vents may have been covered in the winter to prevent cold outside air from blowing in.	F 467	The Correction will be completed by: August 4, 2015 Recurrence will be prevented by: Random weekly audits will be completed for a period of 90 days to ensure compliance. Audit results will be shared with the QA committee for recommendations for further monitoring. The correction will be monitored by: The Administrator/Designee	

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	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/29/2015**

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BETHEL CARE CENTER	**420 MARSHALL AVENUE** **SAINT PAUL, MN 55102**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE 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:	K 000	EPOC	

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us AND Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethel Care Center is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The facility is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 131 beds and had a census of 96 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 029	Continued From page 2	K 029		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 12:30 AM and 04:30 PM on 06/29/2015, it was observed that: 1) 2nd floor Soiled Utility Room door to corridor did not fully close and latch when tested. 2) 1st floor Laundry Room door to corridor did not fully close and latch when tested. This deficiency was verified by the facility Director of Nursing (SR) and Maintenance upervisor (JS) at the time of discovery	K 029	1. The 2nd floor Soiled Utility Room door to corridor has been repaired so that it fully closes and latches. The 1st floor Laundry Room door to corridor has been repaired so that it fully closes and latches. 2. The completion date was July 7, 2015. 3. The Maintenance Director is responsible for correction and monitoring to prevent a re-occurrence.	8/4/15
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance	K 052		8/4/15

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K 052	Continued From page 3 with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to properly maintain the fire alarm system in accordance with NFPA 72, 1999 Edition. This deficient practice could affect all occupants including patients, staff and visitors. Findings include: On facility tour between 12:30 PM and 04:30 PM on 06/29/2015, it was noted during review of fire alarm documentation that the DACT has not been tested on a monthly basis. No documentation of tests conducted during 10 of the last 12 months. This deficiency was verified by the facility Director of Nursing (SR) and Maintenance upervisor (JS) at the time of discovery	K 052	1. The Maintenance Director will ensure all required monthly testing is completed and will obtain all required documentation, including DACT testing, on a monthly basis when testing the fire alarm system. 2. The completion date will be August 4, 2015. 3. The Maintenance Director is responsible for correction and monitoring to prevent a re-occurrence.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	K 054		8/4/15

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K 054	Continued From page 4 This STANDARD is not met as evidenced by: Based on record review all required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 Findings include: On facility tour between 12:30 PM and 04:30 PM on 06/29/2015, it was revealed during record review that there was no documentation of smoke detector sensitivity testing. This deficiency was verified by the facility Director of Nursing (SR) and Maintenance upervisor (JS) at the time of discovery	K 054	1. The documented smoke detector sensitivity testing will be obtained from the contracted vendor that tests the facility's smoke detectors. The required documentation will be obtained from the contracted vendor on a monthly basis. 2. The completion date will be August 4, 2015. 3. The Maintenance Director is responsible for correction and monitoring to prevent a re-occurrence.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, record review and interview the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all occupants of the building if the system were to fail under fire conditions. Findings include: On facility tour between 12:30 PM and 04:30 PM	K 062	1. The documented sprinkler flow testing will be obtained from the contracted vendor that tests the facility's automatic fire sprinkler system. The required documentation will be obtained from the contracted vendor on a monthly basis. The wires strapped to the sprinkler piping in 4th floor central area and 2nd floor room 210 will be removed.	8/4/15

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K 062	Continued From page 5 on 06/29/2015, it was observed and revealed during review of available fire sprinkler records that: 1) There was no documentation for quarterly sprinkler flow testing in the last 12 months. 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	K 062	2. The completion date will be August 4, 2015. 3. The Maintenance Director is responsible for correction and monitoring to prevent a re-occurrence.	
K 067 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD 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 facility failed to maintain the ventilation system in accordance 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 deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 12:30 PM and 04:30 PM on 06/29/2015, based on review of available	K 067	1. The documented smoke/fire damper test and inspection will be obtained from the contracted vendor that tests that facility's ventilation system. The required documentation will be obtained from the contracted vendor on a monthly basis. 2. The completion date will be August 4, 2015. 3. The Maintenance Director is responsible for correction and monitoring to prevent a re-occurrence.	8/4/15

