CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: RX3T

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00312
MEDICARE/MEDICAID PROVIDER (L1)	NO.	3. NAME AND AE (L3) BETHESDA (L4) 1012 EAST (L5) WILLMAR,	HERITAGE C	ENTER	(L6) 56201	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 09/16 8. ACCREDITATION STATUS: 0 Unaccredited 1 TIC 2 AOA 3 Other	/ 2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	125 (L18) 125 (L17)	Complian1. B. Not in Co.		ram	And/Or Approved Waivers Of TI 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNI 5. Life Safety Code * Code: A*	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 125	VN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARKS	RKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Brenda Fischer, Unit	Supervisor		12/26/2013	(L19)	Shellae Dietrich, P	rogram Specialist 12/26/2013
P	ART II - TO BE	COMPLETED	BY HCFA RI	EGIONAI	L OFFICE OR SINGLE ST	ATE AGENCY
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to P 2. Facility is not Eligible	articipate		MPLIANCE WITH GHTS ACT:	CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	FNT 2	4. LTC AGREEM	1FNT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 01/10/1989	BEGINNING		ENDING DAT		VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIV A. Suspension B. Rescind Sus	of Admissions:	(L25)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION 09/13/2013	OF APPROVAL D	ATE		
	(L32)	021 AU AU AU		(L33)	DETERMINATION APPR	OVAL

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: RX3T Facility ID: 00312

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:

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

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245532	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/27/2013
Name	of Facility		Street Address, City, State, Zip Code	
BE	THESDA 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) I	Date
			Correction					Correction					Correction
ID Prefix	F0157		Completed 08/19/2013		ID Prefix	F0243		08/19/2013		ID Prefix	F0278		Completed 08/19/2013
Reg. #	483.10(b)(11)				•	483.15(c)(1)-(5)					483.20(g) - (j)		
LSC					LSC					LSC			
			O					0					0
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0282		08/19/2013		ID Prefix	F0314		08/19/2013		ID Prefix	F0315		08/19/2013
Reg. #	483.20(k)(3)(ii)				Reg.#	483.25(c)					483.25(d)		
LSC					LSC					LSC			_
			Correction Completed					Correction Completed					Correction Completed
ID Prefix	F0329		08/19/2013		ID Prefix	F0428		08/19/2013		ID Prefix	F0431		08/19/2013
Reg. #	483.25(I)				Reg. #	483.60(c)				Reg. #	483.60(b), (d), (e))	
LSC					LSC					LSC			_ _
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg.#								
LSC					LSC					LSC			_ _
			Correction					Correction Completed					Correction
ID Prefix			Completed		ID Prefix					ID Prefix			Completed
Reg. #					Reg. #								
LSC					LSC					LSC			_ _
Reviewed By	, Re	viewed E	Зу	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	y B	BF/sd		1	2/26/1	3	1056	52				08/2	7/13
Reviewed By	, Re	eviewed E	Зу	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed	d on:					-				a Summary of		
	7/11/201	13				Unco	orrecte	d Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245532	(Y2) Multiple Construction A. Building B. Wing 01 - MA	IN BUILDING	(Y3) Date of Revisit 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	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
		(Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			08/09/2013		ID Prefix			08/16/2013		ID Prefix			_
Reg. #	NFPA 101				Reg. #	NFPA 101				Reg. #			_
LSC	K0029				LSC	K0130				LSC			_
									\top				
		(Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
ID Prefix	-				ID Prefix					ID PIEIIX	-		
Reg. #					Reg. #					Reg. #			_
LSC					LSC					LSC			
			O +!					0					0
			Correction					Correction					Correction
ID Prefix			Completed		ID Prefix			Completed		ID Prefix			Completed
Reg. #					Reg. #					Reg. #			
LSC					LSC								_
									+-				
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			·		ID Prefix					ID Prefix			_
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			- -
		(Correction					Correction					Correction
ID Drofiv			Completed		ID Drofiv			Completed		ID Drofiv			Completed
													_
Reg. #					Reg. #					Reg. #			
LSC					LSC				┿-	LSC			_
Reviewed By	Revi	iewed B	у	Da	te:	Signature of	Surve	yor:				Date:	
State Agency	PS	S/sd		1	2/26/13		27	200					09/16/13
Reviewed By	Revi	iewed B	у	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to	Survey Completed of	on:				Check fo	or anv	Uncorrected I	Defici	encies. Was	a Summary of	1	
	7/9/2013						•				to the Facility?	YES	NO

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: RX3T

Facility ID: 00312

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

MEDICARE/MEDICAID PROVIDER NO. (L1) 245532 2.STATE VENDOR OR MEDICAID NO. (L2) 803742600 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 6. DATE OF SURVEY 07/11/2013 (L34) 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TIC	3. NAME AND ADDRESS OF FACIL (L3) BETHESDA HERITA (L4) 1012 EAST THIRD ST (L5) WILLMAR , MN 7. PROVIDER/SUPPLIER CATEGOR 01 Hospital 05 HHA 02 SNF/NF/Dual 06 PRTF 03 SNF/NF/Distinct 07 X-Ray 04 SNF 08 OPT/SP	GE CEN REET	(L6) 56201 02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	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 FISCAL YEAR ENDING DATE: (L35) 09/30
0 Unaccredited 1 TJC 2 AOA 3 Other	04 SNF 08 OF 1/SF	12 KHC	10 HOSPICE	07/30
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS	:		
From (a):	A. In Compliance With Program Requirements		And/Or Approved Waivers Of Th 2. Technical Personnel	
To (b):	Compliance Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds 125 (L18)	1. Acceptable POC		4. 7-Day RN (Rural SNF)5. Life Safety Code	9. Beds/Room
13.Total Certified Beds 125 (L17)	X B. Not in Compliance with Progr Requirements and/or Applied		* Code: B*	(L12)
14. LTC CERTIFIED BED BREAKDOWN			15. FACILITY MEETS	
18 SNF 18/19 SNF 19 SNF	ICF IID		1861 (e) (1) or 1861 (j) (1):	(L15)
125 (L37) (L38) (L39)	(L42) (L43)			
16. STATE SURVEY AGENCY REMARKS (IF APPLICABL	E SHOW LTC CANCELLATION DATE)):		
See Attached Remarks				
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY A	APPROVAL Date:
Karen Aldinger, HFE NEII	08/30/2013	(L19)		(L20)
PART II - TO BE	COMPLETED BY HCFA RE	EGIONAI	L OFFICE OR SINGLE STA	
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate 2. Facility is not Eligible (L21)	20. COMPLIANCE WITH (RIGHTS ACT:	CIVIL	21. 1. Statement of Finan2. Ownership/Control3. Both of the Above	Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC AGREEM	ENT 24. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION BEGINNING	DATE ENDING DAT	Е	VOLUNTARY 00	INVOLUNTARY
01/10/1989			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24) (L41)	(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE: 27. ALTERNATIVE			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
A. Suspension	n of Admissions: (L44)		of other reason for windrawar	07-Provider Status Change 00-Active
(L27) B. Rescind Sus				
28. TERMINATION DATE: 29	. INTERMEDIARY/CARRIER NO.		30. REMARKS	
2)	03001			
(L28)	03001	(L31)	Posted 9/13/2013	3 ML
31. RO RECEIPT OF CMS-1539 32	. DETERMINATION OF APPROVAL DA	ATE		
(L32)				

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00312

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.



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;

Bethesda Heritage Center July 31, 2013 Page 2

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, 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

Bethesda Heritage Center July 31, 2013 Page 4 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

Bethesda Heritage Center July 31, 2013 Page 5

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

Bethesda Heritage Center July 31, 2013 Page 6

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

Colleen Feach

FO BOX 04900

Saint Paul, Minnesota 55164-0900

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

Enclosure

cc: Licensing and Certification File

Administrator Michielettan

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.

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUC		G			(X3) DAT	E SURVEY
	PROVIDER OR SUPPLIER DA HERITAGE CENT	245532 ER	B. WING	101	EET ADDR 2 EAST TI LLMAR, I	HIRD S	TREET		CODE	. 07/	09/2013
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI	×	(EAC	CH CORE	RECTIV	N OF CO E ACTION TO THE CIENCY)	N SHOU		COMPLETION DATE
K 000	Continued From pa By e-mail to: Barbara.lundberg@ and Marian.Whitney@s	gstate.mn.us	KO	000	1/1		e e			3 +	
**	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defici 2. The actual, or pr 3. The name and/or responsible for con	what has been, or will be, done lency. oposed, completion date.		i de la companya de l	s		(4)	* *	-		
	Bethesda Heritage with no basement. at 2 different times constructed in 195 Type II(222) constructed to the east a determined to be o Because the origin meet the construct	Center is a 4-story building The building was constructed The original building was T and was determined to be of action. In 1999, additions were and west which were Type II(222)construction. al building and the additions ion type allowed for existing by was surveyed as one		- Lander	3	20	(#E)		(2)	2	
	sprinkler system. T alarm system with corridors and space	tected by a complete fire the facility has a complete fire smoke detection in the es open to the corridor, that is matic fire department								¥	

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		, ,	MB.NO. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED
	140	245532	B. WING_	A	07/09/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT		_ 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 66201	1 01103/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULT CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DIBE COMPLETION
K 000	Continued From panotification. The facility has a licand had a census osurvey.	ge 2 ensed capacity of 125 beds f 114 at the time of the	K 000		
K 029 SS=D	The requirement at NOT MET as evided NFPA 101 LIFE SAL One hour fire rated fire-rated doors) or a extinguishing system and/or 19.3.5.4 protothe approved automoption is used, the automoption is use	construction (with % hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When eatic fire extinguishing system areas are separated from oke resisting partitions and eff-closing and non-rated or exceed bottom of the door are 1 Inot met as evidenced by: ons, the facility has failed to ection for 1 of several eated throughout the facility in PA Life Safety Code 101 on 19.3.2.1. The following bould affect residents, staff are and fire in this rooms could	K 029	1. The penetration in the ce was sealed with fire caull the maintenance depart. 2. The completion date for August 9th, 2013. 3. Maintenance will be doin walk-thru each month X months, a different floor month, to ensure there a open penetrations in the ceiling. This check will be monitored by the Environmental Services Director.	k by ment. this is g a 6 each ere no

