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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q625

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**

2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

4. TYPE OF ACTION: **7**

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 **07/29/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **124** (L18)

13.Total Certified Beds **124** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	124			
(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 :
Lyla Burkman, Unit Supervisor 08/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/15/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/25/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5500

August 5, 2014

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

Dear Mr. Cerney:

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 July 22, 2014 the above facility is certified for:

124 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 124 skilled nursing facility beds located in rooms .

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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 5, 2014

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500024

Dear Mr. Cerney:

On June 20, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 12, 2014. This survey found the most serious deficiencies 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 July 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 28, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 22, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2014, effective July 22, 2014 and therefore remedies outlined in our letter to you dated June 20, 2014, will not be imposed.

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

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

Sincerely,

Mark Meath

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

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

5500r14

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
245500	A. Building B. Wing	7/29/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **07/22/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **07/22/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/22/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/22/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	08/05/2014	28035	07/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/12/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245500	A. Building B. Wing **01 - MAIN BUILDING**	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0011	Correction Completed **07/15/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 08/05/2014	**Signature of Surveyor:** 27200	**Date:** 07/28/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 6/11/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q625

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**

2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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 **06/12/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **124** (L18)

13.Total Certified Beds **124** (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
	124			
(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 :
Jane Aandal, HFE NEII — 07/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/22/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 20, 2014

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500024

Dear Mr. Cerney:

On June 12, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 July 22, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction. If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by September 12, 2014 (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 12, 2014 (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.

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INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly resolve a resident grievance when 1 of 1 resident (R36) reported missing clothing. Findings include: R36's admission Minimum Data Set (MDS) dated 5/6/14, indicated R36 was cognitively intact. On 6/10/14, at 8:41 a.m. R36 stated he had lost clothing which included 2-3 jogging pants and shirts. R36 stated he had notified the nursing staff	F 166	F 166 #1 Resident #36. Grievance of missing clothing was resolved with resident on June 12th, 2014. #2 All residents were interviewed per facility audit for missing clothing and action taken as appropriate. Completed on 7/10/2014. #3 Re-Education of all staff on labeling and marking clothing will be completed by July 10th 2014. #4 Audits will be done by laundry supervisor or designee for 5 residents per	7/22/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/15/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245500	A. BUILDING _____ B. WING _____	06/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(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 166	Continued From page 1 and they stated they would, "check on it." R36 stated he did not know if the nurses were still looking for the items. On 6/11/14, at 1:09 p.m. the laundry supervisor (LS) stated upon admission to the facility, the admissions coordinator would indicate if the facility or the family would be responsible for laundering the resident's clothing. The LS stated when family brought in clothing for the residents, they needed to notify the nursing staff and let laundry know, however, the LS stated that did not always occur. The LS stated she had not been told that R36 was missing clothing. The LS stated on a weekly basis, she would bring a rack of missing clothing to the station for the staff, residents or therapists to identify missing items and it was facility policy to keep the clothing for 30 and sometimes up to 60 days. Additionally, the LS stated it was nursing staffs responsibility to call the laundry department and leave a message when a resident was missing clothing. On 6/12/14, at 8:40 a.m. NA-A confirmed on 6/9/14, R36's spouse told her R36 was missing some clothes so she told registered nurse (RN)-C that same day about the missing clothes. NA-A stated it was facility procedure to inform the nurse and if they saw a laundry staff they would also let them know. NA-A stated there were no forms on the station to fill out when a resident stated they had lost items. On 6/12/14, at 9:35 a.m. the LS stated she had a procedure for lost items which was dated 2006. The LS stated staff had not been filling out the lost and found forms. The LS stated when the facility went to an electronic health record they got rid of the forms. The LS stated she had	F 166	week for missing clothing for 2 months. Results will be reported to the QA committee for further recommendations.	

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F 166	Continued From page 2 spoken with the guest coordinator yesterday who called R36's spouse and was told there was about 200 dollars worth of R36's clothes that were missing. The LS stated they had "lost communication" between the nursing and laundry department. At 9:49 a.m. RN-B stated if a resident was missing clothing they would tell the social worker and she would inform the laundry department. RN-B stated the notification to the social worker was not put in writing. RN-B stated she was not aware R36 was missing clothing. At 9:58 a.m. the social worker and RN-C stated they were both unaware of R36's missing clothing. At 10:01 a.m. RN-C stated she had spoke with NA-A who confirmed the conversation related to the missing clothes, however, RN-C stated she did not remember the conversation. The RESIDENT'S LOST AND FOUND policy dated 11/06, indicated a record would be kept of lost and found articles.	F 166		
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, interview and document	F 253	F 253	7/22/14

