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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: S915

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245295**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493226900**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHEL CARE CENTER**
(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/04/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **141** (L18)

13.Total Certified Beds **141** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	141			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 04/04/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 04/08/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/05/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245295
April 8, 2016

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

Dear Ms. Schoenecker:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 6, 2016 the above facility is certified for or recommended for:

141 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 141 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 8, 2016

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

RE: Project Number S5295025

Dear Ms. Schoenecker:

On March 7, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 25, 2016. 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 April 4, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 6, 2016 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 February 25, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 25, 2016, effective April 6, 2016 and therefore remedies outlined in our letter to you dated March 7, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245295 Y1	A. Building B. Wing Y2	4/4/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0281	Correction	ID Prefix F0309	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.25	Completed
LSC	03/30/2016	LSC	03/30/2016	LSC	03/30/2016
ID Prefix F0329	Correction	ID Prefix F0406	Correction	ID Prefix F0428	Correction
Reg. # 483.25(l)	Completed	Reg. # 483.45(a)	Completed	Reg. # 483.60(c)	Completed
LSC	03/30/2016	LSC	03/30/2016	LSC	03/30/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	03/30/2016	LSC	03/30/2016	LSC	03/30/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	SR/KJ	04/08/2016	16022	04/04/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/25/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245295 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	4/6/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 04/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	04/08/2016	37010	04/06/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/23/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: S915

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245295**

2.STATE VENDOR OR MEDICAID NO.
(L2) **493226900**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHEL CARE CENTER**
(L4) **420 MARSHALL AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55102**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/25/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **141** (L18)

13.Total Certified Beds **141** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	141			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE NE II 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 03/31/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 04/04/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 7, 2016

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

RE: Project Number S5295025

Dear Ms. Schoenecker:

On February 25, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 6, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 25, 2016 (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 August 25, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	02/25/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		3/30/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2016

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

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	245295	A. BUILDING _____ B. WING _____	02/25/2016

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive plan of care for 1 of 1 resident (R156) reviewed for hospice, for 1 of 1 resident reviewed for death (R90), and for 1 of 1 resident reviewed for Preadmission Screening and Resident Review (R4). Findings include: Record review revealed a Hospice Certification and Plan of Treatment form showing that R156 had been certified for hospice care on 1/22/16 with a diagnosis of Alzheimer's disease. The facility's current plan of care, dated 12/15/15, contained Focus entries for hospice care related to pain, skin integrity, and hygiene. A psycho-social Focus entry only referred to the fact that the resident was on hospice and that the resident's care should be coordinated with the hospice provider. There was no psycho-social Focus that included end-of-life issues. A spirituality Focus described spirituality as important to the resident, but did not include goals or interventions related to end-of-life issues or hospice care. The activities Focus did not include hospice care. There was a generic hospice Focus that read, "I am receiving Hospice Care through [provider name] starting on 10/24/15 for diagnoses of Alzheimers [sic]. I have expectancy of 6 months or less and I am in need of coordinated care efforts by the hospice and the nursing facility to assure all my care needs are met and the risks are addressed in a timely fashion."	F 279	Immediate corrective action: The care plan for R #156 was updated to include considerations for Hospice and end of life cares. The County Agency has been contacted to complete a PASRR for resident #4. Resident #90 no longer resides in the facility. Corrective action as it applies to others: The care plans for other residents receiving Hospice services will be reviewed to ensure the care plans include resident specific considerations for Hospice services and end of life cares. Other residents with MR/MI diagnoses will be reviewed to ensure a PASRR has been completed as required. The policy and procedure Care Planning was reviewed on February 29th, 2016 and remains current. Staff will be reeducated on the policy by March 30th, 2016. Date of Completion: March 30th, 2016 Recurrence will be prevented by: Weekly care plan audits will be conducted on each unit to ensure care plans are developed to address the resident's individual needs including: Pain, Skin integrity, ADL, and hospice/end of life care. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: DON/Designee	

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F 279	Continued From page 2 The record contained a plan of care from the hospice provider that was generic and did not include individualized details specific to the resident. When interviewed on 2/24/16, at 2:29 p.m. registered nurse (RN)-A stated that the facility staff used both the facility care plan and the hospice provider's care plan. R90's initial care plan was not developed to meet the individual's basic needs that included pain, activities of daily living, and skin integrity. R90 was admitted on 9/11/15 with diagnoses that included chronic respiratory failure with hypercapnia, chronic airway obstruction, chronic systolic heart failure, acute volume overload,and dependent on oxygen. Review of the electronic medical record identified a physicians order for R90 to take acetaminophen tablet 1000 milligram (mg) by mouth three times a day for pain, do not exceed 3000 mg acetaminophen/24 hours from all sources and Hydromorphone HCl tablet (2mg), give 2 mg orally every 4 hours as needed for pain. R90 had a physician order for Trilogy settings and to apply at bedtime and remove on waking. The order summary report include multiple orders regarding respiratory care/assess and monitoring respiratory status, and trilogy ventilator monitoring including trilogy on with all sleep (overnight and naps).	F 279		

