DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	_	-	_		AND TRANSMITTAL TE SURVEY AGENCY		ID: T759 Facility ID: 00792	
1. MEDICARE/MEDICAID PROVIDE (L1) 245427 2.STATE VENDOR OR MEDICAID N (L2) 516240800		3. NAME AND AD (L3) BETHESDA (L4) 901 SOUTH (L5) WILLMAR ,	EAST WILL!		UE (L6) 56201	4. TYPE OF AC 1. Initial 3. Termination 5. Validation 7. On-Site Visit	2. Recertification 4. CHOW 6. Complaint	
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	OWNERSHIP 4/2018 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	GORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	8. Full Survey A FISCAL YEAR EN 09/30	After Complaint	
2 AOA 3 Other 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	248 (L18) 248 (L17)	Compliance1. Ac B. Not in Comp	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A* 15. FACILITY MEETS	6. Scope o	of Services Limit I Director Room Size	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 248 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)		
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL Date:			
Brenda Fischer, Unit Sup	ervisor	0	5/30/2018	(L19)	Michaelyn Bruer, Enforcement Specialist 05/30/2018			
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OF PARTICIPATION 02/01/1987	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure		LUNTARY I to Meet Health/Safety	
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		l to Meet Agreement	
25. LTC EXTENSION DATE: (L27)	-	VE SANCTIONS of Admissions:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHE	ovider Status Change	
			(L45)					

30. REMARKS

DETERMINATION APPROVAL

(L31)

29. INTERMEDIARY/CARRIER NO.

32. DETERMINATION OF APPROVAL DATE

03001

(L28)

(L32)

28. TERMINATION DATE:

31. RO RECEIPT OF CMS-1539



Protecting, Maintaining and Improving the Health of All Minnes ot ans

CMS Certification Number (CCN): 245427

May 30, 2018

Ms. Ashley Bormann, Administrator Bethesda 901 Southeast Willmar Avenue Willmar, MN 56201

Dear Ms. Bormann:

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 27, 2018 the above facility is certified for:

248 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 248 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,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Motorly En

Health Regulation Division

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 30, 2018

Ms. Ashley Bormann, Administrator Bethesda 901 Southeast Willmar Avenue Willmar, MN 56201

RE: Project Number S5427029

Dear Ms. Bormann:

On April 4, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 14, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 19, 2018 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 March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 27, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2018, effective April 27, 2018 and therefore remedies outlined in our letter to you dated April 4, 2018, 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,

Michaelyn Bruer, Enforcement Specialist

Minnesota Department of Health

Mostuly

Health Regulation Division

Program Assurance Unit

phone 651-201-4117 fax 651-215-9697

email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICALD CERTIFICATION AND TRANSMITTAL	
DADT I TO BE COMDIFTED BY THE STATE SUBVEY ACENCY	v

Facility ID: 00792

MEDICARE/MEDICAID PROVID (L1) 245427		3. NAME AND AL (L3) BETHESDA				4. TYPE OF ACT 1. Initial	ION: 2 (L8) 2. Recertification	
2.STATE VENDOR OR MEDICAID (L2) 516240800	NO.	(L4) 901 SOUTH (L5) WILLMAR ,		WAR AVEN	(L6) 56201	3. Termination 5. Validation	4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 03/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2/2018 (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 ENI	DING DATE: (L35)	
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16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	
Jennifer Bahr, HFE NE I	I		04/16/2018	(L19)	Debby Baker, Enforcement Specialist 04/30/2018 (L20			
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OF PARTICIPATION 02/01/1987	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00-Merger, Closure		UNTARY o Meet Health/Safety	
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25. LTC EXTENSION DATE: (L27)	_	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	ider Status Change	
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 4, 2018

Ms. Ashley Bormann, Administrator Bethesda 901 Southeast Willmar Avenue Willmar, MN 56201

RE: Project Number S5427029

Dear Ms. Bormann:

On March 22, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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>Electronic 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:

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

Bethesda April 4, 2018 Page 2

<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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us

Phone: (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 May 1, 2018, 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 June 22, 2018 (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

Bethesda April 4, 2018 Page 5

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 September 22, 2018 (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, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Bethesda April 4, 2018 Page 6

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kumalu Fish Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PRINTED: 04/20/2018 FORM APPROVED OMB NO. 0938-0391

