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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RX3T

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245532**
2.STATE VENDOR OR MEDICAID NO.
(L2) **803742600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA HERITAGE CENTER**
(L4) **1012 EAST THIRD STREET**
(L5) **WILLMAR, MN** (L6) **56201**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/16/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **125** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	125			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 12/26/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Program Specialist — 12/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/10/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/13/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5532

At the time of the standard survey completed July 11, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. The facility was given an opportunity to correct before remedies were imposed.

On August 27, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on September 16, 2013, the Minnesota Department of Public Safety completed a PCR and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on July 11, 2013 effective August 19, 2013, therefore the remedies outlined in our letter to you dated July 31, 2013, will not be imposed.
See the attached CMS-2567B forms for the results of the August 27, 2013 and September 16, 2013 revisits.

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5532 December 26, 2013

Mr. Delbert Clark, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, Minnesota 56201

Dear Mr. Clark:

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 19, 2013 the above facility is certified for:

125 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 125 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

December 26, 2013

Mr. Delbert Clark, Administrator
Bethesda Heritage Center
1012 East Third Street
Willmar, Minnesota 56201

RE: Project Number S5532023

Dear Mr. Clark:

On July 31, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 11, 2013. 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 August 27, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 16, 2013 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 July 11, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 19, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 11, 2013, effective August 19, 2013 and therefore remedies outlined in our letter to you dated July 31, 2013, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

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
245532	A. Building B. Wing	8/27/2013

Name of Facility	Street Address, City, State, Zip Code
BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **08/19/2013**	ID Prefix **F0243** Reg. # **483.15(c)(1)-(5)** LSC	Correction Completed **08/19/2013**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **08/19/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/19/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/19/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **08/19/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **08/19/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **08/19/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **08/19/2013**
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:
	BF/sd	12/26/13	10562	08/27/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/11/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245532	A. Building B. Wing **01 - MAIN BUILDING**	9/16/2013

Name of Facility	Street Address, City, State, Zip Code
BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**08/09/2013**	ID Prefix Reg. # **NFPA 101** LSC K0130	**08/16/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/sd	12/26/13	27200	09/16/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/9/2013

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: RX3T

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00312

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA HERITAGE CENTER**
(L4) **1012 EAST THIRD STREET**
(L5) **WILLMAR, MN** (L6) **56201**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/11/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **125** (L18)

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

10.THE FACILITY IS CERTIFIED AS:

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
	125			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, HFE NEII 08/30/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/10/1989
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 9/13/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5127

At the time of the July 11, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2741

July 31, 2013

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

RE: Project Number S5127023

Dear Ms. Haefner:

On July 11, 2013, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 20, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 October 11, 2013 (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 January 11, 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.

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 a PoC 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:

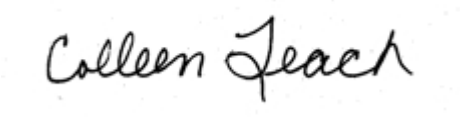
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

F 5532021

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING 01 - MAIN BUILDING B. WING _____	07/09/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Bethesda Heritage Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	RECEIVED AUG 29 2013 MN DEPT OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok JB 8-30-13.	

DC: 08.20.2013

EXIT: 07.11.2013

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

Michelle Laufenburger | Administrator | 8-13-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245532	A. BUILDING 01 - MAIN BUILDING B. WING _____	07/09/2013

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K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and 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. Bethesda Heritage Center is a 4-story building with no basement. The building was constructed at 2 different times. The original building was constructed in 1957 and was determined to be of Type II(222) construction. In 1999, additions were added to the east and west which were determined to be of Type II(222)construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a complete fire sprinkler system. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility has a licensed capacity of 125 beds and had a census of 114 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
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 observations, the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include:	K 029	K 029 1. The penetration in the ceiling was sealed with fire caulk by the maintenance department. 2. The completion date for this is August 9th, 2013. 3. Maintenance will be doing a walk-thru each month X 6 months, a different floor each month, to ensure there are no open penetrations in the ceiling. This check will be monitored by the Environmental Services Director.	

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K 029	Continued From page 3 On facility tour between 12:30 PM to 3:30 PM on 07/09/2013, observation revealed that there was a vertical penetration in the ceiling around a sewage pipe located in the 3rd floor housekeeping room that is not sealed. This deficient practice was verified by the Maintenance Supervisor.	K 029		
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations, the facility had combustibles stored in the elevator equipment room. This deficient practice is in violation of the Minnesota State Fire Code (07) 315.2.3.4, no combustible storage or any other type of storage shall be allowed in elevator equipment rooms or elevator machine rooms. This deficient practice could affect residents, visitors, and staff in the event of a fire. Findings include: On facility tour between 12:30 PM to 3:30 PM on 07/09/2013, it was observed in that there were combustibles being stored in the facility's elevator equipment room. This deficient practice was verified by the Maintenance Supervisor.	K 130	K 130 1. The Maintenance staff will remove non-elevator material from the equipment room. 2. The completion date of this project is August 16th, 2013. 3. Maintenance staff will do a monthly check of this room to ensure it stays free of non-elevator material. Environmental Services Director will monitor this process.	

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F 000	INITIAL COMMENTS The facility's plan of correction (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 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM; ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	8/14/13 AD	

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

Michelle Hanson Administrator 8-13-13

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately notify the physician when 1 of 3 residents (R60) developed a pressure ulcer. Findings include: R60 was interviewed on 7/9/13 at 9:20 a.m. and stated she had developed a sore on her buttocks which hurt. "I got the sore because since I have been here, they won't let me move around myself, I am stuck in the chair or in bed. " R60's buttocks were observed with Registered Nurse (RN)-F on 7/11/13 at 9:30 a.m. The area above the rectum and spreading onto each buttock was bright red to approximately a 6 x 6 centimeter (cm) area. The redness was blanchable on outer edges, but not blanchable towards the center indicating a stage 1 pressure ulcer [the National Pressure Ulcer Advisory Panel (NAPUAP) defines a stage 1 pressure ulcer as "intact skin with non-bleachable redness of a localized area usually over a bony prominence]. In the center was an approximately 2 by 0.5 cm shallow open area with a red wound base, a stage 2 pressure ulcer [NAPUAP defines a stage 2 pressure ulcer as "partial thickness loss of	F 157	F 157 Nurse Practitioner was notified by MDH surveyor of resident #60 pressure area on July 10th, 2013. NP spoke to RN case manager on July 11th, 2013 to discuss plan of treatment. MD or NP have been notified of all other residents with open pressure ulcers. MD or NP will be notified at the onset of an open pressure ulcer. Licensed nursing staff will be educated on August 13th, 14th and 19th, 2013 on notification of MD or NP at the onset of an open pressure ulcer. DON/ADON or designee will do random chart audits to confirm compliance with notification of the MD or NP upon the onset of an open pressure ulcer. 4 chart audits will be done monthly X 3 months starting August 19th, 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19th, 2013.	