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F 253	Continued From page 3 review, the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary and odor free environment for 1 of 1 resident (R46) room with a pervasive urine odor. Findings include: R46's quarterly Minimum Data Set (MDS) dated 5/16/14, identified R46's diagnoses as neurogenic bladder, Parkinson's disease and had a suprapubic catheter (catheter that is inserted into the bladder right above the pubic region). The MDS also indicated R46 had intact cognition, was independent with ambulation, dressing, grooming and requiring limited assistance with toileting and supervision with bathing. R46's Urinary Care Area Assessment (CAA) dated 5/16/14, indicated R46 utilized a suprapubic catheter for the treatment of urinary retention and neurogenic bladder. The CAA also indicated R46 utilized a belly urinary drainage bag during the day and a standard urinary drainage bag at night and indicated the staff were to assist R46 with changing the drainage bags as needed. R46's care plan dated 11/2/12, indicated R46 was able to empty the belly urinary bag into a hat (collection device) independently and directed staff to check R46's toilet hourly to empty the urine collection container as needed. On 6/9/14, at 6:47 p.m. R46's room was noted to have a strong pervasive urine odor in the room which permeated into the hallway outside of the room.	F 253	#1 Resident #46 room was cleaned regarding odor on June 13th 2014. #2 All residents rooms were audited for sanitary conditions and odor and appropriate action taken as needed. This was completed on June 13th, 2014. #3 Re-Education of all staff regarding cleanliness of rooms and odor prevention will be completed on July 17th, 2014. #4 Environmental services or designee will conduct audits on 5 resident rooms per week X2 months with results to QA for further recommendations.	

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F 253	Continued From page 4 On 6/10/14, at 2:18 p.m. R46's room was noted to have a strong urine smell combined with pungent perfume smell. On 6/11/14, at 7:01 a.m. R46 was observed to walk out of her room. The strong urine combined with perfume odors followed R46. R46 stated she had removed the drainage bag and had applied the belly urinary bag independently. On 6/11/14, at 9:30 a.m. the pervasive urine and perfume combination odor was noted on in the hall two doors away from R46's room. On 6/11/14, at 9:32 a.m. nursing assistant (NA)-B confirmed R46 usually had a strong urine odor. On 6/11/14, at 9:32 a.m. licensed practical nurse (LPN)-A stated she had noticed a urine odor at times coming from R46's room because R46 did not flush the toilet after emptying the belly urinary bag. On 6/11/13, at 11:10 a.m. LPN-A stated she had requested the maintenance department wash R46's room carpet in an attempt to reduce the urine odor. She stated she was not sure if the carpet was the source of the odor, but stated it may help decrease some of the odors. On 6/11/14, at 11:15 a.m. the pervasive urine and perfume odor was noted outside of R46's room. On 6/12/14, at 8:00 a.m. registered nurse (RN)-A confirmed R46's room usually had a strong urine and perfume combination smell. RN-A stated this was the "normal" aroma of R46. She stated the maintenance department would be cleaning the carpet in an attempt to decrease the odor.	F 253		

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F 253	Continued From page 5 A policy related to odor control was requested and none was provided.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for 1 of 1 resident (R36) who received dialysis from an outside service. Findings include:	F 279	F 279 #1 Resident #36 care plan was reviewed and updated with necessary dialysis information on June 12th 2014. #2 All residents receiving dialysis care plans were reviewed and updated as appropriate by June 12th, 2014. #3 Re-Education will be provided to	7/22/14

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F 279	Continued From page 6 R36's admission Minimum Data Set (MDS) dated 5/6/14, indicated R36 was cognitively intact. The MDS also indicated R36 was diagnosed with end stage renal disease. R36's care plan dated 4/29/14, indicated R36 required dialysis (the clinical purification of the blood) related to renal failure. The interventions included: monitor for signs/symptoms of bleeding, hemorrhage, change in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds and for signs/symptoms of infection to the access site which was located in the right chest area. The care plan directed staff to relieve any discomfort related to the side effects of treatment. Interventions related to a 1500 cubic centimeter (CC) fluid restriction were also identified. However, the care plan lacked identification of the frequency to monitor the access site, the frequency of the access site dressing change or who was responsible to provide those treatments, where R36 dialyzed and what to do or contact information in case of dialysis related emergency (bleeding) or inclement weather. In addition, the provision of a risk / benefit statement related to R36's noncompliance of the 1500 cc daily fluid restriction was not identified on the care plan. On 6/11/14, at 9:23 a.m. R36 was observed in bed in his room. The dialysis access site was observed to be a port in R36's right chest covered with a dressing. R36 stated the dressing was changed three times a week at the dialysis unit. On 6/12/14, at 8:59 a.m. registered nurse (RN)-B stated R36 frequently went over his daily 1500 cc fluid restriction and confirmed the risk/benefit	F 279	station managers and licensed nurses on policy and procedure for dialysis care planning. The purpose of the dialysis handbook and communication book located on each station will also be reviewed with all nurses on July 17th 2014. #4 Audits of dialysis care plans for resident #36 and random other residents on dialysis will be done by DNS or designee upon admission and weekly X4 then monthly X3. Results will be taken to QA committee for further recommendations.	