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F 279	Continued From page 3 Electronic progress notes were reviewed. The following were noted: On 9/11/15, day of admission, resident was complaining of 10/10 pain (pain scale with 10 being the worst). R90 received pain medication. On 9/12/15 at 2:30 p.m. a progress note read: "Temp 96.9, 66, 22, 100/79 and oxygen sats 79% on nasal cannula. Resident refused to wear Trilogy ventilator until his brother came to visit and was able to talk resident into wearing Trilogy. Vital signs rechecked with Trilogy vent on and were Temp 96.0, 86, 17, 97/73 and oxygen sats 90% on Trilogy with oxygen bleed in." The note indicated the resident had been refusing cares in the morning, had refused breakfast and needed assist of 2 staff persons for boosting up in bed. On 9/12/15 at 10:53 p.m. a progress note "patient did complain of pain rating it a 9/10 and received one as needed pain medication." On 9/13/15 at 6:17 p.m. a progress note indicated the patient needed help with the activities of daily living and needed a full body mechanical lift to get out of bed. A pain assessment completed on 9/11/15 indicated the resident had pain in the last 5 days and the resident had pain medication. The assessment indicated R90 had shortness of breath or trouble breathing when lying flat and should use 02 at 3L via nasal cannula, apply Bipap via trilogy machine and advise patient to relax and do relaxation exercises with shortness of breath. The nurses analysis of pain indicated the patient had shortness of breath at times due to morbid obesity. The patient needed to have Bipap via trilogy at hours sleep and during all naps, the registered nurse needed to assess patient 's pain frequently and the patient had a hydromorphone available as needed.	F 279		

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F 279	Continued From page 4	F 279		

A review of the current initial care plan dated 9/11/15 indicated the patient had no pain. The initial care plan did not direct staff how to care for R90 with activities of daily living, the area was left blank. The care plan for skin integrity was left blank, and did not identify if R90's skin was intact or not. The care plan did identify the health problems of acute volume overload and chronic systolic heart failure and the COPD exacerbation. Interventions did include the use of the Trilogy Bipap (Bilevel Positive airway Pressure) system and its settings and the continuous use of oxygen at 2 litters per nasal cannula. However, it did not identify the trilogy should be on at hours sleep and naps and the care plan did not identify interventions for shortness of breath and lacked identification of resident refusals of care and treatment and possible interventions.

On 2/25/16 at 12:30 p.m. the clinical nurse manager/ registered nurse (RN)-B was interviewed regarding the care of R90. RN-B verified the findings and indicated the resident was admitted at the end of the week and the care plan was initiated. RN-B explained that all the nurses were trained on updating the care plan and usually the basic information such as activities of daily living and treatments are added to the care plan.

On 2/25/16 at approximately 2: 00 p.m. the director of nursing reviewed the initial care plan and verified the findings.

The facility did not develop a comprehensive plan of care for level II Preadmission Screening and Resident Review (PASRR) care for R4.

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F 279	Continued From page 5 R4 was admitted on 4/14/2008 with diagnoses that included Alzheimer's disease, dementia, anxiety and Schizophrenia. Review of the care plan, last revised 2/22/16, lacked R4's Level II preadmission screening for persons with mental retardation (MR) or related conditions. R4's assessment reference date (ARD) 2/2/16, indicated R4 had a significant change related to decline in transfer and eating assistance. A review of the OBRA ANNUAL RESIDENT REVIEW dated 10/9/90 revealed, R4 has a documented mental illness (MR) but "does not need active treatment. Note. Dual diagnosis, MI/MR, see below. Is currently receiving mental health services." A review of the care area assessments (CAAs), dated 2/3/16, revealed no indication R4's PASRR had been included in the assessment process. The CAAs for cognitive loss/ dementia and delirium noted, "CAAs triggered in relation to staff observation of short and long term memory loss; staff observation that pt's (R4) cognition is severely impaired at making decisions for self, pt. presents with inattention, disorganized thinking, and an altered level of consciousness; and evidence of an acute change in mental status from the pt's baseline." At 10:07 a.m. on 2/25/16, registered nurse (RN)-D, stated, R4 had significant change due to decline in transfers and eating and requires additional assistance.	F 279		