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F 157	Continued From page 2 dermis presenting as a shallow open ulcer with a red pink wound bed, without slough]. RN-F stated she did not know if this was a pressure ulcer or not. RN-F stated when she works, she will apply some "calmoseptine" [a protectant ointment] on the red area, but R60 does not have any treatment ordered for this. The calmoseptine is the ointment used on everyone who needs skin protection. RN-F had not reported this area to the unit manager or the physician. A Bethesda Heritage Center Pressure Ulcer/Wound Documentation Policy and Procedure updated 01/12 included under policy, "MD [physician] or NP [nurse practitioner] is to be notified at the onset of an open pressure ulcer."	F 157		
F 243 SS=D	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to make an attempt to form a family council within the past calendar year. This had the potential to affect all 114 residents currently	F 243		

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F 243	Continued From page 3 residing in the facility. Findings include: During entrance conference, on 7/8/13 at 1:15 p.m., the director of nursing (DON) stated there was no active family council and would provide information on when the last attempt was made to form one. During an interview with both social workers (SW-A) and (SW-B) on 7/10/13 at 1:25 p.m., SW-B confirmed the last formal attempt to develop a family council was April 2012. SW-A stated the director of social services usually took care of this. SW-B stated when they started looking through the file "we knew it should have been done." Review of a facility letter titled "Dear Family Member/Friends"; dated April 2012 indicated this was the last attempt to form a family council. No policy or further information was provided as to the attempt to start a family council in the past year.	F 243	F 243 Bethesda Heritage Center reminds resident family members of their opportunity to organize and participate in a Family Council. On July 30, 2013 family members were sent a letter informing them of their right to form a Family Council. The Awareness of and Participation in Family Council Policy was established on August 5, 2013. The Family Council policy was reviewed with Social Service staff on August 5, 2013. Completion date: August 19th, 2013.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		

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F 278	Continued From page 4 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 2 residents (R76) reviewed for a change regarding assistance needed with dressing was accurately coded regarding dressing abilities. Findings include: R76 quarterly minimum data set (MDS) dated 5/7/13 identified the resident had no cognitive impairments and was an extensive one person physical assist with dressing. However, the annual MDS dated 2/8/13 indicated the resident was independent in dressing and required no assistance from staff. Review of the Quarterly nursing summary dated 5/14/13 indicated R76 was an "extensive assist with dressing requiring assist to put her edema	F 278	F 278 MDS was reviewed and modified for resident # 76. MDS modification was sent into CMS per guidelines. All resident will be assessed upon admission, quarterly, with a significant change in status, and annually by using the MDS assessment. Individual ADL care plans will be developed for each resident which coordinates with the MDS assessment. RN staff will be educated on August 13th, 2013 on coding of the ADL section of the MDS assessment and developing the coordinating ADL care plan. CNA staff will be educated in charting the ADLs on August 13th, 14th, and 16th, 2013. DON/ADON or designee will do random chart audits to review ADL section of the MDS assessment for accuracy. 8 chart audits will be done monthly X 3 months starting August 19th, 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19th, 2013.	

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F 278	Continued From page 5 wear (TED hose) on and to take it off." During interview on 7/9/13 at 3:20 p.m. registered nurse (RN)-C stated R76 does not currently, nor has she ever, worn edema wear (TED hose) and the resident had always been independent with dressing since admission nearly a year ago. During interview on 7/10/13 at 12:30 p.m. RN-D stated she did R76 quarterly assessment on 5/7/13. RN-D stated she knows R76 "very well" and the resident had always been independent with dressing. RN-D stated, "I don't know why" she coded the MDS as extensive assist or wrote the quarterly assessment that R76 needed extensive assist. RN-D stated it must have "been keyed in error." No further information was provided in regards to the inaccurate coding for dressing and use of TED hose.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the plan of care for 1 of 1 resident (R12) to provide the assistance with toileting as assessed. Findings include: R12 had diagnoses of Alzheimer disease. The quarterly Minimum Data Set (MDS) dated 4/2/13 identified the resident	F 282	F 282 Toileting schedules will be followed per individual care plan for each resident. Resident care sheets/care plans have been reviewed and are available at the nurses' station on each floor and are to be used by each CNA daily. Toileting and repositioning sheets are at the nurses' stations to document the times these tasks are completed.	

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F 282	Continued From page 6 had severe cognitive impairment, needed extensive assistance with toileting needs, and was frequently incontinent of urine, and always incontinent of bowel. R12's care plan dated July 2013 indicated R12 needed assistance with toileting and was to be toileted every two hours during waking hours. During constant observation of R12 on 7/10/13 from 6:50 a.m. to 9:30 a.m. R12 was observed sitting in her wheelchair without being toileted. At 9:30 a.m. nursing assistant (NA)-B and NA-C assisted R12 from her wheelchair onto the couch in the dayroom and R12 was not offered or assisted to the bathroom at this time. During interview on 7/10/13 at 9:35 a.m. NA-B stated R12 was toileted last at 6:45 a.m. and the resident is to be toileted every two hours. On 7/10/13 at 9:40 a.m. NA-B and NA-C assisted R12 to the bathroom per surveyor request. R12's incontinent product was wet with a "medium amount of urine" per NA-C. R12 urinated a small amount in the toilet.	F 282	CNA staff will be educated on the importance of following the care plans regarding the individualized toileting schedules for our residents and how to document that the task was completed. This education will be on August 13th, 14th, and 16th, 2013. Licensed Nursing staff will be monitoring that CNA staff are compliant with toileting our residents at appropriate times. They will be documenting each time they monitor staff. DON/ADON or designee will do random audits to confirm compliance that staff is following individualized toileting schedule for our residents and documenting completion of the task. 8 random audits will be done monthly X 3 months starting August 19th, 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19th, 2013.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a pressure ulcer which developed in house which includes determine causative factor/s, or provide treatments and preventative measures to promote healing and prevent further development of pressure ulcers for 1 of 3 residents (R60) reviewed for pressure ulcers. In addition, the facility failed to ensure 1 of 3 residents (R12) reviewed at risk for pressure ulcers was assisted with repositioning as assessed to ensure the prevention of pressure ulcers. Findings include: R60 had a nursing note that stated, "Red inflamed skin on coccyx area-warm to touch" on 5/17/13, and the medication nurses were using a protectant ointment to the area on occasion, no further evaluation (comprehensive skin assessment) of this area was completed until 7/11/13 when asked by surveyor. Also the physician had not been immediately notified, and no interventions had been placed to aid in healing of the pressure ulcer, or preventing further pressure ulcers from developing. R60 had required increased assistance for bed mobility after a fall on 7/4/13, however, R60's care plan had not been re-assessed, and care plan had not been updated. R60's diagnosis included back pain, degenerative joint disease, and gout. R60's admission Minimum Data Set (MDS) dated 5/15/13 indicated she was cognitively intact, required extensive assistance with bed mobility, transfers and ambulation. R60 was at risk for developing pressure ulcers, but had not current pressure	F 314	F 314 All residents admitted to the facility will be assessed for skin risk upon admission, quarterly, and upon significant change. An individualized plan of care will be developed depending on the resident's needs and abilities to prevent skin breakdown. If skin breakdown does occur, a skin assessment will be completed by RN upon the onset of the open pressure ulcer. Weekly skin assessments will follow until area is healed. Resident #60 skin has been assessed weekly since July 11, 2013 and is being monitored daily by staff. Skin treatment plan has been established and changed PRN per NP recommendations and orders. RN staff will be educated on Skin Risk Assessment and Wound Documentation policy and procedure on August 13th, 2013.	

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	245532	A. BUILDING _____ B. WING _____	07/11/2013

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F 314	Continued From page 8 ulcers. The pressure ulcer care area assessment (CAA) dated 5/15/13 read, "Resident receives assist with putting feet into bed and with getting up from bed. She is able to roll from side to side when in bed using positioning bars. She is able to stand independently form w/c [wheel chair] if she wishes to change position in w/c...Braden score [a tool used to predict pressure ulcer development] is 21 [indicating low risk for developing pressure ulcers]...no referral at this time. Proceed to care plan. " R60's care plan dated 5/15/13 for "Skin" read, "Resident receives assist with transfers and ambulation." The goal was listed as "Resident's skin will be healthy with no open areas." The only approach listed was, "Monitor skin condition with every bath and peri [perineal]care." R60 was interviewed on 7/9/13 at 9:20 a.m. while she was in bed on her back with legs elevated on a large wedge cushion and head of bed up approximately 30 degrees. R60 stated she had developed a sore on her buttocks which hurt. R60 stated, " I got the sore [located on buttock] because since I have been here, they won't let me move around myself, I am stuck in the chair or in bed." R60 stated her legs were elevated due to swelling of her ankles, but this puts pressure right over the area on her buttocks where she has a sore. Staff has encouraged her to keep her legs elevated due to edema. In addition R60 stated she had fallen on 7/4/13 and has had significantly more pain, causing her to be unable to reposition herself independently, or get pressure off her buttocks. R60's nurse progress notes dated 5/3/13 indicated no pressure ulcers. Dietician note dated	F 314	DON/ADON or designee will do random audits to confirm compliance that Skin Risk Assessment and weekly wound documentation (if applicable) are completed at appropriate times and individualized care plans are being developed to prevent skin breakdown. 8 random audits will be done monthly X 3 months starting August 19th, 2013. Repositioning schedules will be followed per individual care plan for each resident. Resident care sheets/care plans are available at the nurses' station on each floor and are to be used by each CNA daily. Toileting and repositioning sheets are at the nurses' stations to document the times these tasks are completed. CNA staff will be educated on the importance of following the care plans regarding the individualized repositioning schedules for our residents and how to document that the task was completed. This education will be on August 13th, 14th, and 16th, 2013.	