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F 279	Continued From page 7 statement which had been given to R36 was lacking from the care plan. RN-B also verified R36's care plan lacked the frequency of the access site monitoring, emergency related procedures and who was responsible for access site dressing changes. RN-C stated R36 was receiving outside dialysis services Tuesday, Thursday and Saturdays and verified that information along with the contact information was lacking from the care plan At 9:21 a.m. RN-B and the director of nursing verified the care plan was not comprehensive related to dialysis care. The DIALYSIS SERVICES policy dated 9/12, indicated at a minimum the dialysis care plan would include procedures for medical and non-medical emergencies, including but not limited to complications, equipment failure etc. In addition, the care plan would include resident education, follow-up care, observation and monitoring.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 309	F 309	7/22/14

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F 309	Continued From page 8 review, the facility failed to provide proper wheelchair positioning for 1 of 3 residents (R55) reviewed for wheelchair positioning needs. Findings include: R55's quarterly Minimum Data Set (MDS) dated 4/10/14, indicated R55's diagnoses included depression and dementia. The MDS also indicated R55 had severe cognitive impairment, required extensive assistance with all activities of daily living and utilized a wheelchair. R55's care plan dated 10/24/12, indicated R55 had limited physical mobility related to a history of a stroke. The care plan indicated R55 utilized a wheelchair for mobility, however, did not identify the use of any adaptive devices added to the wheelchair. On 6/10/14, at 3:40 p.m. R55, a resident of short stature was observed seated in a wheelchair in the dining room. R55's wheelchair was observed to be equipped with a 6-8 inch foam bolster (lateral support) on the right arm rest. The arm rests of the chair were approximately 2-3 inches below the height of R55's shoulders. The back of the wheelchair was observed approximately 1- 2 inches below the back of R55's head. While seated by the dining room table, R55 was able to reach the items on the table, yet was not able to rest her arms on the arm rests of the wheelchair without extending her shoulders. On 6/11/14, at 8:35 a.m. R55 was observed in the wheelchair. The right sided arm rest bolster was in place. R55 was not observed to utilize the arm rests.	F 309	#1 Resident #55 wheelchair positioning was evaluated by occupational therapy for wheelchair positioning on June 18th 2014. #2 All residents were observed for proper wheelchair positioning with referrals and/or Care plan updates made as appropriate. This was completed on June 18th, 2014. #3 Re-Education will be done for all station directors and licensed nurses on July 17th 2014 regarding proper wheelchair positioning. #4 Audits will be done for resident #55 and random other residents to ensure proper wheelchair positioning on all stations by the DNS or designee weekly X4 and then monthly X3. The results to be reported to QA for further recommendation. #5 Completion date July 22nd, 2014	

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F 309	Continued From page 9 On 6/11/14, at 12:20 p.m. R55 was observed in the wheelchair with the right sided support bolster in place. R55's arms were not on the arm rests. R55 was observed to propel herself in the wheelchair using her feet. Although, R55 was not observed to use her arms to propel the wheelchair, the armrests and bolster were observed to prevent R55 from being able to reach the wheels. The Occupational Therapist Progress and Discharge Summary dated 10/11/12, revealed R55 was to have a 1/2 lap tray on the wheelchair and the wheelchair seat had been lowered to allow R55 to be able to wheel herself. The discharge summary did not mention the support bolster. On 6/11/14, at 1:30 p.m. registered nurse (RN)-A stated R55 had utilized the same chair for a long time. She reported she had found the chair for her over a year ago and had given it to R55 because it was smaller than the chair she had been using. RN-A stated R55 was able to propel the chair with her feet and did not attempt to propel the chair with her arms. RN-A confirmed the plan of care did not mention the bolster which R55 utilized and did not mention the lap tray which had been issued by occupational therapy in 2012. On 6/12/14, at 8:58 a.m. along with the director of nursing (DON), R55 was observed seated in the wheelchair in the dinning room. The DON confirmed R55 did not sit well in her wheelchair. R55's arm rests were observed too high for her to utilize the wheels and the back of the chair was also too high for R55's physical stature. The DON confirmed R55 may benefit from a	F 309		