LAND BLANCE CORRECTION L'ÉIRENTIEIRATION AUGRED		1 ` ′	PLE CONSTRUCTION IG		COMPLETED	
		245427	B. WING _		03	3/22/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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F 000		ull compliance with these no deficiencies are issued. rS	F 00	00		
	was completed by s Department of Hea compliance with the	/18, a recertification survey surveyors from the Minnesota lth (MDH) to determine e regulations at 42 CFR Part uirements for Long Term Care				
	as your allegation of Department's acceptoriolled in ePOC, year the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required of first page of the CMS-2567 nic submission of the POC will tion of compliance.				
F 565 SS=E	on-site revisit of you validate that substa regulations has bee your verification. Resident/Family Gr	•	F 56	55		4/27/18
LABORATORY	and participate in re (i) The facility must group, if one exists	esident has a right to organize esident groups in the facility. provide a resident or family , with private space; and take	NATURE	TITLE		(X6) DATE

Electronically Signed 04/12/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		245427	B. WING		03/:	22/2018
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F 565	reasonable steps, to make residents a upcoming meetings (ii) Staff, visitors, or resident group or fathe respective group (iii) The facility must person who is appr group and the facility providing assistance requests that result (iv) The facility must resident or family githe grievances and groups concerning in the facility. (A) The facility must response and ration (B) This should not facility must implement request of the residents of the residents in family \$483.10(f)(6) The reparticipate in family \$483.10(f)(7) The residents in the factor This REQUIREMED by: Based on interview facility failed to ensithe short-term unit be involved in Residents of 212 res	with the approval of the group, and family members aware of a in a timely manner. To other guests may attend amily group meetings only at p's invitation. It provide a designated staff oved by the resident or family ty and who is responsible for the and responding to written a from group meetings. It consider the views of a roup and act promptly upon recommendations of such issues of resident care and life at be able to demonstrate their male for such response. It be able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response. It is able to demonstrate their male for such response.	F 568	Corrective Action For Resident Practice: Resident Practice: Resident Practice: Resident Practice: Resident Practice information about our plan to reoccurrence. Resident Din meeting was held on 04/10/	lent #34 and ewed regarding d and provided o prevent ing Committee	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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F 565	addressed resident cold food temperation of 12 residents (R3 at resident council facility had not addinissing clothing for concerns during a resident council facility had not addinissing clothing for concerns during a resident council or the pass meeting minutes id held quarterly, with 2/14/18. The facility calendate for the past four modern council or neighbor 1 South Recreation meeting scheduled 2 South Recreation meeting scheduled 1 North Recreation meeting scheduled 1 North Recreation meeting scheduled 2 North Recreation Coneighborhood meeting scheduled MCN Recreation Coneighborhood MCN Recreation Coneighborhood MCN Recreation MCN Recreation Coneighborhood MCN Recreation Coneighborhood MCN Recreation Coneighborhood MCN Recreation C	council concerns regarding ures and food palatability for 2 4, R168)who voiced concerns meetings. In addition, the ress resident grievances of a 1 of 1 residents, who voiced resident group meeting. CIL MEETING: three resident council entified the meetings were the last meeting occurring on ars and neighborhood meetings on this were reviewed and ing: tes: No scheduled resident thood meeting identified. Calendar: Neighborhood for 12/19/17. Calendar: Neighborhood for 12/19/17. Calendar: Neighborhood for 12/19/17. Calendar: Neighborhood for 12/19/17. Calendar: Neighborhood	F 5	Resident #218 has since dis the facility. Follow-up has be to help resolve the concern clothing. Neighborhood Resident Couhave been scheduled for all neighborhoods in April 2017 the short-term rehab unit. Identification Of Other Resident Potential To Be Affected Practice: All residents who attend the resident council resident to express concerns potential to be affected by the practice. Meetings will now leach neighborhood on a modern memory of the provided to all Licensed Social on April 11, 2018 regarding right to be involved in Resident provided to all Licensed Social activities including on the shand promptly addressing resconcerns and grievances. Facility's policy and procedures and grievances. Facility's policy and procedures and grievances. Facility's policy and procedures will now be neighborhood on a monthly Residents will be informed of Resident Council rights at the neighborhood meeting.	scharged from een attempted of missing uncil meetings uncil meetings including in dents Having By Deficient had desire to meetings or had the his deficient be held in onthly basis. Inges Made To ice Will Not cation was cial Workers all residents ent Council nort-term unit sident council ure on wed and be held in each basis.		