		T WILDIOAID SERVICES				0000-0391
STATEMENT ND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING 01 - MAIN BUILDING	(X3) DAT	E SURVEY PLETED
	8.	245532	B. Wing		07/	09/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT			STREET ADDRESS, CITY, STATE, ZIP 1012 EAST THIRD STREET	CODE	*
				WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
K 029	07/09/2013, obser a vertical penetrati sewage pipe locati	ween 12:30 PM to 3:30 PM on vation revealed that there was on in the ceiling around a	KO	29		(4)
	Maintenance Supe				27	
K 130 SS=D		LLANEOUS ICIENCY NOT ON 2786	K1	80 K 130		
				1. The Maintenance	staff will	
	7	#		remove non-eleva	tor material	
				from the equipme		1
	Based on observe	is not met as evidenced by: ations, the facility had ed in the elevator equipment		2. The completion da project is August 1		
		nt practice is in violation of the		3. Maintenance staff	f will do a	
	Minnesota State F	ire Code (07) 315.2.3.4, no ge or any other type of storage		monthly check of		
	elevator machine	elevator equipment rooms or rooms. This deficient practice		ensure it stays fre elevator material.		5.0
	event of a fire.	ents, visitors, and staff in the	(40)	Environmental Se will monitor this p		
	Findings include:					
	07/09/2013, it was	ween 12:30 PM to 3:30 PM on observed in that there were g stored in the facility's elevator			×	
E	This deficient prac	ctice was verified by the	:*		e	
€	wantenance sup	a visut.	χ.		н "	

RECEIVED

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

PRINTED: 07/31/2013 FORM APPROVED

AUG 1 4 2013 OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		MN nebt of Health	(X3) DATE COMP	SURVEY LETED
	•	245532	B. WING		St.Cloud	07/1	1/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		10	REET ADDRESS, CITY, STATE, ZIP CODE 112 EAST THIRD STREET (ILLMAR, MN 58201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION BATE
·F 000	INITIAL COMMEN	тѕ	F	000			
	as your allegation of Department's acce bottom of the first p	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.	·				
F 157 SS=D	revisit of your facili validate that substa regulations has be your verification. 483.10(b)(11) NOT	acceptable POC an on-site ty may be conducted to antial compliance with the en attained in accordance with TIFY OF CHANGES E/ROOM, ETC)	F	167			
	consult with the reknown, notify the ror an interested fa accident involving injury and has the intervention; a sign physical, mental, odeterioration in he status in either life clinical complication significantly (i.e., a existing form of treatment); or a dethe resident from 1 §483.12(a). The facility must a and, if known, the	nediately inform the resident; sident's physician; and if esident's legal representative mily member when there is an the resident which results in potential for requiring physician difficant change in the resident's or psychosocial status (i.e., a faith, mental, or psychosocial threatening conditions or ons); a need to alter treatment an eatment due to adverse to commence a new form of ecision to transfer or discharge the facility as specified in	क्षेम	(b)			
	change in room or specified in §483.	y member when there is a roommate assignment as 15(e)(2); or a change in	, K	8			
LABORATOR	RY DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RX3T11

Facility ID: 00312

If continuation sheet Page 1 of 24

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES. OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING _ B. WING 07/11/2013 245532 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1012 EAST THIRD STREET BETHESDA HERITAGE CENTER WILLMAR, MN 58201 PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 157 Continued From page 1 F 157 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of Nurse Practitioner was notified by MDH this section. surveyor of resident #60 pressure area The facility must record and periodically update on July 10th, 2013. NP spoke to RN case the address and phone number of the resident's manager on July 11th, 2013 to discuss legal representative or interested family member. plan of treatment. MD or NP have been notified of all other residents with open This REQUIREMENT is not met as evidenced pressure ulcers. by: Based on observation, interview and document review, the facility failed to immediately notify the MD or NP will be notified at the onset physician when 1 of 3 residents (R60) developed of an open pressure ulcer. a pressure ulcer. Licensed nursing staff will be educated Findings include: on August 13th, 14th and 19th, 2013 on R60 was interviewed on 7/9/13 at 9:20 a.m. and notification of MD or NP at the onset of stated she had developed a sore on her buttocks an open pressure ulcer. 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. " DON/ADON or designee will do random chart audits to confirm compliance with R60's buttocks were observed with Registered notification of the MD or NP upon the Nurse (RN)-F on 7/11/13 at 9:30 a.m. The area above the rectum and spreading onto each onset of an open pressure ulcer. 4 buttock was bright red to approximately a 6 x 6 chart audits will be done monthly X 3 centimeter (cm) area. The redness was months starting August 19th, 2013. 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

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

"Intact skin with non-bleachable redness of a localized area usually over a bony prominence].

meeting.

Audits will be reviewed at monthly QA

Completion date: August 19th, 2013.

PRINTED: 0//01/2013

ا	DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			· <u> </u>		APPROVED 0938-0391
S	TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILE		CONSTRUCTION		SURVEY PLETED
			245632	B. WING	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		07/	11/2013
_	NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
	BETHESE	A HERITAGE CENT	ER			12 EAST THIRD STREET LLMAR, MN 56201		
	(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
	F 157	red pink wound be stated she did not ulcer or not. RN-F will apply some "ca ointment] on the reany treatment orders the ointment use protection. RN-F the unit manager of the unit manager	as a shallow open ulcer with a d, without slough]. RN-F know if this was a pressure stated when she works, she almoseptine" [a protectant id area, but R60 does not have ared for this. The calmoseptine id on everyone who needs skin had not reported this area to be the physician. ge Center Pressure umentation Policy and do1/12 included under policy, NP [nurse practitioner] is to be		157			
	F 243 SS=D	notified at the onse 483.15(c)(1)-(5) R RESIDENT/FAMIL A resident has the participate in resident's family h facility with the far facility; the facility family group, if on staff or visitors ma group's invitation; designated staff p assistance and re that result from gr This REQUIREM by: Based on intervie facility falled to m council within the	et of an open pressure ulcer." IGHT TO PARTICIPATE IN LY GROUP right to organize and lent groups in the facility; a as the right to meet in the nilles of other residents in the must provide a resident or e exists, with private space; ay attend meetings at the and the facility must provide a erson responsible for providing sponding to written requests	F	243			

PRINTED: 07/31/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 07/11/2013 245532 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1012 EAST THIRD STREET **BETHESDA HERITAGE CENTER** WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE . CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 3 F 243 F 243 F 243 residing in the facility. Bethesda Heritage Center reminds Findings include: resident family members of their opportunity to organize and participate During entrance conference, on 7/8/13 at 1:15 in a Family Council. On July 30, 2013 p.m., the director of nursing (DON) stated there was no active family council and would provide family members were sent a letter Information on when the last attempt was made informing them of their right to form a to form one. Family Council. During an interview with both social workers (SW-A) and (SW-B) on 7/10/13 at 1:25 p.m., The Awareness of and Participation in SW-B confirmed the last formal attempt to Family Council Policy was established develop a family council was April 2012. SW-A stated the director of social services usually took on August 5, 2013. care of this. SW-B stated when they started looking through the file "we knew it should have The Family Council policy was reviewed been done." with Social Service staff on August 5, Review of a facility letter titled "Dear Family 2013.

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assessment is completed.

year.

SS≂D

F 278 | 483.20(g) - (j) ASSESSMENT

resident's status.

Member/Friends"; dated April 2012 indicated this

No policy or further information was provided as to the attempt to start a family council in the past

was the last attempt to form a family council.

ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the

each assessment with the appropriate participation of health professionals.

A registered nurse must conduct or coordinate

A registered nurse must sign and certify that the

Event ID: RX3T11

Facility ID: 00312

F 278

Completion date: August 19th, 2013.

if continuation sheet Page 4 of 24

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

PRINTED: 07/31/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		OAREDO	B. WING		07/4	1/2013
		245532		STREET ADDRESS, CITY, STATE, ZIP C		112013
*=	PROVIDER OR SUPPLIEF DA HERITAGE CEN			1012 EAST THIRD STREET WILLMAR, MN 56201		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	Each Individual wassessment must that portion of the Under Medicare a willfully and know false statement in subject to a civil r \$1,000 for each a willfully and know to certify a materized and the resident assessment. Clinical disagree material and fals This REQUIREM by: Based on intervifacility failed to e reviewed for a cheeded with drest regarding dressi. Findings include set (MDS) dated no cognitive impone person phys However, the anthe resident was required no assi. Review of the Q	the completes a portion of the isign and certify the accuracy of assessment. and Medicald, an Individual who ingly certifies a material and a resident assessment is money penalty of not more than assessment; or an individual who ingly causes another individual all and false statement in a ment is subject to a civil money are than \$5,000 for each the statement. IENT is not met as evidenced the and document review, the naure 1 of 2 residents (R76) mange regarding assistance assing was accurately coded		MDS was reviewed and more resident # 76. MDS modification of the MDS assessment. Indicare plans will be developed resident which coordinate MDS assessment. RN staff will be educated of the MDS assessment and the coordinating ADL care staff will be educated in cl ADLs on August 13 th , 14 th , 2013. DON/ADON or designee we chart audits to review ADI the MDS assessment for a chart audits will be done in months starting August 19 Audits will be reviewed at meeting. Completion date: August	d upon a significant ally by using vidual ADL ed for each s with the on August e ADL section ad developing plan. CNA harting the and 16 th , vill do random L section of accuracy. 8 monthly X 3 9 th , 2013.	
	with dressing re	quiring assist to put her edema		Completion date: August	TA ' YOT?'	<u> </u>