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F 279	Continued From page 6 At 10:50 a.m. on 2/25/16, the social worker (SW)-A, confirmed the PASRR was not in R4's medical record. SW-A reported she was not aware she needed to obtain the PASRR and had not attempted to obtain the PASRR for R4 but would place a call to the local state agency (Ramsey County). On 2/25/16 at 1:42 p.m., the director of nursing verified the PASRR was not in R4's medical record. Also stated, care plan did not address PASRR. Further revealed, resident with level II preadmission screening for persons with MR or related conditions should be in the resident medical record.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete care planning sufficient to meet the needs of a newly admitted resident with a potentially terminal condition and risk of pain for 1 of 3 resident (R83) reviewed for death. Findings include: Record review for R83 revealed an Admission Record showing that the resident was admitted on 11/5/15 and expired 11/17/15. Admitting diagnoses included malignant neoplasm of lower third of esophagus, pathological fracture in neoplastic disease, and depression.	F 281	Immediate corrective action: Resident #83 no longer resides in the facility. Corrective action as it applies to others: Residents newly admitted to the facility with a potential terminal diagnosis will have sufficient preliminary care plans developed to meet their individual pain and comfort needs and the physical and psychosocial needs of terminal care. The policy and procedure Care Planning was reviewed on February 29th, 2016 and remains current. Staff will be educated on the policy	3/30/16

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F 281	Continued From page 7 Review of the care plan in the record showed a comprehensive care plan had not been completed, but a handwritten, temporary care plan had been done that showed the initial discharge plan was for short-term stay, the resident used a wheelchair, required assist of two staff for transfers, was incontinent of bowel and bladder, was cognitively less alert and easily distracted, and received a regular diet. There was no entry for interventions related to pain management or the physical and psychosocial needs of terminal care. A nurse practitioner's progress note, dated 11/9/15, detailed a visit with R83, during which R83 complained of nausea and trouble swallowing solid foods. When asked about pain by the nurse practitioner, R83 stated that, for the most part, his pain was controlled. R83 questioned the nurse practitioner regarding his death, as to when and how it would happen. The topic of hospice was discussed with R83, but he was unable to make a decision on that date about enrolling. The nurse practitioner noted that R83's cancer pain was controlled with Methadone and Oxycodone. Review of the resident's medication administration record confirmed that the resident did routinely receive medication for pain, depression, and shortness of breath. The medication administration record also contained pain monitoring every shift. A nursing progress note, dated 11/16/15, read, "Nurse Practitioner received a call from [hospital name] to notify that patient is being admitted for pain control and for discussing Hospice cares.	F 281	updates by March 30th, 2016. Date of Completion: March 30th, 2016 Recurrence will be prevented by: Weekly care plan audits will be conducted on each unit to ensure preliminary care plans are developed to address the resident's individual needs including: pain and comfort needs and the physical and psychosocial needs of terminal care. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Don/Designee	

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F 281	Continued From page 8 Call received at 1430." When interviewed on 2/25/16, at 9:29 a.m. registered nurse (RN)-B stated that she felt R83's pain was well controlled for most of his time at the facility. She went on to explain that R83 went to an oncology appointment on 11/16/15 and R83's oncologist referred R83 to the hospital for terminal care at that time. RN-B stated that the temporary care plan for this facility generally was focused on needs for activities of daily living and a pain assessment was done for R83 on admission. The facility's Care Plans-Preliminary policy, dated 11/2010, read, "A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement care planning interventions related to the care for 2 of 3 residents (R83, R90) who were reviewed for death, and 1 of 1 resident (R156) reviewed for	F 309	Immediate corrective action: Residents #83 and #90 no longer reside in the facility. The care plan for R #156 was updated to include considerations for Hospice and	3/30/16

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F 309	Continued From page 9 hospice. Findings include: The facility did not complete a temporary care plan that addressed the immediate needs of pain risk and terminal care for R83. Record review for R83 revealed an Admission Record showing that the resident was admitted on 11/5/15 and expired 11/17/15. Admitting diagnoses included malignant neoplasm of lower third of esophagus, pathological fracture in neoplastic disease, and depression. Review of the care plan in the record showed a comprehensive care plan had not been done, but a handwritten, temporary care plan had been done that showed the initial discharge plan was for short-term stay, the resident used a wheelchair, required assist of two staff for transfers, was incontinent of bowel and bladder, was cognitively less alert and easily distracted, and received a regular diet. There was no entry for interventions related to pain management or the physical and psychosocial needs of terminal care. A nurse practitioner's progress note, dated 11/9/15, detailed a visit with R83, during which R83 complained of nausea and trouble swallowing solid foods. When asked about pain by the nurse practitioner, R83 stated that, for the most part, his pain was controlled. R83 questioned the nurse practitioner regarding his death, as to when and how it would happen. The topic of hospice was discussed with R83, but he was unable to make a decision on that date about enrolling. The nurse practitioner noted that R83's	F 309	end of life cares. The hospice provider care plan for resident #156 will be updated to include individualized resident specific details by March 30th, 2016. Corrective action as it applies to others: Newly admitted residents will have a preliminary care plan developed within 24 hours of admission to meet the immediate needs of the resident. Residents receiving hospice services will have a comprehensive care plan developed for hospice care. The policy and procedure Care Planning was reviewed on February 29th, 2016 and remains current. Staff will be educated on the policy updates by March 30th, 2016 Date of Completion: March 30th, 2016 Recurrence will be prevented by: Weekly care plan audits will be conducted on each unit to ensure preliminary care plans are developed to fully address the resident's individual needs. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Don/Designee	