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		245427	B. WING			03/22/2018	
NAME OF	PROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201	1 00/2	12/2010
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F 565	January 2018: Bethesda Club Suit council or neighbor 1 South Recreation resident council or identified. 2 South Recreation resident council or identified. 1 North Recreation resident council or identified. 2 North Recreation resident council or identified. MCN Recreation Cresident council or identified. MCN Recreation Cresident council or identified. E & F Activity Progresident council or identified. G & H Program Cascheduled for 1/29/West Activity Progresident council or identified. February 2018: A facility residnets oscheduled for 2/14/unit calendars with care unit and West March 2018: Bethesda Club Suit identified. 1 South Recreation meeting was scheduled was scheduled for 2/14/south Recreation meeting was scheduled scheduled.	tes: No scheduled resident hood meeting identified. Calendar: No scheduled neighborhood meeting alendar: No scheduled neighborhood meeting ram Calendar: No scheduled neighborhood meeting lendar: Neighborhood meeting 18. am Calendar: No scheduled neighborhood meeting 218. am Calendar: No scheduled neighborhood meeting 218. Council meeting was 218 and was identified on all the exception of the memory D Hall meetings were held. Tes: No neighborhood meeting Calendar: A neighborhood	F	665	How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Administrateview neighborhood meeting/reside council minutes to verify appropriate prompt follow-up of noted concerns minutes will be reviewed monthly x months beginning May 1, 2018. Thaudits will be presented to the facility Quality Assurance committee to vecompliance has been attained.	ent e and s. All 4 ese ty	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		245427	B. WING _		03	/22/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (901 SOUTHEAST WILLMAR AVENUM WILLMAR, MN 56201	CODE	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 565	meeting was sched 1 North Recreation meeting was sched 2 North Recreation meeting was sched West D Hall: No scheding identified. West A Hall: No scheding identified. West A Hall: No scheding identified. E & F Activity Programeting identified. E & F Activity Programeting identified. On 3/21/18, at 10:2 meeting identified. On 3/21/18, at 10:2 meeting was held who lives on various stated the units has on occasion, howevery month. R169 council" was held eadded the meeting was a residents; R168, R2 R73, R20, R84,R17 R218 stated the reme", adding she has for rehabilitation for nothing about any ralso resided in the before transferring never invited to me	Calendar: A neighborhood luled for 3/21/18. Calendar: A neighborhood luled for 3/21/18. Calendar: A neighborhood luled for 3/21/18. heduled neighborhood neduled resident council or ting identified. alendar: No neighborhood ram Calendar: No ting identified. lendar: No neighborhood 6 a.m. a resident group with surveyors from residents is floors of the facility. R168 is floors of the facility. R168 is re "neighbor hood meetings" is resident invery three months. R169 is are "smaller meetings and it with neighborhoods (units). Ittended by the following 218, R34, R59, R102, R121, R0, R38, and R13 sident meetings were "news to the resided in the Club Suites in less than a month and knew meetings. R34 added they had therapy suites since admission to the long term care and "was	F 56	5			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245427	B. WING		03	3/22/2018
NAME OF	PROVIDER OR SUPPLIEF	3		STREET ADDRESS, CITY, S 901 SOUTHEAST WILLM WILLMAR, MN 56201	STATE, ZIP CODE IAR AVENUE	
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F 565	resident council may are held more free meeting occur on any concerns, req suggestions for act these meetings ar appropriate individual through. If there was grievance form council through the approneighborhood meedocumentation that in these meetings Suites rehabilitate routine basis becalong, and are focut to participate in the council meetings. During interview of worker (SW)-B state council meetings as modeled after the interim, there are however, the neigh in the Club Suites information gather meetings may be meetings, however review to determine within the neighboresidents from Club saits and the club saits are the interimant of the club saits are the clu	lage 5 leetings were completed on a tadded neighborhood meetings quently. The neighborhood a monthly basis and address lests for changes, and ctivities. The concerns from the brought to the attention of the dual or department for follow was a formal concern or impleted, these are routed priate parties. The letings do not have any let addressed what was covered at addressed what was covered at concerns or issues. The Club letings do not meet on a leuse they are not here very lesed on rehab. They are invited the facility wide quarterly resident where held on a quarterly basis the process from Heritage. In lare neighborhood meetings, held the facility wide resident are neighborhood meetings are not held rehab unit. SW-B stated from neighborhood shared at the quarterly resident for there are no minutes to the if there are similar concerns withoods. SW-B stated the guarterly facility wide resident quarterly facility wide resident guarterly facility wide resident guarterly facility wide resident guarterly facility wide resident guarterly facility wide resident	F	665		
	the frequency of re	1 p.m. the administrator stated esident council is resident				