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES		•	FORM A	O773172013 PPROVED 0938-0391_	
STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
•		245532	B. WING		07/11/2013		
45.	ROVIDER OR SUPPLIER A HERITAGE CENT	•	10	REET ADDRESS, CITY, STATE, ZIP CODE 112 EAST THIRD STREET FILLMAR, MN 56201	٠.		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE, [(X6) COMPLETION DATE	
F 278	Continued From p	age 5 on and to take it off."	F 278				
	nurse (RN)-C state has she ever, work the resident had a	n 7/9/13 at 3:20 p.m. registered ed R76 does not currently, nor n edema wear (TED hose) and lways been independent with mission nearly a year ago.			-		
F 282 SS=D	stated she did R76 5/7/13. RN-D stated and the resident has with dressing. RN she coded the ME the quarterly assess extensive assist. keyed in error." A provided in regard dressing and use 483.20(k)(3)(ii) Si	ERVICES BY QUALIFIED	F 282				
-	must be provided	rided or arranged by the facility by qualified persons in each resident's written plan of		F 282 Toileting schedules will be follow individual care plan for each resi	ident.		
	by: Based on observereview, the facility for 1 of 1 residen with toileting as a Findings include: Alzheimer disease	ENT is not met as evidenced vation, interview, and document y failed to follow the plan of care t (R12) to provide the assistance assessed. R12 had diagnoses of the interview of the diagnoses		Resident care sheets/care plans been reviewed and are available nurses' station on each floor an be used by each CNA daily. Toil and repositioning sheets are at nurses' stations to document these tasks are completed.	e at the d are to leting the		

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			<u>. Ol</u>		APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
•		245532	B. WING			07/1	1/2013
•	ROVIDER OR SUPPLIER DA HERITAGE CENT		·	10	REET ADDRESS, CITY, STATE, ZIP CODE 12 EAST THIRD STREET ILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION	<u></u>	, (VE)
(X4) ID PREFIX TAG	. (FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	(X6) COMPLETION DATE
F 282	extensive assistant was frequently incommon to fow incontinent of bow R12's care plan daneeded assistance toileted every two During constant of from 6:50 a.m. to sitting in her whee At 9:30 a.m. nursit assisted R12 from in the dayroom an assisted to the batted R12 was to resident is to be to Con 7/10/13 at 9:4 R12 to the bathro incontinent product amount of urine" amount in the toil 483.25(c) TREAT PREVENT/HEAL Based on the corresident, the facil who enters the factors are unavoid pressure sores reservices to promite the continuous of the corresponding to the correspond	ve impairment, needed ce with toileting needs, and ontinent of urine, and always el. ated July 2013 indicated R12 with toileting and was to be hours during waking hours. Deservation of R12 on 7/10/13 2:30 a.m. R12 was observed lichair without being toileted. In a sasistant (NA)-B and NA-C in her wheelchair onto the couch defend R12 was not offered or throom at this time. In 7/10/13 at 9:35 a.m. NA-B illeted last at 6:45 a.m. and the oilleted every two hours. In a.m. NA-B and NA-C assisted om per surveyor request. R12's ot was wet with a "medium per NA-C. R12 urinated a small et.	F	314	CNA staff will be educated on the importance of following the care pregarding the individualized toilet schedules for our residents and he document that the task was compared that the task was compared to task was compared to the task was compared to task was compared to the task was compared to the task was compared to the task was compared to task was compared to task was compared to task was compared to task was co	ing ow to pleted. 13th, inpliant initor andom it staff ing task. 8 thly X 3 3. inly QA	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING_ B. WING 07/11/2013 245532 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1012 EAST THIRD STREET BETHESDA HERITAGE CENTER WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 314 Continued From page 7 F 314 F 314 This REQUIREMENT is not met as evidenced All residents admitted to the facility will by: Based on observation, interview and document be assessed for skin risk upon review, the facility failed to comprehensively admission, quarterly, and upon assess a pressure vicer which developed in significant change. An Individualized house which includes determine causative plan of care will be developed factor/s, or provide treatments and preventative measures to promote healing and prevent further depending on the resident's needs and development of pressure ulcers for 1 of 3 abilities to prevent skin breakdown. If residents (R60) reviewed for pressure ulcers. In addition, the facility failed to ensure 1 of 3 skin breakdown does occur, a skin residents (R12) reviewed at risk for pressure assessment will be completed by RN ulcers was assisted with repositioning as

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been updated.

ulcers.

assessed to ensure the prevention of pressure

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

7/11/13 when asked by surveyor. Also the physician had not been immediately notified, and

of the pressure ulcer, or preventing further pressure ulcers from developing. R60 had

joint disease, and gout. R60's admission

required increased assistance for bed mobility after a fall on 7/4/13, however, R60's care plan

skin assessment) of this area was completed until

no interventions had been placed to aid in healing

had not been re-assessed, and care plan had not

R60's diagnosis included back pain, degenerative

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

Event ID: RX3T11

Facility ID: 00312

2013.

upon the onset of the open pressure

ulcer. Weekly skin assessments will

follow until area is healed. Resident

#60 skin has been assessed weekly

treatment plan has been established

RN staff will be educated on Skin Risk

policy and procedure on August 13th,

Assessment and Wound Documentation

since July 11, 2013 and is being

monitored daily by staff. Skin

recommendations and orders.

and changed PRN per NP

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			. OI		PPROVED 938-0391
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		· 245532	B. WING			07/1	1/2013
NAME OF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BETHES	DA HERITAGE CENT	ER /			12 EAST THIRD STREET ILLMAR, MN 56201	·	,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY))BE ((X6) COMPLETION DATE
F 314	ulcers. The pressu (CAA) dated 5/15/assist with putting up from bed. She when in bed using to stand independs she wishes to character [a tool used development] is 2'developing pressu time. Proceed to a "Resident receiver ambulation." The skin will be health approach listed we every bath and per R60 was interview she was in bed or a large wedge curapproximately 30 developed a sore stated, "I got the because since I me move around or in bed." R60 s due to swelling or pressure right ow where she has a to keep her legs addition R60 stat has had significa	re ulcer care area assessment 3 read, "Resident receives feet into bed and with getting is able to roll from side to side positioning bars. She is able ently form w/c [wheel chair] if inge position in w/cBraden to predict pressure ulcer i [indicating low risk for re ulcers]no referral at this are plan. " ated 5/15/13 for "Skin" read, assist with transfers and goal was listed as "Resident's with no open areas." The only as, "Monitor skin condition with it [perineal]care." yed on 7/9/13 at 9:20 a.m. while in her back with legs elevated on shion and head of bed up degrees. R60 stated she had on her buttocks which hurt. R60 sore [located on buttock] ave been here, they won't let myself, I am stuck in the chair tated her legs were elevated in her ankles, but this puts er the area on her buttocks sore. Staff has encouraged her elevated due to edema. In ed she had fallen on 7/4/13 and not herself independently, or get	9	314	DON/ADON or designee will do re audits to confirm compliance that Risk Assessment and weekly would documentation (if applicable) are completed at appropriate times individualized care plans are beindeveloped to prevent skin break 8 random audits will be done more 3 months starting August 19 th , 2000. Repositioning schedules will be followed per Individual care plane each resident. Resident care sheets/care plans are available nurses' station on each floor and be used by each CNA daily. Toll and repositioning sheets are at nurses' stations to document the these tasks are completed. CNA staff will be educated on the importance of following the care regarding the individualized repositioning schedules for our residents and how to document the task was completed. This exit will be on August 13th, 14th, a 2013.	t Skin nd	

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

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ B. WING 07/11/2013 245532 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1012 EAST THIRD STREET **BETHESDA HERITAGE CENTER** WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 9 Licensed Nursing staff will be 5/6/13 Indicated recent unintended weight loss monitoring that CNA staff are compliant due to not feeling well and to monitor weight with repositioning our residents at status and skin integrity. Nursing progress note appropriate times. They will be dated 5/17/13 read "has red inflamed skin on coccyx area-warm to touch...washed and dried documenting each time they monitor area with applied calmoseptine cream to area at staff. HS [hour of sleep.]" It was noted that there had been no measurement of the pressure ulcer nor DON/ADON or designee will do random further description of this area was evident in the medical record. audits to confirm compliance that staff . is following the individualized Nursing assistant (NA)-D was interviewed on 7/11/13 at 9:00 a.m. and stated R60 requires repositioning schedule for our residents assistance to move in bed, and for transfers they and documenting completion of the use mechanical lift. R60 has had red buttocks for task: 8 random audits will be done several weeks; she will get the nurse passing medications in the morning to put some ointment monthly X 3 months starting August on the red area. Also R60 will usually lays on her 19th, 2013. back in bed to get her legs elevated. Audits will be reviewed at monthly QA R60's buttocks area was observed with Registered Nurse (RN)-F on 7/11/13 at 9:30 a.m. meeting. The area above the rectum and spreading onto each buttock was bright red and measured Completion date: August 19th, 2013. 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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM APPROVED DMB NO. 0938-0391			
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
245532			B. WING			07/11/2013			
	ROVIDER OR SUPPLIER DA HERITAGE CENT	ER		101	REET ADDRESS, CITY, STATE, ZIP CODE 12 EAST THIRD STREET ILLMAR, MN 56201	-			
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F 314	ulcer or not. Also F she will apply som- ointment on the re- not have an order the ointment used protection RN-F so not reported this ro or to the physician. When interviewed licensed practical works with R60 ar ointment on her bredness, no open had been persistent know if the arc LPN-E said she uresidents who had is on the facilities.	know if this was a pressure RN-F stated when she works e "calmoseptine" a protectant d area, even though R60 does for this. The calmoseptine is on everyone who needs skin aid. RN-F then said they had edden area to the unit manager on 7/11/13 at 9:42 a.m., nurse (LPN)-E stated she and has put the calmoseptine uttocks; she had only noticed area on 7/10/13. The redness ont for about a month. She did as was a pressure ulcer or not sed the calmoseptine on a reddened buttocks because it standing orders. Also LPN-E the redden area to the unit		314					
	records from 5/17	and treatment administration 7/13 through 7/11/13 falled to ment/s for the pressure ulcer an almoseptine had been used for	d						
	interviewed on 7/ not aware of the buttocks. She have assessed R60 pressure ulcer when had not been physician or fam pressure ulcer e	manager, RN-E was 11/13 at 10:15 a.m. RN-E was pressure ulcer on R60's ad not assessed the area, or for potential cause of the hen noted on 5/17/13, because n made aware of it. R60's lly had not been notified of the eveloped said RN-E.	A Principal Control of the Control o						