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F 314	Continued From page 9 5/6/13 indicated recent unintended weight loss due to not feeling well and to monitor weight status and skin integrity. Nursing progress note dated 5/17/13 read "has red inflamed skin on coccyx area-warm to touch...washed and dried area with applied calmoseptine cream to area at HS [hour of sleep.]" It was noted that there had been no measurement of the pressure ulcer nor further description of this area was evident in the medical record. Nursing assistant (NA)-D was interviewed on 7/11/13 at 9:00 a.m. and stated R60 requires assistance to move in bed, and for transfers they use mechanical lift. R60 has had red buttocks for several weeks; she will get the nurse passing medications in the morning to put some ointment on the red area. Also R60 will usually lays on her back in bed to get her legs elevated. R60's buttocks area was observed with Registered Nurse (RN)-F on 7/11/13 at 9:30 a.m. The area above the rectum and spreading onto each buttock was bright red and measured approximately 6 x 6 centimeter (cm) area. The redness was blanchable on outer edges, but not blanchable towards the center indicating a stage 1 pressure ulcer (stage 1 pressure ulcer is described by the National Pressure Ulcer Advisory Panel [NAPUAP] as "intact skin with non-bleachable redness of a localized area usually over a bony prominence.) In the center of the ulcer there was an approximately 2 by 0.5 cm shallow, open area with a red wound base, indicating a stage 2 pressure ulcer (a stage 2 pressure ulcer is defined by the NAPUAP as "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough.) On observing the ulcer RN-F	F 314	Licensed Nursing staff will be monitoring that CNA staff are compliant with repositioning our residents at appropriate times. They will be documenting each time they monitor staff. DON/ADON or designee will do random audits to confirm compliance that staff is following the individualized repositioning schedule for our residents and documenting completion of the task. 8 random audits will be done monthly X 3 months starting August 19th, 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19th, 2013.	

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F 314	Continued From page 10 stated she did not know if this was a pressure ulcer or not. Also RN-F stated when she works she will apply some "calmoseptine" a protectant ointment on the red area, even though R60 does not have an order for this. The calmoseptine is the ointment used on everyone who needs skin protection RN-F said. RN-F then said they had not reported this redden area to the unit manager or to the physician. When interviewed on 7/11/13 at 9:42 a.m., licensed practical nurse (LPN)-E stated she works with R60 and has put the calmoseptine ointment on her buttocks; she had only noticed redness, no open area on 7/10/13. The redness had been persistent for about a month. She did not know if the area was a pressure ulcer or not. LPN-E said she used the calmoseptine on residents who had reddened buttocks because it is on the facilities standing orders. Also LPN-E had not reported the redden area to the unit manager or to the physician. R60's medication and treatment administration records from 5/17/13 through 7/11/13 failed to include any treatment/s for the pressure ulcer and did not include calmoseptine had been used for the resident. The units nursing manager, RN-E was interviewed on 7/11/13 at 10:15 a.m. RN-E was not aware of the pressure ulcer on R60's buttocks. She had not assessed the area, or re-assessed R60 for potential cause of the pressure ulcer when noted on 5/17/13, because she had not been made aware of it. R60's physician or family had not been notified of the pressure ulcer either. Also no treatment for the area had been developed said RN-E.	F 314		

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F 314	Continued From page 11 RN-E assessed R60's pressure ulcer on 7/11/13 at 11:00 a.m. RN-E described the ulcer as "Has small slit at apex [the tip, point, or vertex] of buttock cheeks measures 0.2 by 0.3 cm, appears as if top layer of skin has peeled off. Appears to have skin over wound base, not fully open. Has reddened skin over both buttocks, area measuring 6 cm by 8 cm." RN- E described the reddened area being blanchable in all areas and staged the area as a stage 1 pressure ulcer, stating, "The open area is not all the way open, so it is not a stage 2 ulcer." RN-E then placed calmoseptine ointment over area and indicated she would report the ulcer to the nurse practitioner. RN-E stated R60 was recently given the wedge cushion to put her legs up. LPN-E agreed, when R60 had the head of her bed elevated, this would put increased pressure on the reddened area on R60's buttocks. R12 had been comprehensively assessed as being at risk for pressure ulcers and required assistance to be repositioned every two hours to prevent the development of pressure ulcers, staff went 2 hours and 45 minutes before repositioning R12. R12 had diagnoses including dementia. The current Minimum Data Set (MDS) dated 4/2/13 identified R12 had severe cognitive impairment, needed extensive assistance with all activities of daily living, (ADL's), and was at risk for developing pressure ulcers. R12's current plan of care dated July 2013 instructed staff the resident required repositioning assistance every two hours and was at risk for skin breakdown and read, " history of open areas on buttocks." During constant observation on 7/10/13 from 6:50 a.m. to 8:00 a.m. R12 was sitting in her	F 314		

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F 314	Continued From page 12 wheelchair in the dayroom. At 8:00 a.m. (unknown) staff pushed R12 in her wheelchair to eat breakfast. At 8:33 a.m. R12 was pushed in her wheelchair to the dayroom by nursing assistant (NA)-A. At 9:30 a.m., which was 2 hours and 40 minutes later, NA-A and NA-B assisted R12 directly from her wheelchair to the couch in the dayroom. During interview on 7/10/13 at 9:35 a.m. NA-B stated R12 had been assisted to her wheelchair that morning at 6:45 a.m., and had not been repositioned or assisted to the bathroom since that time. NA-B stated R12 should be repositioned and assisted to the toilet every two hours. NA-B verified R12 was at high risk for developing pressure ulcers. During observation on 7/10/13 at 9:40 a.m. NA-A and NA-B assisted R12 to the bathroom. R12 did not have any current pressure ulcers but did have some wrinkling on her buttocks from sitting in the wheelchair. This finding was verified by NA-B. A policy entitled Bethesda Heritage Center Pressure Ulcer/Wound Documentation Policy and Procedure, updated 01/12 included: "Policy: Comprehensive wound assessment and documentation of the assessment will be done by the RN when the wound is initially identified and weekly thereafter to accurately monitor the progress and determine appropriate treatment. MD [physician] or NP [nurse practitioner] is to be notified at the onset of an open pressure ulcer." Under protocol, the policy indicated daily assessment of the wound would be documented as well as weekly comprehensive assessment of the wound. The policy further defined a stage one pressure ulcer as, "Intact skin with non-blanchable redness of a localized area usually over a bony prominence..." Stage two pressure ulcer as, "Partial thickness loss of	F 314		

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F 314	Continued From page 13 dermis presenting as a shallow open ulcer with a red or pink wound bed..."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R12) reviewed for urinary incontinence, was provided assistance with toileting as assessed. Findings include: R12 had diagnoses of Alzheimer disease. The quarterly Minimum Data Set (MDS) dated 4/2/13 identified the resident had severe cognitive impairment, needed extensive assistance with toileting needs, and was frequently incontinent of urine, and always incontinent of bowel. Review of the current plan of care dated July 2013 indicated R12 needed assistance with toileting and was to be toileted every two hours during waking hours.	F 315	F 315 Toileting schedules will be followed per individual care plan for each resident. Resident care sheets/care plans were reviewed and are available at the nurses' station on each floor and are to be used by each CNA daily. Toileting and repositioning sheets are at the nurses' stations to document the times these tasks are completed. CNA staff will be educated on the importance of following the care plans regarding the individualized toileting schedules for our residents and how to document that the task was completed. This education will be on August 13th, 14th, and 16th, 2013. Licensed Nursing staff will be monitoring that CNA staff are compliant with toileting our residents at appropriate times. They will be documenting each time they monitor staff.	