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		245427	B. WING			03/	22/2018
NAME OF F	PROVIDER OR SUPPLIER			90	REET ADDRESS, CITY, STATE, ZIP CODE 1 SOUTHEAST WILLMAR AVENUE ILLMAR, MN 56201	,	
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F 565	initiated or if the frecurrent residents. The facility policy ti 12/17, identified the council was to ensure can exercise their recouncil meetings of DINING CONCERN Review of the quarter.	tled Resident Council dated purpose of the resident ure that residents at Bethesda ight to forma and hold resident a regular basis. NS FOOD PALATABILITY: terly facility side resident	F 5	65			
	idea of a dining coulimplementation of 0 wide resident count 11/15/17 identified formed with representing horizontal wide residual wide residu	nutes of 8/16/17 proposed an uncil with a target date of October 2017. The facility cil meeting minutes of a Dining Committee had been entatives from each the next meeting on 11/17/17. sident council minutes of the Dining Committee will be the end of February, no updates or any planning of stions or concerns.					
	10/30/17 identified identified satisfaction. The minutes reflect regarding the even presentation, cooking identified to work or resident representation meeting minutes of planning for the upper visit old business concerns of the even was scheduled for the identified satisfactory.	ing Committee Minutes of new menu suggestions, and on with the alternate menu. ted there were concerns ing meal related to ng, and choices. A plan was in the evening menus with ative input. A review of the 11/18/17 idenfied menu coming holidays. It did not or address status with ening meals. The next meeting the beginning of January, re no additional meeting					

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		245427	B. WING	i		03/2	22/2018
NAME OF F	PROVIDER OR SUPPLIER			90	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTHEAST WILLMAR AVENUE VILLMAR, MN 56201		
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F 565	minutes following the During the resident surveyors on 3/21/had additional concexperience and foo main topic of concestating some of the when it should have been a long standir related to recent reareas. R34 provide served with the top layers were "not ho example of scramb Additionally, other unexpressed concern being cold, and difficommunication was times they are told gets done." On 3/20/18 at 3:00 the food committee December 2017 be month. Additionally held due to a member hospitalize The next food comfor the first week in been determined. The Resident Couridentified following the staff liaison will	group meeting held with 18, at 10:26 a.m. the residents cerns regarding the dining of served. R34 expressed a erns was "food preparations," food had been served cold to been hot. R34 stated this has not problem and was not modeling of kitchen/dining did an example of lasagna being hot, however the lower that all". R168 offered an olded eggs being served cold. Unidentified residents is with pancakes and waffles it is the key word, adding often "we'll look into it and nothing open. The dietary director stated emeeting was not held in cause it was a busy holiday, the January meeting was not been passing away, two seed and illness in the facility. The mittee meeting was scheduled april, however, no date had encil policy dated 12/17 the resident council meeting involve other departments as concerns/issues brought forth	F	565			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201		
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F 565	dated 3/3/18, indiction facility on 3/2/18. Was cognitively into the surveyor strong interview or told the surveyor strothing missing sing facility. R218 states burgundy-colored spurchased, and was came back." R218 that read "Family wishe also lost two colores. R218 stated was also "sick and During a subsequent 1:15 a.m. R218 stresident meeting to clothes. R218 state (pajamas) she wor laundry, and "they R218 stated she rewhile ago" and was happening with the A facility document Resident Property R218 lost one pair Problem" in Spanis indicated R218 repstaff member. In the	Minimum Data Set (MDS) ated she was admitted to the The MDS also indicated R218 act. 1 3/20/18, at 9:45 a.m., R218 he had numerous items of ince her admission to the ed she had one gray and one sweatshirt she had just as taken to wash "and never 8 pointed to a sign in her room will do my Laundry" and stated apris, two pairs of jeans, two die "I don't know what to do." she "told everybody" and she tired" of losing her clothes. Ent interview on 3/21/18, at tated she has just attended a polet them know about my led she also had a pair of PJ le one time, gave to the facility were gone, too, brand new." Peported the PJs missing "a neted to know what has a missing items. 1. Lost/Found/Damaged Report, dated 3/6/18, indicated of Teal-green PJs, with "No sh on them. The document forted the item missing to a he section When and where	F 565			
	staff member. In the last seen was written here one time and them." Under Place (nursing assistant)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP 901 SOUTHEAST WILLMAR AVEN WILLMAR, MN 56201	CODE	
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F 565	"No" was circled for The pre-printed for lines/questions, all included: Item four Family contacted a satisfied with resolution Comments/Addition. When interviewed assistant director of knew about R218's report on those filler R218 reported mor ADON-A stated whith facility, there we completed, but the clothing, "hopefully ADON-A stated all this unit, (the shorthouse, on the unit, were still looking for items she had lost. When interviewed social worker (SW) missing on the (Mar R218 came to me missing more items conference, which her family were told for the PJs. SW-A still open" and she conversation with Figet a resolution."	llowing "Was item found?" m also had additional of which were blank, and and when/where; found by; nd by whom; Did they seem ation?; and hal information. on 3/21/18 at 4:02 p.m., f nursing (ADON)-A stated we missing PJs, and there was a ed out on the 6th (3/6/18) and re items missing today. en residents are admitted to as no clothing inventory facility marked resident before" it gets done in laundry. resident, personal items on eterm stay) was laundered in ADON-A also stated they or R218's PJs, as well the other		65		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		OMPLETED
		245427	B. WING			3/22/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 901 SOUTHEAST WILLMAR AVEN WILLMAR, MN 56201	CODE	
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	to find them. The a resident clothing has improvement focus and made changes eliminate missing cacknowledged R21 the 6th, and also ur unresolved for R21 was the facility policy promptly and also it concern come to a up to make sure the addressed for R218 Although R218 had 3/6/18, and still lost was still unresolved frustration during the additional missing of the concern come to a property of the document, undated, indicated representative have orally, in writing, and The document indicated region in writing, and fullest extent possibility indicated, "Within a receiving the concerdays, a facility repreparties involved in the concern, and resident and resident indicated representations are received in the concern, and resident and resident in the concern, and resident and resident in the concern, and resident contents are resident and resi	idministrator stated missing and been a facility quality, and the facility evaluated to its process to reduce and lothing. The administrator 8's PJs were missing since aderstood why this was 8. The administrator stated it by to resolve grievances a would be nice to see R218's resolution, and would follow be clothing issues were 3. reported her PJs missing on for sixteen days, the case of for R218, who expressed the survey, and had reported	F 5			4/27/18
	§ 483.25 Quality of Quality of care is a	care fundamental principle that				