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K 067	Continued From page 6 documentation it was reveled that there was no documentation that smoke/fire dampers had been tested and inspected every four years. This deficiency was verified by the facility Director of Nursing (SR) and Maintenance upervisor (JS) at the time of discovery	K 067		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Medical equipment shall be plugged directly into the wall electrical outlet. Findings include: On facility tour between 12:30 PM and 04:30 PM on 06/29/2015, it was observed that medical equipment was connected to a relocatable power tap in resident rooms 204 & 227. This deficiency was verified by the facility Director of Nursing (SR) and Maintenance upervisor (JS) at the time of discovery	K 130	1. Additional outlets were installed in room 204 and 227. Medical equipment is no longer connected to a relocatable power tap. 2. The completion date was July 10, 2015. 3. The Maintenance Director is responsible for correction and monitoring to prevent a re-occurrence.	8/4/15

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00913	A. BUILDING: _____ B. WING _____	06/25/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 22nd through June 25th 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. An investigation of complaint [H5295113] was completed. The complaint was unsubstantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. A recertification survey was conducted and complaint investigation was also completed at the time of the standard survey.	
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		8/4/15

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21015	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain sanitation in the kitchen. This had the potential to affect approximately 60 of the 90 residents in the facility. Findings include: An inspection of the kitchen was completed on 6/22/15 at 12:00 p.m. The food service director (FSD) was present during the inspection. The following issues were found: A manual can opener was heavily soiled with dried on food debris around the entire blade edged, cutting mechanism and down the shaft. The base attached to the counter holding the opener was also soiled around the edges. The FSD verified the state of the can opener and that the mechanism had not been routinely dismantled for cleaning. The can opener was taken out of operation and replaced with a new manual opener and base. According to the posted kitchen cleaning schedule the can opener was to be cleaned weekly. The dirty end of the dish room was observed with dark build up on the counter that could be scratched off. The FSD said they clean with lime away but had not scoured the counter. The wall behind the pot and pan sink had stains and splatters. A stainless steel piece along the back of the sink, designed to keep water from dripping down the back, was not caulked to the wall and was loose allowing wash water to spill along the wall behind the sink. A serving utensil drawer by the stove had sticky build up. According to the posted cleaning schedule the	21015	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00913	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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21015	Continued From page 3 cook's area was to be cleaned daily. The cleaning schedule lacked direction to clean the wall behind the pot and pan sink or to scour the dishwashing area. On 6/22/15 at 5:30 p.m., during the supper meal observation, an unidentified resident handed over a glass to show that it was dirty. The cup was inspected and found to have dried on debris. The resident complained the dishes and silverware are often dirty. A bowl containing beets also had some debris around the edge. The resident said, "I don't want to eat [my beets] anymore, who knows what else is in there. I always look before I leap." Another resident was observed using his napkin to wipe out his cup before use. On 6/25/15 at 11:00 a.m., the dishwasher was observed. The wash water reached a temp of 125 degrees Fahrenheit (F) and the rinse reached a temperature of 130 degrees F. The temperature log indicated wash temperature to be 120 degrees F and rinse to be at 50-100 parts per million for the sanitizing rinse agent. The dishwasher had a thick dark greasy build up on the interior walls, ceiling and along the top of the spray arms. Bits of small foil wrappers had become lodged in four of the sprays arm jets. The FSD verified the condition of the dishwasher interior. The FSD stated the machine was de-limed on a regular basis, but detergent had not been used to clean out the greasy food debris build up. Also the spray arms had not been cleaned on a regular basis. Clean cups were observed and found to have small bits of food debris dried on. The chemical sales representative was called at 11:30 a.m. and verified that the wash temperature of 120 would be adequate.	21015		

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21015	Continued From page 4 The sales representative was called again on 7/1/15 at 3:30 p.m. He verified the build up was most likely from starches from food debris. He stated the spray arms should be removed and inspected daily as they can become dirty inside from re-circulating water and can get plugged. He explained the starchy build up could be cleaned off using a strong detergent. He again verified the wash temperature could be at least 120 F, but, a temperature of at least 139 F is better to dissolve animal fats. The monthly routine preventive maintenance reports for the dishwasher, dated 4/2/15 and 6/1/15, were reviewed. There were no recommendations on the reports for cleaning the interior of the machine. The kitchen cleaning schedule was reviewed (no date). The dishwasher was to be de-limed on a weekly basis. The schedule lacked instructions to check and clean the interior or the spray arms. A facility policy (undated) titled Foodservice Department Sanitation Monitoring indicated sanitation was to be maintained, including equipment. Also, there was to be "a comprehensive system for on-going sanitation inspections of the work environment in the food service department." The policy indicated a temperature of the wash water shall not be less than 150 F for low temperature machines, and the machine was to be thoroughly cleaned at least once per day in accordance with the manufacturer's recommendation. SUGGESTED METHOD OF CORRECTION: The registered dietitian with the food service director could develop and implement cleaning	21015		

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21015	Continued From page 5 procedures for routine cleaning of equipment walls and surfaces. Staff could be educated and audits conducted. The results could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, 1 of 5	21535	corrected	8/4/15

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	00913	A. BUILDING: _____ B. WING _____	06/25/2015

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21535	Continued From page 6	21535		

residents (R165), reviewed for unnecessary medications, exceeded the physicians orders for the prescribed medication dose.