		AND HUMAN SERVICES & MEDICAID SERVICES					•	FORM	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		ONSTRUCTIO	(X3) DATE SURVEY COMPLETED				
		245532	B. WING_		· · · · · · · · · · · · · · · · · · ·	<u> </u>		07/11/2013		
NAME OF PROVIDER OR SUPPLIER					ET ADDRESS		E, ZIP CODE		. [
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F 314	Continued From pa	age 11	F 3′	14				*		
	at 11:00 a.m. RN-small slit at apex [t buttock cheeks me as if top layer of sk have skin over woll reddened skin over measuring 6 cm by reddened area be staged the area as stating, "The open it is not a stage 2 to calmoseptine ointishe would report the practitioner. RN-E the wedge cushion agreed, when R60 elevated, this would the reddened area R12 had been corbeing at risk for prassistance to be revent the developing at risk for prassistance to be revent the developing at risk for prassistance to be revert the developing at risk for prassistance to be revert the developing pressing the reddened extensive daily living, (ADL's developing pressing R12's current plainstructed staff the assistance every	Edescribed the ulcer as "Has he tip, point, or vertex] of easures 0.2 by 0.3 cm, appears in has peeled off. Appears to and base, not fully open. Has r both buttocks, area y 8 cm." RN-E described the ng blanchable in all areas and a stage 1 pressure ulcer, area is not all the way open, so alcer." RN-E then placed ment over area and indicated ne ulcer to the nurse is stated R60 was recently given to put her legs up. LPN-E had the head of her bed and put increased pressure on a non R60's buttocks. In prehensively assessed as ressure ulcers and required epositioned every two hours to appear to pressure ulcers, staff 45 minutes before repositioning as including dementia. The Data Set (MDS) dated 4/2/13 I severe cognitive impairment, assistance with all activities of sp., and was at risk for are ulcers. To for care dated July 2013 are resident required repositioning two hours and was at risk for and read, "history of open areas."								

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

on buttocks."

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED 0938-0391	
STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245532	B. WING			07/11/2013		
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F 314	wheelchair in the d (unknown) staff put eat breakfast. At 8 her wheelchair to the assistant (NA)-A. A and 40 minutes late R12 directly from the the dayroom. During interview of stated R12 had be that morning at 6:	age 12 layroom. At 8:00 a.m. shed R12 in her wheelchair to 3:33 a.m. R12 was pushed in he dayroom by nursing At 9:30 a.m., which was 2 hours her, NA-A and NA-B assisted her wheelchair to the couch in n 7/10/13 at 9:35 a.m. NA-B hen assisted to her wheelchair 45 a.m., and had not been sisted to the bathroom since		314				
	that time. NA-B s repositioned and a hours. NA-B verif developing pressu. During observatio and NA-B assiste not have any curre some wrinkling or wheelchair. This A policy entitled E Pressure Ulcer/W Procedure, updat Comprehensive vidocumentation of the RN when the	tated R12 should be assisted to the toilet every two lied R12 was at high risk for the ulcers. In on 7/10/13 at 9:40 a.m. NA-A d R12 to the bathroom. R12 did ent pressure ulcers but did have in her buttocks from sitting in the finding was verified by NA-B. Bethesda Heritage Center found Documentation Policy and ed 01/12 included: "Policy: wound assessment and if the assessment will be done by wound is initially identified and	d					
	weekly thereafter progress and det MD [physician] or notified at the on Under protocol, the assessment of the as well as weekly the wound. The one pressure uld non-blanchable rusually over a bo	to accurately monitor the ermine appropriate treatment. If NP [nurse practitioner] is to be set of an open pressure ulcer." The policy indicated daily ne wound would be documented a comprehensive assessment of policy further defined a stage fier as, "Intact skin with redness of a localized area only prominence" Stage two s, "Partial thickness loss of	1				eet Page 13 of 2	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A BUILDING (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED

•		245532	B. WING			07/11/2013					
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE						
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BE I RES				<u>W</u>	ILLMAR, MN 58201	<u> </u>	N/C				
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. F 314	dermis presenting	resenting as a shallow open ulcer with a		presenting as a shallow open ulcer with a		tinued From page 13 nis presenting as a shallow open ulcer with a		314			
F 315 SS=D		HETER, PREVENT UT!,	F	315	F 315	i ;					
	assessment, the faresident who enter indwelling catheter resident's clinical catheterization wa who is incontinent treatment and sen infections and to refunction as possib This REQUIREMED by: Based on observer review, the facility (R12) reviewed for provided assistant Findings include: R12 had diagnose quarterly Minimur identified the residing needs, and urine, and always Review of the cur 2013 indicated R	ent plan of care dated July 12 needed assistance with to be			Toileting schedules will be followed individual care plan for each resident care sheets/care plans we reviewed and are available at the nurses' station on each floor and be used by each CNA daily. Toile and repositioning sheets are at the nurses' stations to document the these tasks are completed. CNA staff will be educated on the importance of following the care regarding the individualized toile schedules for our residents and document that the task was common this education will be on August 14th, and 16th, 2013. Licensed Nursing staff will be monitoring that CNA staff are cowith toileting our residents at appropriate times. They will be documenting each time they mostaff.	dent. were are to ting ne times e plans eting how to npleted. 13 th ,	Y* :				

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING ___ 07/11/2013 245532 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1012 EAST THIRD STREET BETHESDA HERITAGE CENTER WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) JD EACH CORRECTIVE ACTION SHOULD BE PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DON/ADON or designee will do random F 315 F 315 Continued From page 14 audits to confirm compliance that staff The quarterly nursing summary dated 4/5/13 indicated R12 is unable to verbalize needs to staff is following individualized toileting and needs are anticipated 24 hours a day. schedule for our residents and The current bladder assessment dated 6/28/13 documenting completion of the task. 8 indicated the resident is incontinent of bladder random audits will be done monthly X 3 and required toileting every two hours. months starting August 19th, 2013. During constant observation of R12 on 7/10/13 the following was observed: Audits will be reviewed at monthly QA 6:50 a.m. - R12 was sitting in her wheelchair in meeting. the dayroom. 8:00 a.m. - R12 was brought down to breakfast in Completion date: August 19th, 2013. 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.

small amount.

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

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

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

every two hours and was currently.

urinate into the toilet "very often."

		AND HUMAN SERVICES				RM APPRO 10, 0938-0	
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I * '			(X3) DATE SURVEY COMPLETED	
	!	245532	B. WING			07/11/201	3
NAME OF F	ROVIDER OR SUPPLIER	1	.		REET ADDRESS, CITY, STATE, ZIP CODE		
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F 329 F 329 SS=D	483.25(I) DRUG RUNNECESSARY ELENT resident's druunecessary drugs drug when used in duplicate therapy); without adequate rindications for its unadverse conseques should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessary and record; and resided drugs receive grabehavioral interves contraindicated, in drugs. This REQUIREM by:	EGIMEN IS FREE FROM DRUGS ug regimen must be free from a. An unnecessary drug is any excessive dose (including or for excessive duration; or monitoring; or without adequate use; or in the presence of ences which indicate the dose of or discontinued; or any he reasons above. The ensive assessment of a symust ensure that residents duripsychotic drugs are not unless antipsychotic drug ary to treat a specific condition documented in the clinical ents who use antipsychotic dual dose reductions, and entions, unless clinically in an effort to discontinue these	F	329	MD orders reviewed for resident #16. MD order for continuation of antidepressant was obtained on July 2013. All MD orders were reviewed to the Pharmacy consultant on July 23 rd , 2020. All resident's medication will be reviewed by Consultant Pharmacist of monthly basis. Their recommendation will be given to MD for their review. Licensed nursing staff will be educated on August 13 th , 14 th and 19 th , 2013 of proper MD orders. Nursing staff will not accept "trial" orders. DON/ADON or designee will do rand chart audits to look at MD orders looking for current MD orders and adequate monitoring. 8 chart audit per month X 3 months starting August 19 th , 2013.	19, oy 13. on a ons ed on I	
	Based on interview	ew and document review, the			Audits will be reviewed at monthly	QA	

FORM CMS-2567(02-99) Previous Versions Obsolete

unnecessary medications.

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

Findings include: R16 received Citalopram and

Event ID: RX3T11

Facility ID: 00312

meeting.

Completion date: August 19th, 2013.