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F 309	Continued From page 10	F 309		

cancer pain was controlled with Methadone and Oxycodone.

Review of the resident's medication administration record confirmed that the resident did routinely receive medication for pain, depression, and shortness of breath. The medication administration record also contained pain monitoring every shift.

A nursing progress note, dated 11/16/15, read, "Nurse Practitioner received a call from [hospital name] to notify that patient is being admitted for pain control and for discussing Hospice cares. Call received at 1430."

When interviewed on 2/25/16, at 9:29 a.m. registered nurse (RN)-B stated that she felt R83's pain was well controlled for most of his time at the facility. She went on to explain that R83 went to an oncology appointment on 11/16/15 and R83's oncologist referred R83 to the hospital for terminal care at that time. She stated that the temporary care plan for this facility generally was focused on needs for activities of daily living and a pain assessment was done for R83 on admission.

The facility's Care Plans-Preliminary policy, dated 11/2010, read, "A preliminary plan of care to meet the resident's immediate needs shall be developed for each resident within twenty-four (24) hours of admission."

R90's initial care plan lacked identification of pain, assistance with activities of daily living, condition of skin, and behavioral issues including refusals.

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F 309	Continued From page 11	F 309		

R90 was admitted on 9/11/15 with diagnoses that included acute on chronic respiratory failure with hypercapnia, chronic airway obstruction, chronic systolic heart failure, acute volume overload,and dependent on oxygen. The hospital discharge summary, dated 9/11/16 indicated R90's prognosis was poor due to frailty and "they agreed to hospice style approach after discharge with no readmit". R90 was admitted with do not resuscitate and do not intubate orders. A POLST (Provider Orders for Life Sustaining Treatment) form was signed by the medical provider on 9/11/15. The form indicated resident was not to be resuscitated or intubated. On 9/14/15 a physician order to obtain a hospice consult was written. R90 expired at the facility on 9/14/15 at approximately 11:45 p.m.

The medical record was reviewed electronically. R90's physician order included acetaminophen tablet give 1000 milligram (mg) by mouth three times a day for pain, do not exceed 3000 mg acetaminophen/24 hours from all sources and Hydromorphone HCl tablet (2mg), give 2 mg orally every 4 hours as needed for pain. R90 had a physician order for Trilogy settings and to apply at bedtime and remove on waking. The order summary report include multiple orders regarding respiratory care/assess and monitoring respiratory status, and trilogy ventilator monitoring including trilogy on with all sleep (overnight and naps).

Electronic progress notes were reviewed. The following were noted:
On 9/11/15, day of admission, resident was complaining of 10/10 pain (pain scale with 10 being the worst). R90 received pain medication. On 9/12/15 at 2:30 p.m. a progress note read:

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F 309	Continued From page 12 "Temp 96.9, 66, 22, 100/79 and oxygen sats 79% on nasal cannula. Resident refused to wear Trilogy ventilator until his brother came to visit and was able to talk resident into wearing Trilogy. Vital signs rechecked with Trilogy vent on and were Temp 96.0, 86, 17, 97/73 and oxygen sats 90% on Trilogy with oxygen bleed in." The note indicated the resident had been refusing cares in the morning, had refused breakfast and needed assist of 2 staff persons for boosting up in bed. On 9/12/15 at 10:53 p.m. a progress notes "patient did complain of pain rating it a 9/10 and received one as needed pain medication." On 9/13/15 at 6:17 p.m. a progress note indicated the patient needed help with the activities of daily living and needed a full body mechanical lift to get out of bed. A pain assessment completed on 9/11/15 indicated the resident had pain in the last 5 days and the resident had pain medication. The assessment indicated R90 had shortness of breath or trouble breathing when lying flat and should use 02 at 3 liter via nasal cannula, apply Bipap via trilogy machine and advise patient to relax and do relaxation exercises with shortness of breath. The nurses analysis of pain indicated the patient had shortness of breath at times due to morbid obesity. The patient needed to have Bipap via trilogy at hours sleep and during all naps, the registered nurse needed to assess patient 's pain frequently and the patient had a hydromorphone available as needed. A review of the current initial care plan dated 9/11/15 indicated the patient had no pain. The initial care plan did not direct staff how to care for R90 with activities of daily living, the area was left blank. The care plan for skin integrity	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	02/25/2016