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F 315	Continued From page 14 The quarterly nursing summary dated 4/5/13 indicated R12 is unable to verbalize needs to staff and needs are anticipated 24 hours a day. The current bladder assessment dated 6/28/13 indicated the resident is incontinent of bladder and required toileting every two hours. During constant observation of R12 on 7/10/13 the following was observed: 6:50 a.m. - R12 was sitting in her wheelchair in the dayroom. 8:00 a.m. - R12 was brought down to breakfast in her wheelchair. 8:33 a.m. - R12 was brought back into the dayroom directly from breakfast and left in her wheelchair. 9:30 a.m. - Nursing assistant (NA)-B and NA-C transferred R12 from the wheelchair to the couch in the dayroom. R12 was not offered to use the bathroom at this time. During interview on 7/10/13 at 9:35 a.m. NA-B verified R12 had not been toileted since 6:45 a.m., which had been 2 hours and 50 minutes. NA-B verified R12 was assessed to be toileted every two hours and was currently. During observation on 7/10/13 at 9:40 a.m. NA-B and NA-C assisted R12 to the toilet per surveyor request. NA-C stated R12's incontinent product was wet a medium amount with urine. R12 was placed on the toilet and urinated into the toilet a small amount. During interview on 7/10/13 at 9:40 a.m. NA-C stated R12 is "always" incontinent and does not urinate into the toilet "very often."	F 315	DON/ADON or designee will do random audits to confirm compliance that staff is following individualized toileting schedule for our residents and documenting completion of the task. 8 random audits will be done monthly X 3 months starting August 19th, 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19th, 2013.	

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F 329	Continued From page 15	F 329		
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, the facility failed to ensure each resident ' s medication regimen had adequate monitoring, and medications were not given beyond the stop date for 1 of 10 residents (R16) reviewed for unnecessary medications. Findings include: R16 received Citalopram and	F 329	F 329 MD orders reviewed for resident #16. MD order for continuation of antidepressant was obtained on July 19, 2013. All MD orders were reviewed by Pharmacy consultant on July 23rd, 2013. All resident's medication will be reviewed by Consultant Pharmacist on a monthly basis. Their recommendations will be given to MD for their review. Licensed nursing staff will be educated on August 13th, 14th and 19th, 2013 on proper MD orders. Nursing staff will not accept "trial" orders. DON/ADON or designee will do random chart audits to look at MD orders-looking for current MD orders and adequate monitoring. 8 chart audits per month X 3 months starting August 19th, 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19th, 2013.	

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F 329	Continued From page 16 antidepressant on a 30 day trial however, the medication was given past the 30 day trial and the physician had not been notified of the effectiveness of the medication. R16's diagnosis included diabetes, a stroke, and depression. The quarterly Minimum Data Set (MDS) dated 6/4/13 indicated R16 was cognitively intact and had signs of depression which included being tired, and did receive an antidepressant medication. R16's care plan dated 4/22/13 read "Mood/behavior: Has diagnosis of depressive disorder. Target behaviors: Sad mood, sad statements, and impatience." "Residents mood will be stable." "Administer antidepressant as ordered. Monitor for worsening mood and possible side effects. Notify physician as needed. Encourage to be out of room and to attend activities of choice." R16's physician orders dated 4/22/13 included; Citalopram an antidepressant 10 mg (milligrams) PO (orally) QD (every day) for 311 (depression code) a 30 day trial. R16's medication administration records (MAR) from 4/22/13 through 7/11/13 indicated R16 had continued to receive the Citalopram daily past the 30 day trial which would have ended on 5/22/13. No additional orders for this medication were in the medical record. Registered nurse (RN)-E stated on 7/11/13 at 8:50 a.m. R16 use to not come out of her room, wouldn't want to attend activities as her husband didn't want to go. She still has days when she just wants to sleep, but this has improved. R16's	F 329		

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F 329	Continued From page 17 family had told her the doctor had started the citalopram because her husband had been placed on hospice care and was expected to decline. She was not aware the order was for only a 30 day trial, or that it was to see if irritability and energy improved. RN-E had not updated the doctor on irritability or energy. When interviewed on 7/10/13 at 3:18 p.m. certified nurse practitioner (CNP)-A stated she had seen R16 on 6/20/13, noted the citalopram, but was unaware the facility failed to obtain a continuing order for the citalopram. When interviewed on 7/11/13 at 11:55 a.m. the facilities pharmacy consultant stated she would have assumed the facility would have obtained a continuation order for the citalopram because she continued to receive the medication. Also the facility should have updated the physician in regards to R16 ' s energy level and irritability, and obtained a new order for the citalopram.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428	F 428 MD orders reviewed for resident #16. MD order for continuation of antidepressant was obtained on July 19th, 2013. All resident's medication regimes were reviewed by the Pharmacy consultant on July 23rd, 2013.	

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F 428	Continued From page 18 by: Based on interview and document review, the facilities pharmacy consultant failed to report medication irregularities to the physician and director of nursing so they can act upon them for 1 of 10 residents (R16) reviewed for unnecessary medications. Findings include: R16 received Citalopram and antidepressant on a 30 day trial however, the medication was given past the 30 day trial and the physician had not been notified of the effectiveness of the medication. R16's diagnosis included diabetes, a stroke, and depression. The quarterly Minimum Data Set (MDS) dated 6/4/13 indicated R16 was cognitively intact and had signs of depression which included being tired, and did receive an antidepressant medication. R16's care plan dated 4/22/13 read "Mood/behavior: Has diagnosis of depressive disorder. Target behaviors: Sad mood, sad statements, and impatience." "Residents mood will be stable." "Administer antidepressant as ordered. Monitor for worsening mood and possible side effects. Notify physician as needed. Encourage to be out of room and to attend activities of choice." R16's physician orders dated 4/22/13 included; Citalopram an antidepressant 10 mg (milligrams) PO (orally) QD (every day) for 311 (depression code) a 30 day trial. R16's medication administration records (MAR) from 4/22/13 through 7/11/13 indicated R16 had continued to receive the Citalopram daily past the	F 428	All resident's medication regimes will be reviewed by Consultant Pharmacist on a monthly basis. Their recommendations will be given to MD for their review. Licensed nursing staff will be educated on proper MD orders on August 13th, 14th and 19th, 2013. DON/ADON or designee will audit the completion of the Pharmacy Consultant's monthly review of each resident's medication regime and their recommendation reports. 8 chart audits per month X 3 months starting August 19th, 2013. Audits will be reviewed at QA meeting monthly. Completion date: August 19th, 2013.	