If continuation sheet Page 16 of 24

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			-		APPROVED . 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION		E SURVEY MPLETED	-	
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F 329	medication was giv	a 30 day trial however, the ven past the 30 day trial and not been notified of the	F 3:	29					
	depression. The q (MDS) dated 6/4/1 intact and had sign	cluded diabetes, a stroke, and guarterly Minimum Data Set 3 indicated R16 was cognitively as of depression which included d receive an antidepressant						*, *, *, *, *, *, *, *, *, *, *, *, *, *	
	disorder. Target to statements, and in will be stable." "A ordered. Monitor possible side effect	Has diagnosis of depressive behaviors: Sad mood, sad mpatience." "Residents mood dminister antidepressant as for worsening mood and cis. Notify physician as needed but of room and to attend						•	
-	Citalopram an ani	rders dated 4/22/13 included; lidepressant 10 mg (milligrams) very day) for 311 (depression al.						•	
	from 4/22/13 thro continued to rece 30 day trial which	administration records (MAR) ugh 7/11/13 indicated R16 had ive the Citalopram dally past the would have ended on 5/22/13. ers for this medication were in d.	e	.					
	8:50 a.m. R16 us wouldn't want to didn't want to go.	(RN)-E stated on 7/11/13 at e to not come out of her room, attend activities as her husband She still has days when she ep, but this has improved. R16/s			·				

	DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM A		
3	TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			245532	B. WING			07/11/2013		
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		citalopram becaus placed on hospice decline. She was only a 30 day trial.	the doctor had started the ender husband had been care and was expected to not aware the order was for or that it was to see if irritability ed. RN-E had not updated the	F 3	29				
		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.				; ·			
	F 428 SS=D	facilities pharmacy have assumed the continuation order continued to recei facility should hav regards to R16's obtained a new or 483.60(c) DRUG	on 7/11/13 at 11:55 a.m. the consultant stated she would a facility would have obtained a for the citalopram because she we the medication. Also the e updated the physician in energy level and irritability, and der for the citalopram. REGIMEN REVIEW, REPORT TON		428	F 428			
		reviewed at least pharmacist. The pharmacist notice attending physical	of each resident must be once a month by a licensed nust report any irregularities to sician, and the director of e reports must be acted upon.		•	MD orders reviewed for resident #16. MD order for continuation of antidepressant was obtained on July 19 th , 2013. All resident medication regimes were reviewed by the Pharmacy consultant on July 23 rd , 2013.	n I		

This REQUIREMENT is not met as evidenced

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:		-	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245532	B. WING		07/	11/2013
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F 428	facilities pharmacy medication irregula director of nursing 1 of 10 residents (medications. Findings include: I antidepressant on medication was githe physician had effectiveness of the R16's diagnosis in depression. The (MDS) dated 6/4/intact and had sign being tired, and direction. R16's care plan dimedication. R16's physician of code activities of choice. R16's physician of code) a 30 day trend and and and and and and and and and a	w and document review, the consultant falled to report arities to the physician and so they can act upon them for R16) reviewed for unnecessary R16 received Citalopram and a 30 day trial however, the ven past the 30 day trial and not been notified of the medication. Included diabetes, a stroke, and quarterly Minimum Data Set 13 indicated R16 was cognitively ns of depression which included id receive an antidepressant at dated 4/22/13 read Has diagnosis of depressive behaviors: Sad mood, sad mpatience." "Residents mood administer antidepressant as for worsening mood and ects. Notify physician as needed out of room and to attend e." Orders dated 4/22/13 included; atidepressant 10 mg (milligrams) every day) for 311 (depression		All resident's medication rewill be reviewed by Consult Pharmacist on a monthly be Their recommendations will given to MD for their review Licensed nursing staff will be educated on proper MD or on August 13 th , 14 th and 19 2013. DON/ADON or designee we the completion of the Phat Consultant's monthly revieweach resident's medication regime and their recommendation reports. Chart audits per month X months starting August 19 2013. Audits will be reviewed at meeting monthly. Completion date: August 2013.	tant asis. Il be w. be rders oh, ill audit rmacy ew of n 8 3	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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ļ	PROVIDER OR SUPPLIER DA HERITAGE CENT			10	TREET ADDRESS, CITY, STATE, ZIP CODE 012 EAST THIRD STREET VILLMAR, MN 56201	CODE	
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F 428	No additional order the medical record Registered nurse (8:50 a.m. R16 use wouldn't want to at didn't want to sleep family had told her citalopram because placed on hospice	vould have ended on 5/22/13. rs for this medication were in	F	428			-
	only a 30 day trial, and energy improv doctor on irritability R16's Monthly Med dated 5/20/13, the citalopram, and on review of medicatic were made for app	or that it was to see if irritability ed. RN-E had not updated the				. •	
F 431 SS=D	facilities pharmacy have assumed the continuation order receive the medica been monitoring R irritability, updated new order for the consultant had not citalopram had not it for, nor had she past the stop date.	on 7/11/13 at 11:55 a.m. the consultant stated she would facility would have obtained a because she continued to ation. The facility should have 16 for energy level and the physician and obtained a ditalopram. The pharmacy noted the monitoring of the been what the doctor ordered noted the medication continued DRUG RECORDS, RUGS & BIOLOGICALS	F	431			

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PR AND PLAN OF CORRECTION IDE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATÈ SURVEY COMPLÈTED	
		246532	B. WING		07/11/20)13
	ROVIDER OR SUPPLIER DA HERITAGE CENT	<u></u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE 012 EAST THIRD STREET VILLMAR, MN 66201		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	DBE COM	(X5) PLETION DATE
F 431	Continued From particles a licensed pharma of records of receip controlled drugs in accurate reconciliar records are in order controlled drugs is reconciled. Drugs and biologic labeled in accorda professional princi appropriate access instructions, and the applicable. In accordance with facility must store locked compartme controls, and permit have access to the The facility must permanently affixed controlled drugs in Comprehensive Drugs and permit controlled drugs in Comprehensive Drugs abuse, except which package drug distinguished.	age 20 mploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an atlon; and determines that drug er and that an account of all maintained and periodically cals used in the facility must be nee with currently accepted ples, and include the sory and cautionary he expiration date when all drugs and biologicals in ents under proper temperature hit only authorized personnel to be keys. Provide separately locked, and compartments for storage of sted in Schedule II of the large Abuse Prevention and 6 and other drugs subject to en the facility uses single unit wibution systems in which the minimal and a missing dose car	F 431	The 2 Medication carts that wer to not be in working order were on July 11, 2013 by maintenance All other medication carts were for proper working order. On July 2013, nursing staff was instructed check their medication cart drawdaily to ensure they are locking appropriately and to report to maintenance immediately if it is working order. Medication bottles for resident and #59 were removed and new were ordered on 7/11/2013. All medications that were not proplabeled and/or expired were refrom the all medication carts or 23 rd , 2013. Licensed nursing staff will be edd on the medication cart and storpolicy, proper medication labelid dating medications when opened shortened expiration dates on A 13 th , 14 th , and 19 th , 2013.	fixed e staff. checked aly 15 th , ed to wers not in #150 bottles l erly moved a July lucated age ng, ed, and	
	by: Based on observ	ENT is not met as evidenced ation, interview, and document falled to ensure 2 of 7				

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING

(X3) DATE SURVEY
COMPLETED

245532

B. WING

07/11/2013

NAME OF PROVIDER OR SUPPLIER

BETHESDA HERITAGE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 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 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		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 19 th , 2013. Audits will be reviewed at monthly QA meeting. Completion date: August 19 th , 2013.	

FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		E SURVEY PLETED
		245532	B. WING		07/	11/2013
	PROVIDER OR SUPPLIE DA HERITAGE CEN	*	10 ⁻	REET ADDRESS, CITY, STATE, ZIP C 12 EAST THIRD STREET LLMAR, MN 56201	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	name. The bottle drops dated 5/25 verified R59 recenight, and they shad expire on Ju form the open dathe outside the nurse at 9:19 a.m. Upon cart one side of the wall. The melocked, however opened and the locked. The top contained 5 bottles of various contained prescribed prescribed and the locked. The top contained prescribed prescribed and the locked. The top contained prescribed and the wall 9: she was not away medication cart still opened which medication. RN maintenance "In returned from bit condition of the defective lock he "Several days and locking prop it she had been wall" until it can maintenance (Minedication cart fixed the problem	here was a bottle with R59 's was labeled lantanoprost eye /13 as the open date. LPN-A lived these eye drops every hould no longer be used as they ly 6, 2013 which was 42 days ate. ation cart on 3rd floor was sitting as 'station with no staff nearby on inspection of the medication he cart was pushed up against edication cart appeared to be the top and middle drawer were drawer of the medication cart es of various eye drops and 8 insulins. The middle drawer ription medication for R8, R108, and R48. There was no staff 35 a.m. RN-B stated at 9:35 a.m. are there were problems with the and verified although the was locked, 2 of the 4 drawers the contained prescription—B stated she would call medication cart LPN-B stated the medication cart LPN-B stated the ad been passed on in report go" that the medication cart was erly and at the time she reported told to "push it up against the be fixed. At 9:40 a.m. I)-A stated he looked at the yesterday and thought he had it				
	into the resident	t dayroom. Upon inspection of the it appeared it was locked	9			

FORM APPROVED OMB NO. 0938-0391

MAJE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
BETHESDA HERITAGE CENTER 1912			245532	B. WING		·	07/1	1/2013
F 431 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 5'-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 prescription cart the top drawer contained prescription cart the top drawer contained at tuberculin syringe with 10 mi 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 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 immedications 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	• • • • • • • • • • • • • • • • • • •		ER		10	012 EAST THIRD STREET		-
although the 3rd drawer of the medication cart opened. The drawer contained prescription medication for R133, R101, R25, R19, R199, 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 mi 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 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 adjoal 3 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	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL	DBE	(X5) COMPLETION DATE
	F 431	although the 3rd dropened. The draw medication for R13 R40, R102, and R6 at 9:46 a.m. she vest the 3rd drawer was not aware the order. Upon further cart the top drawer with 10 ml of liquid it. There was no let the syringe or pill of the medication nur currently on break. During interview or stated the unlabeled who had been bus the insulin and mo back in the drawer she needed to labe one usually goes in me." During interview or consulting pharmacy label or verified the facility maintenance is comedication in the cunauthorized access The facility policy is Storage dated 3/2 cart should be "locuse" and "License maintenance department of the consultance depart	awer of the medication cart er contained prescription 3, R101, R82, R19, R139, 5. During interview with RN-C orifled the cart was locked but still opening. She stated she drawer was not in working in inspection of the medication contained a tuberculin syringe in and a pill cup with 7 pills in the or resident name on either up. RN-C stated LPN-C was see and used this cart but was a 7/11/13 at 12:02 p.m. LPN-C at medications was for R56 by when she went to give her rning pills, so she just placed it. LPN-C stated she did not feel the medication because "Non my medication cart except a 7/11/13 at 12:05 p.m. facility cist stated resident the in from home need a they should not be used. She should be ensuring intacted immediately and the cart needs to be secured from iss. iitled Medication cart and 013 instructed the medication cart and 013 instructed the medication the cart needs to be secured from the artment of any repairs needed		431			



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

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.