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F 309	Continued From page 13	F 309		

was left blank, and did not identify if R90's skin was intact or not. The care plan did identify the health problems of acute volume overload and chronic systolic heart failure and the COPD exacerbation. Interventions did include the use of the Trilogy Bipap system and its settings and the continuous use of oxygen at 2 litters per nasal cannula. However, it did not identify the trilogy should be on at hours sleep and naps and the care plan did not identify interventions for shortness of breath and the care plan lacked identification resident refusals of care and treatment and possible interventions.

On 2/25/16 at 12:30 p.m. the clinical nurse manager/ registered nurse (RN)-B was interviewed regarding the care of R90. RN-B verified the findings and indicated the resident was admitted at the end of the week and the care plan was initiated. RN-B explained that all the nurses were trained on updating the care plan and usually the basic information such as activities of daily living and treatments are added to the care plan.

On 2/25/16 at approximately 2: 00 p.m. the director of nursing reviewed the initial care plan and verified the findings.

The facility did not develop a comprehensive plan of care for hospice care for R156.

Record review revealed a Hospice Certification and Plan of Treatment form showing that R156 had been certified for hospice care on 1/22/16 with a diagnosis of Alzheimer's disease.

The facility's current plan of care, dated 12/15/15,

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F 309	Continued From page 14 contained Focus entries for hospice care related to pain, skin integrity, and hygiene. A psycho-social Focus entry only referred to the fact that the resident was on hospice and that the resident's care should be coordinated with the hospice provider. There was no psycho-social Focus that included end-of-life issues. A spirituality Focus described spirituality as important to the resident, but did not include goals or interventions related to end-of-life issues or hospice care. The activities Focus did not include hospice care. There was a generic hospice Focus that read, "I am receiving Hospice Care through [provider name] starting on 10/24/15 for diagnoses of Alzheimers [sic]. I have expectancy of 6 months or less and I am in need of coordinated care efforts by the hospice and the nursing facility to assure all my care needs are met and the risks are addressed in a timely fashion." The record contained a plan of care from the hospice provider that was generic and did not include individualized details specific to the resident. When interviewed on 2/24/16, at 2:29 p.m. registered nurse (RN)-A stated that the facility staff use both the facility care plan and the hospice provider's care plan.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		3/30/16

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F 329	Continued From page 15 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure orthostatic blood pressures were monitored for 1 of 5 residents (R130) reviewed for unnecessary medications. Findings include: R130 was admitted to the facility on 12/8/15. Medication review report dated 2/25/16, included diagnosis of dementia with behavioral disturbance. Order dated 12/29/15, indicated R130 received haloperidol (an antipsychotic medication) 0.5 milligrams (mg) by mouth three times a day for	F 329	Immediate corrective action: Orthostatic Blood Pressure monitoring was implemented for resident #130. Corrective action as it applies to others: Residents who receive antipsychotic medications will have orthostatic blood pressure monitoring implemented, unless clinically contraindicated. The policy and procedure Antipsychotic Use was reviewed and updated March 2016. Staff will be educated on the policy updates by March 30th, 2016 Date of Completion: March 30th, 2016 Recurrence will be prevented by: Weekly record review audits will be	

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F 329	Continued From page 16 agitation related to dementia with behavioral disturbance. Admission Minimum Data Set (MDS) dated 12/15/15, indicated R130 was rarely/never understood, and required extensive assist with bed mobility, transfers, dressing, toileting, and personal hygiene. Admission MDS Care Area Assessment (CAA) summary dated 12/15/15, identified cognitive loss/dementia, and behavioral symptoms. On 2/24/16, at 8:12 a.m. R130 was observed seated at a table waiting for breakfast, with no behaviors noted. R130 then ate independently. Care plan dated 12/9/15, indicated R130 displayed agitation manifested as physical aggression, combativeness with cares, hitting staff, and throwing items in room. Goal was to demonstrate decrease in agitation. Interventions were to identify and address immediate needs, provide redirection, and 1:1. When agitated attempt interventions to address physical needs, offer reassurance, and attempt distraction or activity. On 2/24/16, at 1:03 p.m. nursing assistant (NA)-A stated R130 can be agitated early in the morning when first wakes. R130 will lash out at staff who provide redirection to complete work. R130's medical record indicated R130 did not have orders for orthostatic blood pressures and they were not being recorded. On 2/25/16, at 10:41 a.m. registered nurse (RN)-A stated staff does not take orthostatic	F 329	conducted on each unit to ensure residents who receive antipsychotic medications are being monitored for orthostatic hypotension. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Don/Designee	