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BETHESDA HERITAGE CENTER	1012 EAST THIRD STREET WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 19 30 day trial which would have ended on 5/22/13. No additional orders for this medication were in the medical record. Registered nurse (RN)-E stated on 7/11/13 at 8:50 a.m. R16 use to not come out of her room, wouldn't want to attend activities as her husband didn't want to go. She still has days when she just wants to sleep, but this has improved. R16's family had told her the doctor had started the citalopram because her husband had been placed on hospice care and was expected to decline. She was not aware the order was for only a 30 day trial, or that it was to see if irritability and energy improved. RN-E had not updated the doctor on irritability or energy. R16's Monthly Medication Regimen Reviews dated 5/20/13, the pharmacist noted start of citalopram, and on 6/18/13 had documented review of medications, but no recommendations were made for appropriate monitoring or that the medication had continued past the stop date. When interviewed on 7/11/13 at 11:55 a.m. the facilities pharmacy consultant stated she would have assumed the facility would have obtained a continuation order because she continued to receive the medication. The facility should have been monitoring R16 for energy level and irritability, updated the physician and obtained a new order for the citalopram. The pharmacy consultant had not noted the monitoring of the citalopram had not been what the doctor ordered it for, nor had she noted the medication continued past the stop date.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 20 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 7	F 431	F 431 The 2 Medication carts that were found to not be in working order were fixed on July 11, 2013 by maintenance staff. All other medication carts were checked for proper working order. On July 15th, 2013, nursing staff was instructed to check their medication cart drawers daily to ensure they are locking appropriately and to report to maintenance immediately if it is not in working order. Medication bottles for resident #150 and #59 were removed and new bottles were ordered on 7/11/2013. All medications that were not properly labeled and/or expired were removed from the all medication carts on July 23rd, 2013. Licensed nursing staff will be educated on the medication cart and storage policy, proper medication labeling, dating medications when opened, and shortened expiration dates on August 13th, 14th, and 19th, 2013.	

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F 431	Continued From page 21 medication carts inspected were in appropriate working condition to ensure secure storage of resident's medication. In addition, the facility failed to ensure medications were appropriately labeled including expiration dates to prevent resident use of outdated medication. This was observed in 3 of 7 medication carts in the facility this included resident (R) R150, R59, R133, R101, R82, R19, R139, R40, R102, and R5. Findings include: During medication storage tour on 7/11/13 the following was observed: The medication cart on first floor was observed at 8:50 a.m. with registered nurse (RN)-A. In the top drawer; R150 had a 2.5 ml bottle of lantopost (eye drops) about 1/4 full. There was no pharmacy label on the bottle, and R150 ' s first name was hand written on the bottle as well as the date "7/3/13." RN-A verified all medications need to have a pharmacy label on them, as well as an open date. RN-A verified R150 receives one drop of lantopost in left eye once a day and this would not account for the amount missing from the bottle. She stated R150 ' s family often brings medications in from home, and the nurses were told it was okay to just put the residents name date the bottle with the date the family brings in the medication. RN-A verified 7/3/13 was "probably" the date the family brought in the medications and not when they were first opened. RN-A also indicated that Lantopost eye drops expire after 42 days and should not be used. The medication cart on 3rd floor was sitting in front of room 310 at 9:12 a.m. The medication cart was unlocked and there were no residents wandering the area. Licensed practical nurse (LPN)-A returned to the unlocked medication cart at 9:18 a.m. and verified she had "Forgot to lock" the medication cart. Upon inspection of the	F 431	DON/ADON or designee will do random audits to confirm compliance that staff is aware of medication cart and storage policy, aware of proper medication labeling, dating medications when opened, and proper expiration dates. 8 random audits will be done monthly X 3 months starting August 19th, 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19th, 2013.	

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F 431	Continued From page 22 medication cart there was a bottle with R59 ' s name. The bottle was labeled lantanoprost eye drops dated 5/25/13 as the open date. LPN-A verified R59 received these eye drops every night, and they should no longer be used as they had expire on July 6, 2013 which was 42 days form the open date. The other medication cart on 3rd floor was sitting outside the nurses ' station with no staff nearby at 9:19 a.m. Upon inspection of the medication cart one side of the cart was pushed up against the wall. The medication cart appeared to be locked, however, the top and middle drawer opened and the second and bottom drawer were locked. The top drawer of the medication cart contained 5 bottles of various eye drops and 8 bottles of various insulins. The middle drawer contained prescription medication for R8, R108, R35, R24, R117, and R48. There was no staff available until 9:35 a.m. RN-B stated at 9:35 a.m. she was not aware there were problems with the medication cart and verified although the medication cart was locked, 2 of the 4 drawers still opened which contained prescription medication. RN-B stated she would call maintenance "Immediately." At 9:38 LPN-B returned from break and on asking about the condition of the medication cart LPN-B stated the defective lock had been passed on in report "Several days ago" that the medication cart was not locking properly and at the time she reported it she had been told to "push it up against the wall" until it can be fixed. At 9:40 a.m. maintenance (M)-A stated he looked at the medication cart yesterday and thought he had it fixed the problem. At 9:44 a.m. 4th floor medication cart was pushed into the resident dayroom. Upon inspection of the medication cart it appeared it was locked	F 431		

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F 431	Continued From page 23 although the 3rd drawer of the medication cart opened. The drawer contained prescription medication for R133, R101, R82, R19, R139, R40, R102, and R5. During interview with RN-C at 9:46 a.m. she verified the cart was locked but the 3rd drawer was still opening. She stated she was not aware the drawer was not in working order. Upon further inspection of the medication cart the top drawer contained a tuberculin syringe with 10 ml of liquid in and a pill cup with 7 pills in it. There was no label or resident name on either the syringe or pill cup. RN-C stated LPN-C was the medication nurse and used this cart but was currently on break. During interview on 7/11/13 at 12:02 p.m. LPN-C stated the unlabeled medications was for R56 who had been busy when she went to give her the insulin and morning pills, so she just placed it back in the drawer. LPN-C stated she did not feel she needed to label the medication because "No one usually goes in my medication cart except me." During interview on 7/11/13 at 12:05 p.m. facility consulting pharmacist stated resident medications brought in from home need a pharmacy label or they should not be used. She verified the facility should be ensuring maintenance is contacted immediately and the medication in the cart needs to be secured from unauthorized access. The facility policy titled Medication cart and Storage dated 3/2013 instructed the medication cart should be "locked for security when not in use" and "Licensed nursing staff will inform the maintenance department of any repairs needed of the carts right away."	F 431		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 2741

July 31, 2013

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5532023

Dear Ms. Haefner:

The above facility was surveyed on July 8, 2013 through July 11, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

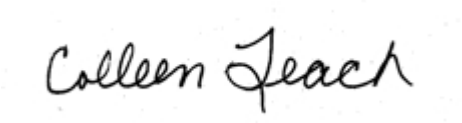
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 3333 West Division, #212 St Cloud, Minnesota 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with 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,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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F 000	INITIAL COMMENTS The facility's plan of correction (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 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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157		

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

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F 157	Continued From page 1	F 157		

resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to immediately notify the physician when 1 of 3 residents (R60) developed a pressure ulcer.

Findings include:

R60 was interviewed on 7/9/13 at 9:20 a.m. and stated she had developed a sore on her buttocks which hurt. "I got the sore because since I have been here, they won't let me move around myself, I am stuck in the chair or in bed. "

R60's buttocks were observed with Registered Nurse (RN)-F on 7/11/13 at 9:30 a.m. The area above the rectum and spreading onto each buttock was bright red to approximately a 6 x 6 centimeter (cm) area. The redness was blanchable on outer edges, but not blanchable towards the center indicating a stage 1 pressure ulcer [the National Pressure Ulcer Advisory Panel (NAPUAP) defines a stage 1 pressure ulcer as "intact skin with non-bleachable redness of a localized area usually over a bony prominence]. In the center was an approximately 2 by 0.5 cm shallow open area with a red wound base, a stage 2 pressure ulcer [NAPUAP defines a stage 2 pressure ulcer as "partial thickness loss of