Bethesda Heritage Center July 31, 2013 Page 2

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

Colleen Feach

Saint Paul, Minnesota 55164-0900

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

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

PRINTED: 07/31/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245532	B. WING		07	7/11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, S 1012 EAST THIRD STREE WILLMAR, MN 56201	STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 0	00		
F 157 SS=D	as your allegation of Department's accept bottom of the first pube used as verificated. Upon receipt of an revisit of your facilities validate that substate regulations has been your verification. 483.10(b)(11) NOT (INJURY/DECLINE) A facility must immedent with the resident involving the resident involving the injury and has the printervention; a significant physical, mental, or deterioration in heast at us in either life the clinical complication significantly (i.e., a existing form of treatment); or a decident involving the resident from the \$483.12(a). The facility must also and, if known, the resident from or interested family change in room or interested family	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with	F 1	57		

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.

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245532	B. WING	i		07/·	11/2013
	PROVIDER OR SUPPLIER	ER		10	REET ADDRESS, CITY, STATE, ZIP CODE 112 EAST THIRD STREET ILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	regulations as specthis section. The facility must rethe address and phenomenative. This REQUIREMENT by: Based on observer review, the facility of physician when 1 or a pressure ulcer. Findings include: R60 was interviewed stated she had deventher when the word of the physician when 1 or a pressure ulcer. Findings include: R60 was interviewed stated she had deventher where, they would am stuck in the character (RN)-F on 7/1 above the rectum abuttock was bright centimeter (cm) are blanchable on oute towards the center ulcer [the National In (NAPUAP) defines "intact skin with nor localized area usual in the center was a shallow open area stage 2 pressure ulcer stage 2 pressure ulcer the same and the center was a shallow open area stage 2 pressure ulcer the same and the center was a shallow open area stage 2 pressure ulcer the same and the center was a shallow open area stage 2 pressure ulcer the same and the center was a shallow open area stage 2 pressure ulcer the same and the center was a shallow open area stage 2 pressure ulcer the same and the center was a shallow open area stage 2 pressure ulcer the same and t	cord and periodically update one number of the resident's e or interested family member. NT is not met as evidenced tion, interview and document ailed to immediately notify the f 3 residents (R60) developed ed on 7/9/13 at 9:20 a.m. and eloped a sore on her buttocks he sore because since I have n't let me move around myself,	F	157			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245532	B. WING	· · · · · · · · · · · · · · · · · · ·	07/	11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	red pink wound bed stated she did not k ulcer or not. RN-F will apply some "ca ointment] on the red any treatment order is the ointment used protection. RN-F h the unit manager of A Bethesda Heritage	as a shallow open ulcer with a d, without slough]. RN-F know if this was a pressure stated when she works, she Imoseptine" [a protectant d area, but R60 does not have red for this. The calmoseptine d on everyone who needs skin ad not reported this area to r the physician.	F 1	57		
F 243 SS=D	Procedure updated "MD [physician] or I notified at the onse 483.15(c)(1)-(5) RIG RESIDENT/FAMIL' A resident has the participate in resideresident's family ha facility with the fam facility; the facility in family group, if one staff or visitors may group's invitation; a designated staff pe	right to organize and ent groups in the facility; a s the right to meet in the illes of other residents in the nust provide a resident or exists, with private space; attend meetings at the nd the facility must provide a reson responsible for providing ponding to written requests	F 2	43		
	by: Based on interview facility failed to make council within the page 2.	NT is not met as evidenced and document review, the se an attempt to form a family ast calendar year. This had ct all 114 residents currently				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245532	B. WING		07/	11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 243		ty. nference, on 7/8/13 at 1:15	F 2	43		
	was no active family	f nursing (DON) stated there y council and would provide n the last attempt was made				
	(SW-A) and (SW-B SW-B confirmed the develop a family co stated the director of care of this. SW-B	with both social workers) on 7/10/13 at 1:25 p.m., e last formal attempt to uncil was April 2012. SW-A of social services usually took stated when they started file "we knew it should have				
	Member/Friends"; o	letter titled "Dear Family dated April 2012 indicated this of to form a family council.				
F 278 SS=D	to the attempt to sta year. 483.20(g) - (j) ASSI	information was provided as art a family council in the past ESSMENT RDINATION/CERTIFIED	F 2	78		
	The assessment m resident's status.	ust accurately reflect the				
	A registered nurse each assessment w participation of heal					
	A registered nurse assessment is com	must sign and certify that the pleted.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		E SURVEY MPLETED
		245532	B. WING _		07.	/11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 4	F 27	78		
		o completes a portion of the sign and certify the accuracy of issessment.				
	willfully and knowin false statement in a subject to a civil mo \$1,000 for each asswillfully and knowin to certify a material resident assessme	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each				
	Clinical disagreeme material and false s	ent does not constitute a statement.				
	by: Based on interview facility failed to ens reviewed for a char	NT is not met as evidenced and document review, the ure 1 of 2 residents (R76) age regarding assistance and was accurately coded abilities.				
	set (MDS) dated 5/ no cognitive impairs one person physica However, the annua	R76 quarterly minimum data 7/13 identified the resident had ments and was an extensive all assist with dressing. The all MDS dated 2/8/13 indicated dependent in dressing and noce from staff.				
	5/14/13 indicated R	terly nursing summary dated 76 was an "extensive assist ring assist to put her edema				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245532	B. WING		07/	11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	nurse (RN)-C stated has she ever, worn the resident had alv	n and to take it off." 7/9/13 at 3:20 p.m. registered d R76 does not currently, nor edema wear (TED hose) and ways been independent with	F 2	78		
F 282 SS=D	During interview on stated she did R76 5/7/13. RN-D state and the resident ha with dressing. RN-she coded the MDS the quarterly assess extensive assist. R keyed in error." No provided in regards dressing and use of 483.20(k)(3)(ii) SEF PERSONS/PER CA	RVICES BY QUALIFIED	F 2	82		
	must be provided by accordance with ear care. This REQUIREMENT by: Based on observative review, the facility for 1 of 1 resident (1) with toileting as assigned include: Representation of the second review of the second	y qualified persons in ich resident's written plan of ich resident i				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		245532	B. WING			07/1	1/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP COL 1012 EAST THIRD STREET WILLMAR, MN 56201	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE		(X5) COMPLETION DATE
F 282	Continued From pa	ge 6	F 2	282			
	extensive assistance	e impairment, needed se with toileting needs, and ntinent of urine, and always l.					
	needed assistance toileted every two h During constant obs from 6:50 a.m. to 9: sitting in her wheeld At 9:30 a.m. nursing assisted R12 from I in the dayroom and assisted to the bath During interview on stated R12 was toile resident is to be toil	ed July 2013 indicated R12 with toileting and was to be ours during waking hours. Servation of R12 on 7/10/13 (30 a.m. R12 was observed chair without being toileted. It is assistant (NA)-B and NA-C her wheelchair onto the couch R12 was not offered or room at this time. 7/10/13 at 9:35 a.m. NA-B eted last at 6:45 a.m. and the eted every two hours. a.m. NA-B and NA-C assisted					
F 314 SS=D	R12 to the bathroor incontinent product amount of urine" pe amount in the toilet. 483.25(c) TREATM	m per surveyor request. R12's was wet with a "medium or NA-C. R12 urinated a small ENT/SVCS TO	F3	314			
	resident, the facility who enters the facil does not develop prindividual's clinical of they were unavoidal pressure sores received.	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245532	B. WING _		07	/11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201		711/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	by: Based on observatoreview, the facility fassess a pressure house which included factor/s, or provided measures to promodevelopment of presidents (R60) reveaddition, the facility residents (R12) reveaddition (R12) reveaddition, the facility residents (R12) reveaddition (R12) reveaddition, the facility residents (R12) reveaddition (R12) reveaddition, the facility residents (R12) reveaddition (R12) re	NT is not met as evidenced tion, interview and document ailed to comprehensively ulcer which developed in es determine causative treatments and preventative of the healing and prevent further essure ulcers for 1 of 3 riewed for pressure ulcers. In failed to ensure 1 of 3 riewed at risk for pressure d with repositioning as the prevention of pressure the prevention of pressure that ned skin on coccyx area-warm 3, and the medication nurses cant ointment to the area on revaluation (comprehensive of this area was completed until d by surveyor. Also the preventing further m developing. R60 had assistance for bed mobility	F 31	,		