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F 329	Continued From page 17 blood pressures. On 2/25/15, at 10:46 a.m. director of nursing (DON) stated orthostatic blood pressures should be done monthly. "That is standard, it is expected when antipsychotics are given." Facility Antipsychotic Use policy revision date: August 2009, March 2013 indicated: "6. Nursing staff shall monitor and report any of the following side effects to the physician: b. orthostatic hypotension."	F 329		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a level II Preadmission Screening and Resident Review (PASRR) was completed for 1 of 1 resident (R4) reviewed for Preadmission Screening and Resident Review (PASRR). Findings include:	F 406	Immediate corrective action: The County Agency was contacted to complete a level II PASRR for resident #4 Corrective action as it applies to others: Other residents with MR/MI diagnoses will be reviewed to ensure a Level II PASRR was completed in accordance with MN DHS guidelines. A request to the County Agency for a	3/30/16

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F 406	Continued From page 18 R4 was admitted on 4/14/2008 with diagnoses that included Alzheimer's disease, dementia, anxiety and schizophrenia. R4's assessment reference date (ARD) 2/2/16, indicated R4 had a significant change related to decline in transfer and eating assistance. A review of the OBRA ANNUAL RESIDENT REVIEW dated 10/9/90 revealed, Resident has a documented mental illness (MI) but does not need active treatment. Note. Dual diagnosis, MI/mental retardation (MR), see below. Is currently receiving mental health services. A review of the care area assessments (CAAs), dated 2/3/16, revealed no indication R4's PASRR had been included in the assessment process. The CAAs for cognitive loss/ dementia and delirium noted, "CAAs triggered in relation to staff observation of short and long term memory loss; staff observation that pt's (R4) cognition is severely impaired at making decisions for self, pt. presents with inattention, disorganized thinking, and an altered level of consciousness; and evidence of an acute change in mental status from the pt's baseline." Review of the care plan, last revised 2/22/16, lacked R4's Level II preadmission screening for person with MR or related conditions. At 10:07 a.m. on 2/25/16, registered nurse (RN)-D, stated, had significant change due to decline in transfers and eating and requires additional assistant. At 10:50 a.m. on 2/25/16, the social worker (SW)-A, confirmed the PASRR was not in R4's	F 406	Level II PASRR screening for residents with MR/MI diagnosis will be completed by March 30th, 2016. Social Service Staff will be educated on the PASRR program by March 30th, 2016. Date of Completion: March, 30th, 2016 Recurrence will be prevented by: Weekly record review audits will be conducted on each unit to ensure residents with MR/MI diagnoses requiring a Level II PASRR have them in accordance with MN DHS guidelines. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Social Services/Designee	

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F 406	Continued From page 19 medical record. SW-A reported she was not aware she needed to obtain the PASRR and had not attempted to obtain the PASRR for R4 but she will place a call to the local state agency (Ramsey County). On 2/25/16 at 1:42 p.m., the director of nursing verified the PASRR was not in R4's medical record. Also stated, care plan did not address PASRR. Further revealed, resident with level II preadmission screening for person with MR or related conditions should be in their resident medical record.	F 406		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure orthostatic blood pressures were monitored for 1 of 5 residents (R130) reviewed for unnecessary medications. Findings include:	F 428	Immediate corrective action: Orthostatic blood pressure monitoring was implemented for resident # 130 Corrective action as it applies to others: Residents who receive antipsychotic medications will have orthostatic blood pressure monitoring implemented, unless clinically contraindicated.	3/30/16

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F 428	Continued From page 20 R130 was admitted to the facility on 12/8/15. Medication review report dated 2/25/16, included diagnosis of dementia with behavioral disturbance. Order dated 12/29/15, indicated R130 received haloperidol (an antipsychotic medication) 0.5 milligrams (mg) by mouth three times a day for agitation related to dementia with behavioral disturbance. Admission Minimum Data Set (MDS) dated 12/15/15, indicated R130 was rarely/never understood, and required extensive assist with bed mobility, transfers, dressing, toileting, and personal hygiene. Admission MDS Care Area Assessment (CAA) summary dated 12/15/15, identified cognitive loss/dementia, and behavioral symptoms. On 2/24/16, at 8:12 a.m. R130 was observed seated at table waiting for breakfast, with no behaviors noted. R130 then ate independently. Care plan dated 12/9/15, indicated R130 displayed agitation manifested as physical aggression, combativeness with cares, hitting staff, and throwing items in room. Goal was to demonstrate decrease in agitation. Interventions were to identify and address immediate needs, provide redirection, and 1:1. When agitated attempt interventions to address physical needs, offer reassurance, and attempt distraction or activity. On 2/24/16, at 1:03 p.m. nursing assistant (NA)-A stated R130 can be agitated early in the morning when first wakes. R130 will lash out at staff who	F 428	The policy and procedure Medication Monitoring was reviewed on February 29th, 2016 and remains current. Staff will be educated on the policy updates by March 30th, 2016 Date of Completion: March 30th, 2016 Recurrence will be prevented by: Weekly record review audits will be conducted on each unit to ensure medication regimen reviews are completed in accordance with facility policy. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Don/Designee	