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F 157	Continued From page 2 dermis presenting as a shallow open ulcer with a red pink wound bed, without slough]. RN-F stated she did not know if this was a pressure ulcer or not. RN-F stated when she works, she will apply some "calmoseptine" [a protectant ointment] on the red area, but R60 does not have any treatment ordered for this. The calmoseptine is the ointment used on everyone who needs skin protection. RN-F had not reported this area to the unit manager or the physician. A Bethesda Heritage Center Pressure Ulcer/Wound Documentation Policy and Procedure updated 01/12 included under policy, "MD [physician] or NP [nurse practitioner] is to be notified at the onset of an open pressure ulcer."	F 157		
F 243 SS=D	483.15(c)(1)-(5) RIGHT TO PARTICIPATE IN RESIDENT/FAMILY GROUP A resident has the right to organize and participate in resident groups in the facility; a resident's family has the right to meet in the facility with the families of other residents in the facility; the facility must provide a resident or family group, if one exists, with private space; staff or visitors may attend meetings at the group's invitation; and the facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to make an attempt to form a family council within the past calendar year. This had the potential to affect all 114 residents currently	F 243		

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F 243	Continued From page 3 residing in the facility. Findings include: During entrance conference, on 7/8/13 at 1:15 p.m., the director of nursing (DON) stated there was no active family council and would provide information on when the last attempt was made to form one. During an interview with both social workers (SW-A) and (SW-B) on 7/10/13 at 1:25 p.m., SW-B confirmed the last formal attempt to develop a family council was April 2012. SW-A stated the director of social services usually took care of this. SW-B stated when they started looking through the file "we knew it should have been done." Review of a facility letter titled "Dear Family Member/Friends"; dated April 2012 indicated this was the last attempt to form a family council. No policy or further information was provided as to the attempt to start a family council in the past year.	F 243		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.	F 278		

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F 278	Continued From page 4 Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 2 residents (R76) reviewed for a change regarding assistance needed with dressing was accurately coded regarding dressing abilities. Findings include: R76 quarterly minimum data set (MDS) dated 5/7/13 identified the resident had no cognitive impairments and was an extensive one person physical assist with dressing. However, the annual MDS dated 2/8/13 indicated the resident was independent in dressing and required no assistance from staff. Review of the Quarterly nursing summary dated 5/14/13 indicated R76 was an "extensive assist with dressing requiring assist to put her edema	F 278		

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F 278	Continued From page 5 wear (TED hose) on and to take it off." During interview on 7/9/13 at 3:20 p.m. registered nurse (RN)-C stated R76 does not currently, nor has she ever, worn edema wear (TED hose) and the resident had always been independent with dressing since admission nearly a year ago. During interview on 7/10/13 at 12:30 p.m. RN-D stated she did R76 quarterly assessment on 5/7/13. RN-D stated she knows R76 "very well" and the resident had always been independent with dressing. RN-D stated, "I don't know why" she coded the MDS as extensive assist or wrote the quarterly assessment that R76 needed extensive assist. RN-D stated it must have "been keyed in error." No further information was provided in regards to the inaccurate coding for dressing and use of TED hose.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the plan of care for 1 of 1 resident (R12) to provide the assistance with toileting as assessed. Findings include: R12 had diagnoses of Alzheimer disease. The quarterly Minimum Data Set (MDS) dated 4/2/13 identified the resident	F 282		

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F 282	Continued From page 6 had severe cognitive impairment, needed extensive assistance with toileting needs, and was frequently incontinent of urine, and always incontinent of bowel. R12's care plan dated July 2013 indicated R12 needed assistance with toileting and was to be toileted every two hours during waking hours. During constant observation of R12 on 7/10/13 from 6:50 a.m. to 9:30 a.m. R12 was observed sitting in her wheelchair without being toileted. At 9:30 a.m. nursing assistant (NA)-B and NA-C assisted R12 from her wheelchair onto the couch in the dayroom and R12 was not offered or assisted to the bathroom at this time. During interview on 7/10/13 at 9:35 a.m. NA-B stated R12 was toileted last at 6:45 a.m. and the resident is to be toileted every two hours. On 7/10/13 at 9:40 a.m. NA-B and NA-C assisted R12 to the bathroom per surveyor request. R12's incontinent product was wet with a "medium amount of urine" per NA-C. R12 urinated a small amount in the toilet.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		

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F 314	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a pressure ulcer which developed in house which includes determine causative factor/s, or provide treatments and preventative measures to promote healing and prevent further development of pressure ulcers for 1 of 3 residents (R60) reviewed for pressure ulcers. In addition, the facility failed to ensure 1 of 3 residents (R12) reviewed at risk for pressure ulcers was assisted with repositioning as assessed to ensure the prevention of pressure ulcers. Findings include: R60 had a nursing note that stated, "Red inflamed skin on coccyx area-warm to touch" on 5/17/13, and the medication nurses were using a protectant ointment to the area on occasion, no further evaluation (comprehensive skin assessment) of this area was completed until 7/11/13 when asked by surveyor. Also the physician had not been immediately notified, and no interventions had been placed to aid in healing of the pressure ulcer, or preventing further pressure ulcers from developing. R60 had required increased assistance for bed mobility after a fall on 7/4/13, however, R60's care plan had not been re-assessed, and care plan had not been updated. R60's diagnosis included back pain, degenerative joint disease, and gout. R60's admission Minimum Data Set (MDS) dated 5/15/13 indicated she was cognitively intact, required extensive assistance with bed mobility, transfers and ambulation. R60 was at risk for developing pressure ulcers, but had not current pressure	F 314		

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ulcers. The pressure ulcer care area assessment (CAA) dated 5/15/13 read, "Resident receives assist with putting feet into bed and with getting up from bed. She is able to roll from side to side when in bed using positioning bars. She is able to stand independently form w/c [wheel chair] if she wishes to change position in w/c...Braden score [a tool used to predict pressure ulcer development] is 21 [indicating low risk for developing pressure ulcers]...no referral at this time. Proceed to care plan. "

R60's care plan dated 5/15/13 for "Skin" read, "Resident receives assist with transfers and ambulation." The goal was listed as "Resident's skin will be healthy with no open areas." The only approach listed was, "Monitor skin condition with every bath and peri [perineal]care."

R60 was interviewed on 7/9/13 at 9:20 a.m. while she was in bed on her back with legs elevated on a large wedge cushion and head of bed up approximately 30 degrees. R60 stated she had developed a sore on her buttocks which hurt. R60 stated, " I got the sore [located on buttock] because since I have been here, they won't let me move around myself, I am stuck in the chair or in bed." R60 stated her legs were elevated due to swelling of her ankles, but this puts pressure right over the area on her buttocks where she has a sore. Staff has encouraged her to keep her legs elevated due to edema. In addition R60 stated she had fallen on 7/4/13 and has had significantly more pain, causing her to be unable to reposition herself independently, or get pressure off her buttocks.

R60's nurse progress notes dated 5/3/13 indicated no pressure ulcers. Dietician note dated

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5/6/13 indicated recent unintended weight loss due to not feeling well and to monitor weight status and skin integrity. Nursing progress note dated 5/17/13 read "has red inflamed skin on coccyx area-warm to touch...washed and dried area with applied calmoseptine cream to area at HS [hour of sleep.]" It was noted that there had been no measurement of the pressure ulcer nor further description of this area was evident in the medical record.

Nursing assistant (NA)-D was interviewed on 7/11/13 at 9:00 a.m. and stated R60 requires assistance to move in bed, and for transfers they use mechanical lift. R60 has had red buttocks for several weeks; she will get the nurse passing medications in the morning to put some ointment on the red area. Also R60 will usually lays on her back in bed to get her legs elevated.

R60's buttocks area was observed with Registered Nurse (RN)-F on 7/11/13 at 9:30 a.m. The area above the rectum and spreading onto each buttock was bright red and measured approximately 6 x 6 centimeter (cm) area. The redness was blanchable on outer edges, but not blanchable towards the center indicating a stage 1 pressure ulcer (stage 1 pressure ulcer is described by the National Pressure Ulcer Advisory Panel [NAPUAP] as "intact skin with non-bleachable redness of a localized area usually over a bony prominence.) In the center of the ulcer there was an approximately 2 by 0.5 cm shallow, open area with a red wound base, indicating a stage 2 pressure ulcer (a stage 2 pressure ulcer is defined by the NAPUAP as "partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough.) On observing the ulcer RN-F

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stated she did not know if this was a pressure ulcer or not. Also RN-F stated when she works she will apply some "calmoseptine" a protectant ointment on the red area, even though R60 does not have an order for this. The calmoseptine is the ointment used on everyone who needs skin protection RN-F said. RN-F then said they had not reported this redden area to the unit manager or to the physician.