	had not been re-as been updated. R60's diagnosis incipoint disease, and g Minimum Data Set she was cognitively assistance with bed	3, however, R60's care plan sessed, and care plan had not cluded back pain, degenerative yout. R60's admission (MDS) dated 5/15/13 indicated intact, required extensive d mobility, transfers and was at risk for developing				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245532	B. WING			07/·	11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, 2 1012 EAST THIRD STREET WILLMAR, MN 56201	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 314	(CAA) dated 5/15/1 assist with putting further putting further promised. She is when in bed using put to stand independence she wishes to change score [a tool used to development] is 21 developing pressure time. Proceed to care plan dat "Resident receives ambulation." The gray skin will be healthy approach listed was every bath and perior R60 was interviewed she was in bed on hard large wedge cush approximately 30 developed a sore of stated, "I got the she because since I have move around mor in bed." R60 stated to swelling of his pressure right over where she has a so to keep her legs eleaddition R60 stated has had significantly unable to reposition pressure off her but R60's nurse progressure progressur	e ulcer care area assessment 3 read, "Resident receives eet into bed and with getting s able to roll from side to side positioning bars. She is able ntly form w/c [wheel chair] if ge position in w/cBraden o predict pressure ulcer [indicating low risk for e ulcers]no referral at this are plan. " The def 5/15/13 for "Skin" read, assist with transfers and loal was listed as "Resident's with no open areas." The only s, "Monitor skin condition with [perineal]care." The don 7/9/13 at 9:20 a.m. while her back with legs elevated on alon and head of bed up egrees. R60 stated she had in her buttocks which hurt. R60 ore [located on buttock] we been here, they won't let byself, I am stuck in the chair ted her legs were elevated er ankles, but this puts the area on her buttocks ore. Staff has encouraged her evated due to edema. In the she had fallen on 7/4/13 and by more pain, causing her to be a herself independently, or get	F3				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	((X3) DATE SURVEY COMPLETED		
		245532	B. WING			07/	11/2013	
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CO 1012 EAST THIRD STREET WILLMAR, MN 56201)DE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E		(X5) COMPLETION DATE	
F 314	5/6/13 indicated redue to not feeling wistatus and skin interest dated 5/17/13 read coccyx area-warm area with applied carea with a 9:00 a.m. assistance to move use mechanical lift. several weeks; she medications in the ron the red area. All back in bed to get have a ba	rent unintended weight loss rell and to monitor weight grity. Nursing progress note "has red inflamed skin on to touchwashed and dried almoseptine cream to area at It was noted that there had rent of the pressure ulcer nor of this area was evident in the NA)-D was interviewed on and stated R60 requires in bed, and for transfers they R60 has had red buttocks for will get the nurse passing morning to put some ointment so R60 will usually lays on her	F3	14				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245532	B. WING _		07	/11/2013	
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP CODI 1012 EAST THIRD STREET WILLMAR, MN 56201		, , , , , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 314	stated she did not he ulcer or not. Also R she will apply some ointment on the recont have an order of the ointment used of protection RN-F sa not reported this record to the physician. When interviewed olicensed practical neworks with R60 and ointment on her burredness, no open a had been persisten not know if the area LPN-E said she useresidents who had is on the facilities shad not reported the manager or to the process of the protection of the protection of the probability of th	know if this was a pressure N-F stated when she works e "calmoseptine" a protectant I area, even though R60 does or this. The calmoseptine is on everyone who needs skin id. RN-F then said they had dden area to the unit manager on 7/11/13 at 9:42 a.m., urse (LPN)-E stated she id has put the calmoseptine ettocks; she had only noticed area on 7/10/13. The redness it for about a month. She did a was a pressure ulcer or not. and the calmoseptine on reddened buttocks because it tanding orders. Also LPN-E is eredden area to the unit ohysician. Indicate the pressure ulcer and the noseptine had been used for an anager, RN-E was essure ulcer on R60's not assessed the area, or or potential cause of the noted on 5/17/13, because had aware of it. R60's had not been notified of the er. Also no treatment for the	F 31	4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED		
		245532	B. WING			07/	11/2013		
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		1012	EET ADDRESS, CITY, STATE, ZIP CODE 2 EAST THIRD STREET LMAR, MN 56201				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 314	at 11:00 a.m. RN-I small slit at apex [th buttock cheeks me as if top layer of sk have skin over woureddened skin over measuring 6 cm by reddened area beir staged the area as stating, "The open it is not a stage 2 u calmoseptine ointry she would report the practitioner. RN-E the wedge cushion agreed, when R60 elevated, this would the reddened area R12 had been combeing at risk for preassistance to be reprevent the develop went 2 hours and 4 R12. R12 had diagnoses current Minimum Didentified R12 had needed extensive a daily living, (ADL's) developing pressur R12's current plan instructed staff the assistance every to skin breakdown an on buttocks." During constant ob	Go's pressure ulcer on 7/11/13 E described the ulcer as "Has he tip, point, or vertex] of asures 0.2 by 0.3 cm, appears in has peeled off. Appears to and base, not fully open. Has both buttocks, area 8 cm." RN- E described the ag blanchable in all areas and a stage 1 pressure ulcer, area is not all the way open, so lcer." RN-E then placed nent over area and indicated the ulcer to the nurse stated R60 was recently given to put her legs up. LPN-E had the head of her bed diput increased pressure on on R60's buttocks. prehensively assessed as essure ulcers and required positioned every two hours to oment of pressure ulcers, staff 5 minutes before repositioning including dementia. The eata Set (MDS) dated 4/2/13 severe cognitive impairment, assistance with all activities of and was at risk for	F3	314					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245532	B. WING			07/1	11/2013	
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		STREET ADDRESS, CITY, STATE, ZIP 1012 EAST THIRD STREET WILLMAR, MN 56201	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E E APPROPRI	3E	(X5) COMPLETION DATE	
F 314	(unknown) staff puse eat breakfast. At 8 her wheelchair to the assistant (NA)-A. A and 40 minutes late R12 directly from he the dayroom. During interview on stated R12 had been that morning at 6:48 repositioned or assistant time. NA-B starepositioned and as hours. NA-B verified developing pressure During observation and NA-B assisted not have any currer some wrinkling on he wheelchair. This fir A policy entitled Been Pressure Ulcer/Wo Procedure, updated Comprehensive word documentation of the RN when the way weekly thereafter to progress and determ MD [physician] or Notified at the onse Under protocol, the assessment of the as well as weekly content as well	ayroom. At 8:00 a.m. shed R12 in her wheelchair to :33 a.m. R12 was pushed in the dayroom by nursing to 9:30 a.m., which was 2 hours er, NA-A and NA-B assisted the er wheelchair to the couch in 7/10/13 at 9:35 a.m. NA-B and assisted to her wheelchair to a.m., and had not been isted to the bathroom since atted R12 should be assisted to the toilet every two at R12 was at high risk for the ulcers. The interest of a.m. NA-A R12 to the bathroom. R12 did not pressure ulcers but did have the buttocks from sitting in the anding was verified by NA-B. The shad Heritage Center and Documentation Policy and the assessment will be done by by ound is initially identified and accurately monitor the mine appropriate treatment. IP [nurse practitioner] is to be to fan open pressure ulcer." policy indicated daily wound would be documented omprehensive assessment of licy further defined a stage	F 3					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245532	B. WING			07/	11/2013	
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 012 EAST THIRD STREET VILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 314 F 315 SS=D	red or pink wound b	as a shallow open ulcer with a bed" HETER, PREVENT UTI,		314 315				
	assessment, the fa resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	ent's comprehensive cility must ensure that a set the facility without an is not catheterized unless the condition demonstrates that a necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder e.						
	by: Based on observative review, the facility for (R12) reviewed for provided assistance	NT is not met as evidenced tion, interview, and document ailed to ensure 1 of 1 resident urinary incontinence, was e with toileting as assessed.						
	quarterly Minimum identified the reside impairment, needed toileting needs, and urine, and always in Review of the curre 2013 indicated R12	s of Alzheimer disease. The Data Set (MDS) dated 4/2/13 ent had severe cognitive d extensive assistance with a was frequently incontinent of acontinent of bowel. ent plan of care dated July a needed assistance with be toileted every two hours s.						