Findings include:

Review of R165's physician order summary report, dated June 9, 2015, R165 had an order for "Acetaminophen Tablet Give 500 mg by mouth every 6 hours as needed for pain-document on pain index before and 30 minutes after administration- do not exceed 3000 mg(milligrams)/24 hours. change to 1000 mg TID [three times a day]" Review of R165's Medication Administration Record (MAR) dated 6/1/15 - 6/30/15, identified an order for the following: "Acetaminophen Tablet Give 1000 mg by mouth three times a day for pain Not to exceed 3 grams of Acetaminophen in 24 hours Start date 6/10/2015 1400." Review of the MAR indicated R165 had received the medication three times a day since admission on 6/9/15. Review of the MAR indicated R165 had received an additional dose of Acetaminophen 650 mg on 6/22/15 at 2322, which exceeded the physician order for 3000 mg in 24 hours.

When interviewed on 6/25/15 at 12:15 p.m., registered nurse (RN)-A stated the nurse who administered 650 mg of Acetaminophen to R165 had taken the "as needed" order from the standing orders. RN-A acknoweldged the current physician's order and stated the nurse should have called the on-call physician before administering the additional Acetaminophen. RN-A verified that no call had been made to the MD and that the additional medication dose given to R165 was a medication error.

SUGGESTED METHOD OF CORRECTION:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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21535	Continued From page 7 The Director of Nursing (DON) or desigee could work with the medical director and consultant pharmacist to ensure medications were reviewed for appropriate interventions and monitoring. The DON could ensure the staff were educated on the importance of monitoring for unnecessary medications. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21535		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the facility did not maintain a sanitary and comfortable room environment for 1 of 3 residents (R60) reviewed for urinary catheter use and failed to provide a comfortable, safe and sanitary living condition for 5 of 6 residents (R 24, R148, R63, R96 and R21) who utilized shared bathrooms that were not clean, 2 of 2 (R65 and R63) residents residing in a room with a dirty floor, 1 of 1 resident (R5) residing in a room with	21695	corrected	8/4/15

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	00913	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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21695	Continued From page 8 splintered cupboards and worn flooring, 3 of 3 residents (R25, R13 and R39) residing in rooms with doors that did not shut, and all residents on 2nd floor who utilized a shower chair for bathing. Findings include: During observation on 6/23/15, at 9:48 a.m. there was a strong odor of urine near and around the bed of R60. The resident, resident's clothing, and resident's bedding were all clean and dry. The resident's catheter system was intact. The resident did not respond to any questions or open his eyes when an interview was attempted by a surveyor. The odor near this resident's bed continued on 6/24/15 at 2:05 p.m. Record review revealed a quarterly Minimum Data Set, dated 3/31/15, that described the resident as severely cognitively impaired, not interviewable, and without speech. When interviewed on 6/24/15 at 2:06 p.m., registered nurse (RN)-B, the nurse manager for this unit, acknowledged the odor in the room and stated that he did not know where the odor was coming from. He stated that this resident had experienced urine leakage in the past, but none was present at this time. When interviewed on 6/24/15 at 2:07 p.m., nursing assistant (NA)-A stated that the resident experienced a significant leakage of urine from his catheter system a few weeks ago and the urine pooled on the floor near the resident's bed. NA-A wondered if some of that urine had been retained by the floor surface or the mats on the	21695		

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	00913	A. BUILDING: _____ B. WING _____	06/25/2015