When interviewed on 7/11/13 at 9:42 a.m., licensed practical nurse (LPN)-E stated she works with R60 and has put the calmoseptine ointment on her buttocks; she had only noticed redness, no open area on 7/10/13. The redness had been persistent for about a month. She did not know if the area was a pressure ulcer or not. LPN-E said she used the calmoseptine on residents who had reddened buttocks because it is on the facilities standing orders. Also LPN-E had not reported the redden area to the unit manager or to the physician.

R60's medication and treatment administration records from 5/17/13 through 7/11/13 failed to include any treatment/s for the pressure ulcer and did not include calmoseptine had been used for the resident.

The units nursing manager, RN-E was interviewed on 7/11/13 at 10:15 a.m. RN-E was not aware of the pressure ulcer on R60's buttocks. She had not assessed the area, or re-assessed R60 for potential cause of the pressure ulcer when noted on 5/17/13, because she had not been made aware of it. R60's physician or family had not been notified of the pressure ulcer either. Also no treatment for the area had been developed said RN-E.

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RN-E assessed R60's pressure ulcer on 7/11/13 at 11:00 a.m. RN-E described the ulcer as "Has small slit at apex [the tip, point, or vertex] of buttock cheeks measures 0.2 by 0.3 cm, appears as if top layer of skin has peeled off. Appears to have skin over wound base, not fully open. Has reddened skin over both buttocks, area measuring 6 cm by 8 cm." RN- E described the reddened area being blanchable in all areas and staged the area as a stage 1 pressure ulcer, stating, "The open area is not all the way open, so it is not a stage 2 ulcer." RN-E then placed calmoseptine ointment over area and indicated she would report the ulcer to the nurse practitioner. RN-E stated R60 was recently given the wedge cushion to put her legs up. LPN-E agreed, when R60 had the head of her bed elevated, this would put increased pressure on the reddened area on R60's buttocks.

R12 had been comprehensively assessed as being at risk for pressure ulcers and required assistance to be repositioned every two hours to prevent the development of pressure ulcers, staff went 2 hours and 45 minutes before repositioning R12.

R12 had diagnoses including dementia. The current Minimum Data Set (MDS) dated 4/2/13 identified R12 had severe cognitive impairment, needed extensive assistance with all activities of daily living, (ADL's), and was at risk for developing pressure ulcers.

R12's current plan of care dated July 2013 instructed staff the resident required repositioning assistance every two hours and was at risk for skin breakdown and read, " history of open areas on buttocks."

During constant observation on 7/10/13 from 6:50 a.m. to 8:00 a.m. R12 was sitting in her

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wheelchair in the dayroom. At 8:00 a.m. (unknown) staff pushed R12 in her wheelchair to eat breakfast. At 8:33 a.m. R12 was pushed in her wheelchair to the dayroom by nursing assistant (NA)-A. At 9:30 a.m., which was 2 hours and 40 minutes later, NA-A and NA-B assisted R12 directly from her wheelchair to the couch in the dayroom.

During interview on 7/10/13 at 9:35 a.m. NA-B stated R12 had been assisted to her wheelchair that morning at 6:45 a.m., and had not been repositioned or assisted to the bathroom since that time. NA-B stated R12 should be repositioned and assisted to the toilet every two hours. NA-B verified R12 was at high risk for developing pressure ulcers.

During observation on 7/10/13 at 9:40 a.m. NA-A and NA-B assisted R12 to the bathroom. R12 did not have any current pressure ulcers but did have some wrinkling on her buttocks from sitting in the wheelchair. This finding was verified by NA-B.

A policy entitled Bethesda Heritage Center Pressure Ulcer/Wound Documentation Policy and Procedure, updated 01/12 included: "Policy: Comprehensive wound assessment and documentation of the assessment will be done by the RN when the wound is initially identified and weekly thereafter to accurately monitor the progress and determine appropriate treatment. MD [physician] or NP [nurse practitioner] is to be notified at the onset of an open pressure ulcer." Under protocol, the policy indicated daily assessment of the wound would be documented as well as weekly comprehensive assessment of the wound. The policy further defined a stage one pressure ulcer as, "Intact skin with non-blanchable redness of a localized area usually over a bony prominence..." Stage two pressure ulcer as, "Partial thickness loss of

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F 314	Continued From page 13 dermis presenting as a shallow open ulcer with a red or pink wound bed..."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R12) reviewed for urinary incontinence, was provided assistance with toileting as assessed. Findings include: R12 had diagnoses of Alzheimer disease. The quarterly Minimum Data Set (MDS) dated 4/2/13 identified the resident had severe cognitive impairment, needed extensive assistance with toileting needs, and was frequently incontinent of urine, and always incontinent of bowel. Review of the current plan of care dated July 2013 indicated R12 needed assistance with toileting and was to be toileted every two hours during waking hours.	F 315		

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The quarterly nursing summary dated 4/5/13 indicated R12 is unable to verbalize needs to staff and needs are anticipated 24 hours a day.

The current bladder assessment dated 6/28/13 indicated the resident is incontinent of bladder and required toileting every two hours.

During constant observation of R12 on 7/10/13 the following was observed:
6:50 a.m. - R12 was sitting in her wheelchair in the dayroom.
8:00 a.m. - R12 was brought down to breakfast in her wheelchair.
8:33 a.m. - R12 was brought back into the dayroom directly from breakfast and left in her wheelchair.
9:30 a.m. - Nursing assistant (NA)-B and NA-C transferred R12 from the wheelchair to the couch in the dayroom. R12 was not offered to use the bathroom at this time.

During interview on 7/10/13 at 9:35 a.m. NA-B verified R12 had not been toileted since 6:45 a.m., which had been 2 hours and 50 minutes. NA-B verified R12 was assessed to be toileted every two hours and was currently.

During observation on 7/10/13 at 9:40 a.m. NA-B and NA-C assisted R12 to the toilet per surveyor request. NA-C stated R12's incontinent product was wet a medium amount with urine. R12 was placed on the toilet and urinated into the toilet a small amount.

During interview on 7/10/13 at 9:40 a.m. NA-C stated R12 is "always" incontinent and does not urinate into the toilet "very often."

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F 329	Continued From page 15	F 329		
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, the facility failed to ensure each resident ' s medication regimen had adequate monitoring, and medications were not given beyond the stop date for 1 of 10 residents (R16) reviewed for unnecessary medications. Findings include: R16 received Citalopram and	F 329		

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antidepressant on a 30 day trial however, the medication was given past the 30 day trial and the physician had not been notified of the effectiveness of the medication.

R16's diagnosis included diabetes, a stroke, and depression. The quarterly Minimum Data Set (MDS) dated 6/4/13 indicated R16 was cognitively intact and had signs of depression which included being tired, and did receive an antidepressant medication.

R16's care plan dated 4/22/13 read "Mood/behavior: Has diagnosis of depressive disorder. Target behaviors: Sad mood, sad statements, and impatience." "Residents mood will be stable." "Administer antidepressant as ordered. Monitor for worsening mood and possible side effects. Notify physician as needed. Encourage to be out of room and to attend activities of choice."

R16's physician orders dated 4/22/13 included; Citalopram an antidepressant 10 mg (milligrams) PO (orally) QD (every day) for 311 (depression code) a 30 day trial.

R16's medication administration records (MAR) from 4/22/13 through 7/11/13 indicated R16 had continued to receive the Citalopram daily past the 30 day trial which would have ended on 5/22/13. No additional orders for this medication were in the medical record.