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	COMPLETED		
	245532	B. WING		07/	11/2013	
NAME OF PROVIDER OR SUPPLIER BETHESDA HERITAGE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201			
(X4) ID SUMMARY STATEMENT OF D PREFIX (EACH DEFICIENCY MUST BE PRE TAG REGULATORY OR LSC IDENTIFYIN	ECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
The quarterly nursing summary indicated R12 is unable to vertand needs are anticipated 24 in the current bladder assessme indicated the resident is incontand required toileting every two During constant observation of the following was observed: 6:50 a.m R12 was sitting in interview on the dayroom. 8:00 a.m R12 was brought of the wheelchair. 8:33 a.m R12 was brought of dayroom directly from breakfast wheelchair. 9:30 a.m Nursing assistant (It transferred R12 from the wheel in the dayroom. R12 was not of bathroom at this time. During interview on 7/10/13 at verified R12 had not been toile a.m., which had been 2 hours and NA-B verified R12 was assess every two hours and was curred. During observation on 7/10/13 and NA-C assisted R12 to the request. NA-C stated R12's in was wet a medium amount with placed on the toilet and urinate small amount. During interview on 7/10/13 at stated R12 is "always" incontinurinate into the toilet "very ofter.	palize needs to staff nours a day. Int dated 6/28/13 inent of bladder to hours. FR12 on 7/10/13 her wheelchair in own to breakfast in ack into the st and left in her NA)-B and NA-C elchair to the couch offered to use the 9:35 a.m. NA-B ted since 6:45 and 50 minutes. ed to be toileted ently. at 9:40 a.m. NA-B toilet per surveyor continent product h urine. R12 was ed into the toilet a 9:40 a.m. NA-C ent and does not	F3	15			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245532	B. WING			07/·	11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 012 EAST THIRD STREET VILLMAR, MN 56201	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 F 329 SS=D	Each resident's druunnecessary drugs drug when used in duplicate therapy); without adequate nindications for its unadverse conseques should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessars diagnosed and record; and resider drugs receive grad behavioral interventil	egimen must be free from an		329			
	by: Based on interview facility failed to ens medication regime and medications w date for 1 of 10 resunnecessary medic	NT is not met as evidenced v and document review, the ture each resident 's in had adequate monitoring, ere not given beyond the stop didents (R16) reviewed for cations.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	TIPLE CO	(X3) DATE SURVEY COMPLETED			
		245532	B. WING			07/	/11/2013
	PROVIDER OR SUPPLIER	ER		1012 E	T ADDRESS, CITY, STATE, ZIP CODE EAST THIRD STREET MAR, MN 56201	1 0.,	,20.0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	antidepressant on a medication was give the physician had neffectiveness of the R16's diagnosis incomplete (MDS) dated 6/4/13 intact and had significated being tired, and did medication. R16's care plan dat "Mood/behavior: Hedisorder. Target be statements, and im will be stable." "Ad ordered. Monitor for possible side effect Encourage to be out activities of choice. R16's physician ord Citalopram an antion PO (orally) QD (evecode) a 30 day trial R16's medication a from 4/22/13 throug continued to receive 30 day trial which we no additional order the medical record. Registered nurse (F8:50 a.m. R16 use wouldn't want to atte didn't want to go.	a 30 day trial however, the en past the 30 day trial and not been notified of the emedication. Sluded diabetes, a stroke, and parterly Minimum Data Set a indicated R16 was cognitively sof depression which included receive an antidepressant set a diagnosis of depressive enaviors: Sad mood, sad patience." "Residents mood minister antidepressant as or worsening mood and is. Notify physician as needed. It of room and to attend to diere dated 4/22/13 included; depressant 10 mg (milligrams) ery day) for 311 (depression diministration records (MAR) of 7/11/13 indicated R16 had the Citalopram daily past the rould have ended on 5/22/13. Is for this medication were in		229			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245532	B. WING		07/	11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENTI	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329 F 428 SS=D	citalopram because placed on hospice of decline. She was nonly a 30 day trial, of and energy improved doctor on irritability. When interviewed of certified nurse practical nurse practical had seen R16 on 66 but was unaware the continuing order for the work of acilities pharmacy have assumed the continuation order frontinued to receive facility should have regards to R16 's erobtained a new order 483.60(c) DRUG RI IRREGULAR, ACT. The drug regimen of reviewed at least or pharmacist. The pharmacist must the attending physical nursing, and these in the second strength of the second strength	the doctor had started the her husband had been care and was expected to ot aware the order was for or that it was to see if irritability ed. RN-E had not updated the or energy. On 7/10/13 at 3:18 p.m. titioner (CNP)-A stated she (20/13, noted the citalopram, e facility failed to obtain a the citalopram. On 7/11/13 at 11:55 a.m. the consultant stated she would facility would have obtained a or the citalopram because she ethe medication. Also the updated the physician in energy level and irritability, and er for the citalopram. EGIMEN REVIEW, REPORT	F 3:			
	orkEgonkEME					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				COMPLETED	
		245532	B. WING			07	/11/2013
	PROVIDER OR SUPPLIER DA HERITAGE CENT	ER		101	REET ADDRESS, CITY, STATE, ZIP CODE 2 EAST THIRD STREET LLMAR, MN 56201	<u> </u>	, 20.10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	by: Based on interview facilities pharmacy medication irregula director of nursing s 1 of 10 residents (Findings include: Rantidepressant on a medication was given the physician had neffectiveness of the R16's diagnosis includeression. The question of the R16's diagnosis includeression. The question of the R16's diagnosis includes and had significated and had sign	and document review, the consultant failed to report rities to the physician and so they can act upon them for (216) reviewed for unnecessary 16 received Citalopram and a 30 day trial however, the en past the 30 day trial and not been notified of the emedication. Sluded diabetes, a stroke, and warterly Minimum Data Set indicated R16 was cognitively sof depression which included receive an antidepressant ted 4/22/13 read as diagnosis of depressive ehaviors: Sad mood, sad patience." "Residents mood minister antidepressant as or worsening mood and is. Notify physician as needed. It of room and to attend " ders dated 4/22/13 included; depressant 10 mg (milligrams) ery day) for 311 (depression		228			

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245532	B. WING			07/11/2013
NAME OF PROVIDER OR SUPPLIER BETHESDA HERITAGE CENTER				STREET ADDRESS, CITY, STATE, ZIP COL 1012 EAST THIRD STREET WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	No additional orders the medical record. Registered nurse (F. 8:50 a.m. R16 use the wouldn't want to attend to a subject of the subject of t	ould have ended on 5/22/13. In for this medication were in a second this medication were in a second to the still has days when she with this has improved. R16's the doctor had started the sher husband had been care and was expected to out aware the order was for or that it was to see if irritability and. RN-E had not updated the or energy. Idication Regimen Reviews contained and documented in the still had a second the start of a second the start of second the still had documented in the still had documented in the still had a second the start of second the	F 4:	28		
F 431 SS=D	past the stop date. 483.60(b), (d), (e) D	oted the medication continued DRUG RECORDS, UGS & BIOLOGICALS	F 4	31		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245532	B. WING		07/	11/2013	
NAME OF PROVIDER OR SUPPLIER BETHESDA HERITAGE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 431	a licensed pharmacof records of receip controlled drugs in accurate reconciliar records are in orde controlled drugs is reconciled. Drugs and biological labeled in accordar professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and perminave access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe package drug distriquantity stored is more presented in the readily detected.	inploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be not with currently accepted oles, and include the ory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. Ovide separately locked, discompartments for storage of the din Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ninimal and a missing dose can.	F 43				
	by: Based on observa	NT is not met as evidenced tion, interview, and document ailed to ensure 2 of 7					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245532	B. WING		07/	11/2013
NAME OF PROVIDER OR SUPPLIER BETHESDA HERITAGE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 431	working condition to resident's medication failed to ensure me labeled including exresident use of out observed in 3 of 7 r this included reside R101, R82, R19, R Findings include: During medication of following was obsert the medication car 8:50 a.m. with regist drawer; R150 had a (eye drops) about 1 pharmacy label on name was hand writhe date "7/3/13." Fineed to have a pha as an open date. From the bottle. She brings medications were told it was okaname date the bottle brings in the medications and not RN-A also indicated expire after 42 days. The medication car front of room 310 a cart was unlocked a wandering the area (LPN)-A returned to at 9:18 a.m. and verside at 15 and 15	spected were in appropriate of ensure secure storage of on. In addition, the facility dications were appropriately expiration dates to prevent dated medication. This was medication carts in the facility nt (R) R150, R59, R133, 139, R40, R102, and R5.	F4	31		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245532	B. WING			07/1	1/2013	
NAME OF PROVIDER OR SUPPLIER BETHESDA HERITAGE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 1012 EAST THIRD STREET WILLMAR, MN 56201	DE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		SHOULD BE		(X5) COMPLETION DATE	
F 431	name. The bottle w drops dated 5/25/13 verified R59 received night, and they show had expire on July 6 form the open date. The other medicatio outside the nurses at 9:19 a.m. Upon cart one side of the the wall. The medic locked, however, the opened and the secondarined 5 bottles bottles of various in contained prescripting R35, R24, R117, and available until 9:35 she was not aware medication cart was still opened which of medication. RN-B signal maintenance "Immereturned from break condition of the medication of the medication of the medication cart yes fixed the problem. At 9:44 a.m. 4th flocinto the resident date.	re was a bottle with R59 's as labeled lantanoprost eye as the open date. LPN-A ed these eye drops every ald no longer be used as they 6, 2013 which was 42 days on cart on 3rd floor was sitting station with no staff nearby inspection of the medication cart was pushed up against cation cart appeared to be e top and middle drawer cond and bottom drawer were awer of the medication cart of various eye drops and 8 sulins. The middle drawer con medication for R8, R108, and R48. There was no staff a.m. RN-B stated at 9:35 a.m. there were problems with the laterity of the 4 drawers contained prescription stated she would call ediately." At 9:38 LPN-B at and on asking about the dication cart LPN-B stated the open passed on in report that the medication cart was and at the time she reported to "push it up against the	F 4	31				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245532	B. WING		07/	11/2013	
NAME OF PROVIDER OR SUPPLIER BETHESDA HERITAGE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1012 EAST THIRD STREET WILLMAR, MN 56201	·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 431	opened. The drawer medication for R13: R40, R102, and R5 at 9:46 a.m. she ve the 3rd drawer was was not aware the corder. Upon further cart the top drawer with 10 ml of liquid it. There was no lathe syringe or pill cuthe medication nurse currently on break. During interview on stated the unlabeled who had been busy the insulin and mor back in the drawer. she needed to labe one usually goes in me." During interview on consulting pharmacy label or twerified the facility smaintenance is con medication in the caunauthorized access The facility policy tit Storage dated 3/20 cart should be "lockuse" and "Licensed"	awer of the medication cart be contained prescription 3, R101, R82, R19, R139, During interview with RN-C rified the cart was locked but still opening. She stated she drawer was not in working inspection of the medication contained a tuberculin syringe in and a pill cup with 7 pills in one or resident name on either up. RN-C stated LPN-C was see and used this cart but was a range of the medications was for R56 when she went to give her ning pills, so she just placed it LPN-C stated she did not feel the medication because "No my medication cart except range of the resident with in from home need a shey should not be used. She should be ensuring tacted immediately and the part needs to be secured from some security when not in nursing staff will inform the thement of any repairs needed	F 43				