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F 428	Continued From page 21 provide redirection. R130's medical record indicated R130 did not have orders for orthostatic blood pressures and they were not being recorded. On 2/25/16, at 10:41 a.m. registered nurse (RN)-A stated staff does not take orthostatic blood pressures. On 2/25/15, at 10:46 a.m. director of nursing (DON) stated orthostatic blood pressures should be done monthly. "That is standard, it is expected when antipsychotics are given." On 2/26/16, at 8:08 a.m. consultant pharmacist (CP) stated when at facility visit she will look for order and on 1/14/16, she completed report for orthostatic blood pressure monitoring. She further stated "typically orthostatic blood pressures should be done monthly " Facility Antipsychotic Use policy revision date: August 2009, March 2013 indicated: "6. Nursing staff shall monitor and report any of the following side effects to the physician: b. orthostatic hypotension."	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		3/30/16

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F 431	Continued From page 22 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were stored and labeled properly for 2 of 29 residents (R15 and R62) reviewed for medication storage. Findings include: During observations of multiple medication storage areas throughout the facility, medications for R15 and R62, which included eye drops and	F 431	Immediate corrective action: The medications for residents # 15 and 62 were removed from the medication cart and reordered from the pharmacy. Corrective action as it applies to others: An audit of all medication storage areas was completed on March 8th, 2016 and any undated items were removed from use and reordered from the pharmacy. The policy and procedure for Medication Storage was reviewed and remains	

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F 431	Continued From page 23 inhaler, lacked dates to indicate when they were opened. The medication storage area of fourth floor was reviewed on 2/22/16, at 7:15 p.m. with licensed practical nurse (LPN)-B: R15's Latanoprost and Dorzolamide -Timolol bottles (medication for Glaucoma) were opened, undated and had been used. At 7:18 p.m. LPN-B verified the medication was opened, undated and used. At 7:21 p.m. LPN-B informed registered nurse (RN)-B and verified the findings and stated will removed medication bottles from the medication cart because medication bottles lacked open date. Review of R15's electronic medication administration record (eMAR) for 2/2016, revealed eye drop bottle had been used to administer the medications to R15. During the medication storage tour on 2/23/16 at 11:50 a.m. with RN-C, in the third floor medication cart C, R62's Advair Diskus (medication for chronic obstructive asthma) was opened, undated and used. RN-C verified Advair Diskus was opened, undated and had been used. Review of R62's electronic medication administration record (eMAR) for 2/2016, revealed Advair Diskus had been administered to R62. During interview on 2/23/16 at 1:50 p.m. the director of nursing (DON) verified the medications needed to be labeled and stored properly. DON added that opened medications should be dated when opened and staff were supposed to date medication bottles when opened. OMNICARE RECOMMENDED MINIMUM	F 431	current. Medication administration staff will be educated on the policy by March 30th, 2016. Date of Completion: March 30th, 2016 Recurrence will be prevented by: Weekly visual inspection audits will be completed on each unit to ensure compliance with the medication storage policy. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Don/Designee	

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F 431	Continued From page 24 MEDICATION STORAGE PARAMETERS dated September 29, 2015, read, "Advair Diskus (fluticasone / salmeterol) Store between ..... in a dry place. Date the Diskus when removed from the foil pouch and discard 1 month after removal from foil pouch or after all blisters have been used, whichever comes first. Cosopt PF Ophthamic Solution (dorzolamide / timolol) Store in the original pouch between ... Do not freeze. Protect from light. Date the foil pouch when opened and discard any remaining unopened, single-use containers after 15 days. Xalatan Ophthalmic Solution (latanoprost) Refrigerate until ready to use. Date when opened and store at room temperature up to ..., protected from light. Discard unused portion 6 weeks after opening." Policy and procedure titled MEDICATIIONS: STORAGE OF revision last dated July 2013, indicated, "To ensure that medications are stored in a safe, secure, and orderly manner."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		3/30/16