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		245427	B. WING		03/22/201	18
NAME OF F	PROVIDER OR SUPPLIER		9	STREET ADDRESS, CITY, STATE, ZIP CODE 001 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201		
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F 684	applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with propractice, the compressive plan, and the resident resident resident resident review, the facility for assess and develop good posture and propressive review, the facility for assess and develop good posture and propressive resident (R97) who history of cardiac propressive resident (R97) who history of cardiac propressive resident requires on and off the unit, mobility. R96's care plan reviewed an activities of and ambulated in the wheelchair. R96 was push in [wheelchair regarding what type information on how	ent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, interview and document ailed to comprehensively or interventions to promote residents and for wheelchair positioning. In failed to ensure consistent was completed for 1 of 1 m had a low pulse rate and a roblems. Immum Data Set (MDS) dated and severe cognitive and used a wheelchair for rised 11/2/17, identified R96 daily living (ADL) impairment the hallway pushing a las recorded as, "may agree to air] for longer distances." plan lacked any dictation of wheelchair R96 used, nor often R96 used her	F 684	Corrective Action For Residents Af By Deficient Practice: Resident #96 under the care of Occupational The obtain a proper fitting wheelchair th is agreeable to. Resident #28 has had her foot peda modified so her feet sit properly and supported while she sits in her whe She is also being seen by Occupati Therapy for proper wheelchair posit Resident #97 heart rate has been monitored, MD has been notified of results and no treatment is indicate Identification Of Other Residents Hithe Potential To Be Affected By Def Practice: A facility audit will be comby April 25, 2018 on all residents what wheelchair to ensure all residents wheelchairs are appropriate and resis well supported. A facility audit was completed to en residents heart rates are being mor and are within appropriate parameters.	is sarapy to at she als d are elchair. onal tioning. d. aving icient apleted no use sident sure all nitored	
		g or rest. on 3/22/18, at 8:25 a.m. R96 lining room with her wheelchair		Measures Or Systemic Changes M Ensure That Deficient Practice Will Recur: Nursing staff will be educate	Not	