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F 309	Continued From page 10 wheelchair positioning evaluation. She verified R55 had not been evaluated by occupational therapy for wheelchair positioning since 2012, and stated she had requested a re-evaluation to be completed. The Mobility Support and Positioning policy revised on 11/2013, directed staff to provide proper body alignment for residents in wheelchairs. The policy directed staff to ensure the back height of the chair reached the middle of the scapula bones. The policy did not address the position of the arm rest.	F 309		
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.	F 329		7/22/14

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F 329	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R44) received side effect monitoring when receiving an antipsychotic medication (Risperdal). Findings include: R44's admission Minimum Data Set (MDS) dated 5/22/14, indicated R44 was cognitively intact. The Diagnosis Report dated 5/28/14, indicated R44 was diagnosed with hallucinations (apparent perception of something not present). R44's care plan dated 5/15/14, indicated R44 had episodes of visual and auditory hallucinations. R44's physician orders indicated on 5/28/14, R44 was prescribed Risperdal 0.5 milligrams (mg) daily and on 6/3/14, the Risperdal 0.5 mg was increased to twice daily. On 6/12/14, at 10:13 a.m. registered nurse (RN)-B verified there had been no side effect monitoring done related to R44's use of the Risperdal. RN-B stated their process was to do an assessment if the resident was admitted on an antipsychotic medication. RN-B stated since R44 was not admitted on the medication it was "missed." RN-B stated it would be the nurse / station manager's responsibility when processing	F 329	F 329 #1 Resident #44 was assessed using the AIMS on June 12th, 2014. #2 All residents receiving antipsychotic medications were reviewed to ensure proper screening for TDK was completed on June 12th, 2014. #3 Re-Education will be done for all station directors and licensed nurses on July 17th 2014 to ensure that the proper screening for TDK is done per facility policy and procedure. #4 DNS or designee will complete audits weekly X4 then monthly X3 for resident #44 and random other residents to ensure AIMS are completed and appropriate monitoring id documented per facility policy and procedure. Results will be taken to the QA committee for further recommendations. #5 Completion date July 22nd 2014.	

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F 329	Continued From page 12 the new order to complete the side effect monitoring assessment. At 10:24 a.m. the director of nursing stated a side effect monitoring assessment should be done within 72 hours of a resident taking antipsychotic medications. The PSYCHOPHARMACOLOGICAL PROCEDURE revised 6/14, indicated if a physician prescribed an antipsychotic medication for the resident, a RN must complete an Abnormal Involuntary Movement Scale (AIMS) assessment.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/11/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET BRAINERD, MN 56401**

(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
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 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 Good Samaritan Society Bethany 01 Main Building 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 (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/15/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as one building. Good Samaritan Society Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1- story and was determined to be of Type II(000) construction. In 1974, two, 1-story additions were constructed, one to the south west and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2- hour fire barriers form the existing building. In 1980 an 1- story addition was constructed to the south and east of the 1974 south addition, was determined to be Type II (111) construction and is separated with a 2- hour fire barrier. In 1983 a small 1- story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V (000) construction. This link is not separated from the facility but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the	K 000		

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K 000	Continued From page 2 original building and was determined to be Type II (111) construction. In 1998 an 1- story addition was constructed to the north of the 1960 building and 1974 addition, was determined to be Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90 minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with quick response heads in the 1998 addition and standard response heads in all other areas. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas and in all sleeping rooms that is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for automatic fire department notification. Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 140 beds and had a census of 109 at the time of the survey.	K 000		
K 011 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance	K 011		7/15/14

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K 011	Continued From page 3 rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 1 fire barriers located within the facility did not meet the rated requirements for a two hour fire separation and is not maintained in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.3,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 20 of 124 residents, staff and visitors of the facility. Findings include: On facility tour between 11:00 AM to 3:00 PM on 06/11/2014, observations revealed, that the door in the fire barrier separating the station 3 from the apartments was rated as a 60 minute fire rated door and not the required 1 1/2 hour rated fire door. This deficient condition was verified by the Maintenance Engineer (RN).	K 011	K011 #1 The 60 minute door was replaced with a required fire door in the fire barrier separating Station 3 from the apartments. #2 Date of completion is 7/7/2014 #3 Rich Nelson, Environmental Services Director will be responsible for correction and monitoring to prevent a reoccurrence of this deficiency.	