Registered nurse (RN)-E stated on 7/11/13 at 8:50 a.m. R16 use to not come out of her room, wouldn't want to attend activities as her husband didn't want to go. She still has days when she just wants to sleep, but this has improved. R16's

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F 329	Continued From page 17 family had told her the doctor had started the citalopram because her husband had been placed on hospice care and was expected to decline. She was not aware the order was for only a 30 day trial, or that it was to see if irritability and energy improved. RN-E had not updated the doctor on irritability or energy. When interviewed on 7/10/13 at 3:18 p.m. certified nurse practitioner (CNP)-A stated she had seen R16 on 6/20/13, noted the citalopram, but was unaware the facility failed to obtain a continuing order for the citalopram. When interviewed on 7/11/13 at 11:55 a.m. the facilities pharmacy consultant stated she would have assumed the facility would have obtained a continuation order for the citalopram because she continued to receive the medication. Also the facility should have updated the physician in regards to R16 ' s energy level and irritability, and obtained a new order for the citalopram.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		

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by:
Based on interview and document review, the facilities pharmacy consultant failed to report medication irregularities to the physician and director of nursing so they can act upon them for 1 of 10 residents (R16) reviewed for unnecessary medications.

Findings include: R16 received Citalopram and antidepressant on a 30 day trial however, the medication was given past the 30 day trial and the physician had not been notified of the effectiveness of the medication.

R16's diagnosis included diabetes, a stroke, and depression. The quarterly Minimum Data Set (MDS) dated 6/4/13 indicated R16 was cognitively intact and had signs of depression which included being tired, and did receive an antidepressant medication.

R16's care plan dated 4/22/13 read "Mood/behavior: Has diagnosis of depressive disorder. Target behaviors: Sad mood, sad statements, and impatience." "Residents mood will be stable." "Administer antidepressant as ordered. Monitor for worsening mood and possible side effects. Notify physician as needed. Encourage to be out of room and to attend activities of choice."

R16's physician orders dated 4/22/13 included; Citalopram an antidepressant 10 mg (milligrams) PO (orally) QD (every day) for 311 (depression code) a 30 day trial.

R16's medication administration records (MAR) from 4/22/13 through 7/11/13 indicated R16 had continued to receive the Citalopram daily past the

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F 428	Continued From page 19 30 day trial which would have ended on 5/22/13. No additional orders for this medication were in the medical record. Registered nurse (RN)-E stated on 7/11/13 at 8:50 a.m. R16 use to not come out of her room, wouldn't want to attend activities as her husband didn't want to go. She still has days when she just wants to sleep, but this has improved. R16's family had told her the doctor had started the citalopram because her husband had been placed on hospice care and was expected to decline. She was not aware the order was for only a 30 day trial, or that it was to see if irritability and energy improved. RN-E had not updated the doctor on irritability or energy. R16's Monthly Medication Regimen Reviews dated 5/20/13, the pharmacist noted start of citalopram, and on 6/18/13 had documented review of medications, but no recommendations were made for appropriate monitoring or that the medication had continued past the stop date. When interviewed on 7/11/13 at 11:55 a.m. the facilities pharmacy consultant stated she would have assumed the facility would have obtained a continuation order because she continued to receive the medication. The facility should have been monitoring R16 for energy level and irritability, updated the physician and obtained a new order for the citalopram. The pharmacy consultant had not noted the monitoring of the citalopram had not been what the doctor ordered it for, nor had she noted the medication continued past the stop date.	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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	245532	A. BUILDING _____ B. WING _____	07/11/2013

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F 431	Continued From page 20 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 7	F 431		

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F 431	Continued From page 21	F 431		

medication carts inspected were in appropriate working condition to ensure secure storage of resident's medication. In addition, the facility failed to ensure medications were appropriately labeled including expiration dates to prevent resident use of outdated medication. This was observed in 3 of 7 medication carts in the facility this included resident (R) R150, R59, R133, R101, R82, R19, R139, R40, R102, and R5.
Findings include:
During medication storage tour on 7/11/13 the following was observed:
The medication cart on first floor was observed at 8:50 a.m. with registered nurse (RN)-A. In the top drawer; R150 had a 2.5 ml bottle of lantopost (eye drops) about 1/4 full. There was no pharmacy label on the bottle, and R150 ' s first name was hand written on the bottle as well as the date "7/3/13." RN-A verified all medications need to have a pharmacy label on them, as well as an open date. RN-A verified R150 receives one drop of lantopost in left eye once a day and this would not account for the amount missing from the bottle. She stated R150 ' s family often brings medications in from home, and the nurses were told it was okay to just put the residents name date the bottle with the date the family brings in the medication. RN-A verified 7/3/13 was "probably" the date the family brought in the medications and not when they were first opened. RN-A also indicated that Lantopost eye drops expire after 42 days and should not be used.
The medication cart on 3rd floor was sitting in front of room 310 at 9:12 a.m. The medication cart was unlocked and there were no residents wandering the area. Licensed practical nurse (LPN)-A returned to the unlocked medication cart at 9:18 a.m. and verified she had "Forgot to lock" the medication cart. Upon inspection of the

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F 431	Continued From page 22	F 431		

medication cart there was a bottle with R59 ' s name. The bottle was labeled lantanoprost eye drops dated 5/25/13 as the open date. LPN-A verified R59 received these eye drops every night, and they should no longer be used as they had expire on July 6, 2013 which was 42 days form the open date.
The other medication cart on 3rd floor was sitting outside the nurses ' station with no staff nearby at 9:19 a.m. Upon inspection of the medication cart one side of the cart was pushed up against the wall. The medication cart appeared to be locked, however, the top and middle drawer opened and the second and bottom drawer were locked. The top drawer of the medication cart contained 5 bottles of various eye drops and 8 bottles of various insulins. The middle drawer contained prescription medication for R8, R108, R35, R24, R117, and R48. There was no staff available until 9:35 a.m. RN-B stated at 9:35 a.m. she was not aware there were problems with the medication cart and verified although the medication cart was locked, 2 of the 4 drawers still opened which contained prescription medication. RN-B stated she would call maintenance "Immediately." At 9:38 LPN-B returned from break and on asking about the condition of the medication cart LPN-B stated the defective lock had been passed on in report "Several days ago" that the medication cart was not locking properly and at the time she reported it she had been told to "push it up against the wall" until it can be fixed. At 9:40 a.m. maintenance (M)-A stated he looked at the medication cart yesterday and thought he had it fixed the problem.
At 9:44 a.m. 4th floor medication cart was pushed into the resident dayroom. Upon inspection of the medication cart it appeared it was locked

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F 431	Continued From page 23 although the 3rd drawer of the medication cart opened. The drawer contained prescription medication for R133, R101, R82, R19, R139, R40, R102, and R5. During interview with RN-C at 9:46 a.m. she verified the cart was locked but the 3rd drawer was still opening. She stated she was not aware the drawer was not in working order. Upon further inspection of the medication cart the top drawer contained a tuberculin syringe with 10 ml of liquid in and a pill cup with 7 pills in it. There was no label or resident name on either the syringe or pill cup. RN-C stated LPN-C was the medication nurse and used this cart but was currently on break. During interview on 7/11/13 at 12:02 p.m. LPN-C stated the unlabeled medications was for R56 who had been busy when she went to give her the insulin and morning pills, so she just placed it back in the drawer. LPN-C stated she did not feel she needed to label the medication because "No one usually goes in my medication cart except me." During interview on 7/11/13 at 12:05 p.m. facility consulting pharmacist stated resident medications brought in from home need a pharmacy label or they should not be used. She verified the facility should be ensuring maintenance is contacted immediately and the medication in the cart needs to be secured from unauthorized access. The facility policy titled Medication cart and Storage dated 3/2013 instructed the medication cart should be "locked for security when not in use" and "Licensed nursing staff will inform the maintenance department of any repairs needed of the carts right away."	F 431		