l', '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245427	B. WING		03/:	22/2018	
NAME OF BETHES	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP 901 SOUTHEAST WILLMAR AVEN WILLMAR, MN 56201	CODE		
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F 684	with a bedside tabhad been served a consisted of eggs centered on the serveral inches of hips, and the arm upwards and near R96 had to lift her rest(s) of the whethe arm rest while them using her had concerns about he "[I] never sit in it lowers wheelchair often used it to sit and during activition her wheelchair she looked "tiny in NA-A stated she with the terapy (OT) or the R96's positioning NA-A stated R96 shoulder or arm persistence R96 s	ole placed in front of her. R96 a breakfast meal which and pancakes. R96 was eat of the wheelchair with spacing on each side of her rest(s) of the chair extending rly level with R96's shoulders. Tarms up and over the arm elchair, resting her inner arm on a picking up her pancakes to eat ands. R96 stated she had no er wheelchair, however, added ong enough to notice." If on 3/22/18, at 8:40 a.m. (NA)-A stated R96 had the for the past several years and in during meals, in her room es. NA-A observed R96 sitting in the dining room and stated in it," and the chair was "too big." was not aware if occupational the nurse had ever reviewed in the chair before. Further, had never complained about	F6	identifying wheelchair posheart rate parameters. Training and re-education all nursing staff beginning and will be completed by complete and will be completed by complete and complete will random wheelchair position monthly x 4 months begin 2018. DON, ADON, or descomplete random audits complete random audits of heart rate for 8 residents remonths beginning May 1, audits will be presented to Quality Assurance commit compliance has been attained.	was provided to April 10, 2018 completion date. itor re That Occupational complete 8 oning audits ning May 1, signee will on resident's monthly x 4 2018. These of the facility ttee to verify that		