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BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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21695	Continued From page 9 floor next to the resident's bed. On 6/25/15 at 9:52 a.m. the resident's room was observed again and there was no urine odor. The nurse manager was again interviewed at that time and he stated that he had removed the mats from the resident's floor and replaced the mattress on the resident's bed. On 6/22/15 at 1:30 p.m., the 3rd floor unit was observed to have a heavy musty odor particularly on the south wing of resident rooms. On 6/24/15 between 10:30 a.m. and 12:00 p.m. a facility environmental tour was conducted. The administrator and maintenance director were present during the tour. They denied detecting any stale environmental odors, although the administrator mentioned there were residents who had programs to improve hygiene. During the tour two bathrooms on 3rd floor were observed to have stale urine odors, toilets that were dirty on the outer surfaces, peeling paint from the cement toilet base and unclean floors. These findings were verified by the maintenance director and administrator. On 6/25/15 at 10:30 a.m., the housekeeping director was interviewed. He explained he was new to the position, but had recognized the stale odors and dirty bathrooms on 3rd floor and was working on a plan to complete deep cleaning of the resident bathrooms. He explained 3rd floor was "difficult to keep up with" as some residents had poor hygiene which also contributed to the odors. Deep Clean Calendar schedules were provided for the months of March and April, 2015. There	21695		

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21695	Continued From page 10	21695		

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 door from shutting all the way. A curtain was

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	00913	A. BUILDING: _____ B. WING _____	06/25/2015

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BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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21695	Continued From page 11	21695		

pulled around the end of the bed for privacy. The maintenance director and administrator stated being un-aware of the issue. The administrator stated R13 had recently moved into the room. The maintenance director examined the bed and determined an extra bar protruding out the end of the bed could be removed so the bed would fit in the space and not occlude the doorway. At 1:30 p.m. on 6/24/15, the administrator stated the piece had been removed and the bed now fit in the room.

The shower room on the 2nd floor was observed during the tour. A shower chair was in place in the shower area. There were brown stains along the bottom frame of the chair and on the seat cushion. A housekeeper was called in to determine if the stains could be wiped clean. The housekeeper was able to wipe off the stains with a rag and cleaning spray. The administrator stated the policy was to clean the equipment after use.

A policy from the contracted cleaning company, dated 1/1/2001, indicated a guiding principle "To provide our clients (resident, families, visitiors and employees) with the best service possible with a concentration on consistency, quality control and systems operations."

SUGGESTED METHOD OF CORRECTION:
The facility administrator or designee could review and revise policies and procedures in relation to the facility's preventative and ongoing maintenance and housekeeping program. The facility staff could investigate to determine causal factors for odors in residents rooms, specific to residents who are unable to communicate preferences, to assure the source of unpleasant

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	00913	A. BUILDING: _____ B. WING _____	06/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL CARE CENTER	420 MARSHALL AVENUE SAINT PAUL, MN 55102

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21695	Continued From page 12 odors are identified and eliminated by removing and/or cleaning soiled bedding, flooring, floor pads, etc . The administrator or designee could ensure proper ventilation in all areas. The administrator or designee could could do weekly/monthly audits for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21695		
23240	MN Rule 4658.5405 Ventilation Requirements; Existing Constructn Existing facilities must have mechanical exhaust ventilation in the kitchen, laundry, soiled linen collection room, soiled utility rooms, and toilet areas, except if the toilet area is private or semiprivate, and is provided with window ventilation. Ventilation must be provided according to part 4658.4520. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to provide proper ventilation in 3 bathrooms. This had the potential to affect 7 residents (R9, R12, R71, R94, R107, R117 and R144) who utilized the shared bathrooms of the 90 residents who resided in the facility. Findings include: On 6/24/15 at 10:30 a.m., a facility environmental tour was conducted. The administrator and maintenance director were present during the tour. The facility ventilation system utilized bathroom vents to draw air out of the facility. There were no vents in the hallways or common	23240	corrected	8/4/15

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	00913	A. BUILDING: _____ B. WING _____	06/25/2015

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
23240	Continued From page 13 areas to draw air out of the facility. Resident bathrooms were alligned directly above each other for the 3 floors of resident rooms. Each stack of bathrooms utilized a separate fan on the roof to draw air out. Three bathrooms in one stack were observed to have the vents covered over with cardboard and duct tape, preventing any air flow. When the covering was removed, the air was observed to be blowing in. The maintenance director verified the air should be drawing out. The maintenance director explained that the fan on the roof must be turning the wrong direction and needed to be corrected. He had not been aware of the vents being covered and thought the vents may have been covered in the winter to prevent cold outside air from blowing in. SUGGESTED METHOD OF CORRECTION: The director of environmental services (DES) could review and revise procedures related to regular maintenance and monitoring of the exhaust ventilation system. The DES could train all staff on these procedures and how to report concerns. The DES could monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	23240		