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(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 441	Continued From page 25 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper infection control techniques were followed to minimize the spread of infection related to storing reusable ice packs with food, in dining room freezers on 2 floors which had the potential to affect 3 residents that had food stored in the freezers. Findings include: On 2/22/16 at 12:40 p.m., during random observations of fourth floor dining room's freezer, 3 large unlabeled blue reusable ice packs were	F 441	Immediate corrective action: The ice packs were immediately removed from the nursing unit freezers and discarded. Corrective action as it applies to others: Reusable ice packs have been removed from use and replaced with single use disposable ice packs. The policy and procedure for the Use of Disposable Ice Packs was reviewed and remains current on February 29th, 2016 Staff will be educated on the policy by March 30th, 2016 Date of Completion: March 30th, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING _____ B. WING _____	02/25/2016

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F 441	Continued From page 26 observed to be stored in the refrigerator freezer next to a resident's ice cream box and another resident's 3 boxes of frozen dinners that included Shrimp Alfredo, orange chicken, Boneless chicken. At 2/22/16 at 12:45 p.m. licensed practical nurse (LPN)-C verified the observations and stated ice packs are not supposed to be stored with food. On 2/22/16 at 6:25 p.m., registered nurse (RN)-B stated ice packs are not to be stored in that freezer and her expectation was staff to store ice packs in the medication room freezer and not with food, for infection control reasons. During an interview with the director of nursing (DON) on 2/23/16, at 12:01 p.m. the DON stated the facility did not have a policy and procedure related to the storage of reusable ice packs, however, it was her expectation not to store reusable ice packs and food together in the same freezer. Surveyor: Wentkiewicz, Cynthia On 2/22/16, at 1:31 p.m. observed six ice packs in the third floor unit freezer. One ice pack was wrapped in a pillowcase. Also on the shelf were two pint size containers of mint chip ice cream. When asked about the ice packs, registered nurse (RN)-A stated the freezer was only used for resident ice packs and food should not be stored in there. RN-A stated he thought a resident had put the ice cream in there. On 2/23/16, at 2:51 p.m. the director of nursing (DON) stated she was aware staff was storing ice	F 441	Recurrence will be prevented by: Weekly visual audits will be conducted on each unit to ensure ice packs are no longer stored in nursing unit freezers. Audits will be completed for a period of 90 days and audit results will be reviewed by the QA committee to determine the need for ongoing monitoring. The correction will be monitored by: Don/Designee	

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F 441	Continued From page 27 packs in the freezer. She stated they started doing audits that morning and her expectation was ice packs were not stored in the unit freezer. They will now have disposable ice packs on the units. She further stated not currently having an ice pack storage policy.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure 1 of 6 resident rooms (R185) was kept in good repair. Findings include: R185 's room had a worn splinter exposed wooden window sill in need of repair and a portion of the wall was in need of paint. During initial tour, R185's room was found to have an approximate 2 foot by 2 foot area behind the entrance door that had been spackled roughly and left to dry. The area had not been sanded down or repainted. The wooden window sill had at least a 2 inch area that had been broken off and had rough and splintered wood exposed. R185's bed was pushed near the window sill. On 2/25/16 at approximately 11:30 a.m., during the environment tour with the administrator and	F 465	Immediate corrective action: The window sill, wall spackle and paint repairs in the room for resident # 185 is complete Corrective action as it applies to others: An environmental tour was completed was completed to identify other resident rooms in need of window sill, wall repair and painting needs. Needed repairs identified during the tour will be completed by March 30th, 2016 Date of Completion: March 30th, 2016 Recurrence will be prevented by: Weekly environmental audits will be conducted in resident living areas to identify any newly noted concerns. Minor repairs will be completed upon discovery. Repairs requiring more than minor repair will be submitted to the administrator for approval. Audits will continue and remain ongoing. Audit results will be reviewed by	3/30/16

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F 465	Continued From page 28 head of housekeeping, the room was toured. The administrator agreed the window sill and the wall were both in need of repair.	F 465	the QA committee during the monthly QAPI meeting. The correction will be monitored by: Maintenance Director/ Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Bethel Care Center was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us>	K 000		

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

Bethel Care Center is a 4-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1968 and was determined to be of Type II(222) construction. In 1982, an addition was constructed to the East side of the building that was determined to be of Type II(222) construction. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The facility is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 131 beds and had a census of 96 at the time of the survey.

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	245295	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/23/2016**

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to provide a proper exit to the outside. This deficient practice could affect the safe and rapid evacuation of all residents, visitors, and staff in the event of an emergency that may require quick evacuation in accordance with section 7.1. 19.2.1 Findings include: On facility tour between 09:00 AM and 11:30 AM on 02/25/2016, it was observed that the east stair 1st floor exit door to the outside was difficult to open and took several attemps to open the door. This deficient practice was verified by the facility staff (JS), at the time of discovery.	K 038	1. The East Stair 1st floor exit door to the outside will be replaced. 2. A new door was ordered from Empire Door & Glass Co. on March 9th, 2016 and will be installed upon arrival. 3. The Maintenance Director is responsible for completion.	4/6/16