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NAME OF F	PROVIDER OR SUPPLIER			901 S	ET ADDRESS, CITY, STATE, ZIP CODE COUTHEAST WILLMAR AVENUE MAR, MN 56201		
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F 684	on both side(s) of and chair sides. When interviewed registered nurse (Findependent with his wheelchair for most observed R96 sea wheelchair and state wheelchair." RN-Ereferred to OT for the past, however, ensure R96 had go comfortable in her. On 3/22/18, at 11:2 therapy assistant (the lunch meal in hinterviewed immed R96 voiced she was however, COTA-A approximately four side of her while seit should be 2", not COTA-A stated she and obtain her inpulmaybe she could Further, COTA-A enever been approach wheelchair or positiseeing these thing OT and get an assis options could be for	on 3/22/18, at 9:32 a.m. RN)-B stated R96 was her mobility, however, sits in her st of the meals. RN-B ted in the commons area in her sted R96 "needs a smaller stated R96 had never been her wheelchair positioning in one should be completed to bod posture and was chair. 27 a.m. certified occupational COTA)-A observed R96 eating her wheelchair. When liately following, COTA-A stated as happy with her wheelchair, expressed R96 had inches (4") of space on each eated in the wheelchair adding 4" in size, for positioning. It was going to notify the OT at on R96's wheelchair as use a more narrow chair." explained their department had ached before about R96's tioning and if floor staff were s, "they're supposed to contact essment," to see if better	F6	84			
	R28 had moderate	e cognitive impairment, required th mobility, and used a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		TE SURVEY MPLETED
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 901 SOUTHEAST WILLMAR AVENUE 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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	R28 had chronic godifficulty in walking, and mononeuropath cause increased paragraph of the state of the use of her wheeled in the use of her wheeled increased increased in the use of her wheeled increased in the use of her wheeled increased increased in the use of her wheeled increased increased in the use of her wheeled increased in	ce Sheet, undated, indicated out (inflammation of joints), dependence on wheelchair, thy (a nerve disorder which can ain or weakness). iated 9/13/16, identified aloskeletal (injuries and to the human body's nent related to neuropathic the care plan also identified tance with ADL's related to reased mobility. The care plan provide total assistance with elchair. on 3/21/18, at 11:29 a.m. R28 inverange of motion (PROM) ities from the restorative aide wearing support hose and at this time R28 was seated in her leg rests in place on both es resting on the leg rests. The foot rest, however, the orest her foot on the full foot A-A stated R28's leg rests and the positioned like this but it rests should be adjusted by use just the toes are touching. Ilevation of the leg rests would support to legs. While 28 stated her legs and feet in unsupported position, but	F 68	4		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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	PREFIX TAG (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 15 Upon observation on 3/21/18, at 12:38 p.m. R28 was noted to have her leg rests adjusted so her left foot was able to rest fully on the foot pedal when a towel was placed behind her left calf to support this. R28's right leg rest was elevated, and the length had been adjusted, however, R28's right leg was dangling unsupported behind the leg rest.		STREET ADDRESS, CITY, STATE, ZIP C 901 SOUTHEAST WILLMAR AVENU WILLMAR, MN 56201	ODE		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 684	Upon observation was noted to have left foot was able to when a towel was support this. R28's and the length had R28's right leg was the leg rest. During interview of licensed practical rests had been ad the adjustment to important for both During observation was observed to be her left foot resting pedal. R28's right inch foam block seposition, however, the foot pedal. On 3/22/18, at 1:2 stated R28's leg resupportive foam we pedal, however statements and the adjustment of the pedal. During interview of director of nursing positioning of leg resting positioning positioning positioning positioning positioning positioning positioning positioning positioning p	her leg rests adjusted so her o rest fully on the foot pedal placed behind her left calf to s right leg rest was elevated, I been adjusted, however,	F6	584		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 684	and Procedure, rev the responsibility of residents are positi indicated the staff v occupational Thera	vised 2/2017 identified it was f the nursing staff to ensure oned properly. The policy also was to consult with upy (OT) and physical therapy	F 68	4		
	R97's quarterly MD resident had mode extensive assistant R97's medical diag	S dated 1/26/18 identified rate cognitive an required ce of two to complete ADL's.				
	identified diagnose hypotension (low blacerebrovascular disblood supply to the (decreased thyroid valve disease and to f heart function), h	sease (conditions that affect brain), hypothyroidism functioning), rheumatic mitral tricuspid deficiency (alteration hypertensive chronic kidney bregaly (an enlarged heart),				
	was laying on his beyes closed, relaxed respirations. The bemat at bedside. At	on 3/22/18, at 7:14 a.m. R97 ed, under a sheet, with his ed facial expression and easy ed was in a low position with a 8:40 a.m. R97 remained in acial expression relaxed, and				
	bed resting at this topen, watching tele	81 p.m. R97 was observed in ime, however his eyes were evision. His bed was in the low bedside. Resident mumbled				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245427	B. WING _		03	/22/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (901 SOUTHEAST WILLMAR AVENUM WILLMAR, MN 56201	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 BE	(X5) COMPLETION DATE
F 684	in response to gree television. The narrative notes had been minimally his eyes to question yes or no. R97's or sats-level of oxyger be low at 88% on relevel 93-96%) and on asal cannula (proving from an oxygen sor afebrile (without fev Fahrenheit, respirative per minute per minute which we R97's blood pressur narrative note of 1/identified a report who inform the facility hospital with influence second degree head R97 returned from the diagnosis of a lawhich he was on an discharge summary was dehydrated with sugar) on admission positive for influenziantiviral treatment of four chronic kidney damage with a sever function). The diagnaddressed in the didischarge orders id receive furosemide	s identified on 1/15/18, R97 responsive and did not open as, though did shake his head aygen saturation levels (O2 in the blood) were noted to com air (normal saturation exygen was started through a vides oxygen through tubing curce). At that time R97 was ver) at 97.5 degrees tion (breathing) rate of 20 and a heart rate of 72 beats are all within normal limits. The was high at 139/75. The 15/18 written by RN-E vas received from the hospital R97 was admitted to the laza B, dehydration, and a new	F 68	4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 684	A review of R97's of initiated on 12/3/14 impairment related hypertension, mitravalve disease, a his (heart attack), cere occlusion/cerebrow the circulatory syst a transient ischemicare plan directed medications as ord directed the RN to and update the phyroutinely and as neaddress heart bloc the discrepancy or hospital report of a	care plan revised 2/14/18, identified a cardiovascular to diagnoses including al valve disease and tricuspid story of a myocardial infarction coral arrester ascular disease (alteration in m/blood vessels) and history of c attacks (little strokes). The the staff to administer lered. The care plan also asses changes in vital signs visician or nurse practioner reded. R97's care does not k. The record did not identify any clarification from the heart block, or the absence of ital discharge summary to	F 68	4		
	follow up of his hos diagnoses of somn identified on the as does not identify th to cares to be prov A review of R97's rethe vitals report fro R97's heart rate raminute with the excrate note on 3/12/1 heart rate of 50 beard documented on 3/10 practical nurse (LP On 3/11/18, the elewritten by trained note of some diagrams.)	outine heart rate as noted on m 1/19/18 to 3/18/18 identified nged from 61 to 79 beats per ception of a decreased heart 8 at 8:32 p.m. by RN-F. A ats per minute was 15/18 at 2:54 p.m. by licensed				

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	ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			901 8	ET ADDRESS, CITY, STATE, ZIP CODE SOUTHEAST WILLMAR AVENUE LMAR, MN 56201	•	
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	obtained with hear no fever noted, and R97 had a low blood orange juice was generated or docur. On 3/12/18, an elea.m. by RN-F indict not think resident for resident has been vitals as follows: To R[respirations]-24, O2[oxygen saturation air]room, P [pulse]. Encouraged fluids vitals an hour later pulse 45. Resident and stated he wanted the medical record of any additional vitals. The medical record of any additional vitals and stated he wanted the medical record of any additional vitals. The next electronic Progress Notes on indicate a follow up 3/15/18, a narrative indicated R97's far R97 was not feelin temperature, pulse noted a heart rate fine." A subsequen R97 ate little for su sugar but no additional vitals and pulse in the electror report. A review of indicates R97's he on 3/16/18 at 9:15 p.m., two days late	trate at 55, respirations at 18, d a blood pressure 144/66. In design of 65 and a glass of iven. No subsequent heart rate mental on that date. Sectronic narrative note of 8:33 ated R97's family member diduct well and RN-F indicated sleepy today. RN-F "obtained sleeps" and O2 was at 94% on RA and began swearing and yelling ted to be left alone to sleep." It lacked further documentation tal signs for that date. Seentries in the Resident 3/13/18 and 3/14/18 did not on R97's low heart rate. On anoted of LPN-C at 2:50 p.m. mily member informed staff g well. LPN-C obtained a sand respiratory count and of 50. R97 told LPN-C "I feel thote at 8:39 p.m. indicated pper and addressed his blood onal vital signs were recorded onal vital signs	F6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245427	B. WING_		03	3/22/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	information regarding provided verbally	B7 p.m. RN-E stated the ng R97's heart block was ia a report from the hospital. andard for monitoring residents a weekly basis, with vital signs itionally if there were other tated when a resident was a heart rate, she would expect ng the residents vitals, skin evel in addition to monitoring. E stated it would be important ere was a decrease in pulse normal perimeter, indicating would warrant monitoring. It is included it is a stated it exact that she be notified of RN-E stated she had not extra trate being so low and not extra trate being so low and not extra the stated it would be indicated to the enting and with (R97s) history nnolence. In 3/22/18, at 3:25 p.m. the extra she would expect prior to primary care provider the ent monitoring per nursing provide accurate information to rovider. The DON stated the ry care provider should be sident were symptomatic.	F 64	34		
	the policy of Bethe	lated 12/17, identified it was sda to consult with the if there is a significant				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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)	LD BE	(X5) COMPLETION DATE	
F 686 SS=D	change in the resid psychosocial status should be gathered the DON/designee condition and docu completed with this states the follow up resident stabilizes. Treatment/Svcs to CFR(s): 483.25(b)(\$483.25(b)(1) Pres Based on the compresident, the facility (i) A resident receiv professional standards pressure ulcers and ulcers unless the indemonstrates that (ii) A resident with pnecessary treatmen with professional standards pressure ulcers and ulcers unless the indemonstrates that (iii) A resident with pnecessary treatmen with professional standards pressure ulcers from de This REQUIREMEI by: Based on observative with pressure ulcer for 10 current pressure ulcer for 11 current pressure ulcer for 12 current pressure ulcer for 12 current pressure ulcer for 13 current pressure ulcer for 14 current pressure ulcer for 15 current pressure ulcer for 15 current pressure ulcer for 16 current pressure ulcer for 17 current pressure ulcer for 18 current pressure ulce	ent's physical, mental or a. The policy indicates data for a complete assessment, or nursing supervisor of mentation should be information. The policy further should continue until the Prevent/Heal Pressure Ulcer 1)(i)(ii) egrity sure ulcers. The pressure ulcers are ulcers. The prevent with ards of practice, to prevent addes not develop pressure dividual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent and ards of practice, to revent infection and prevent veloping. Note that the properties of a prevent with an end of the prevent wellow and document alled to consistently implement went the reoccurrence of a of 2 residents (R2) who had	F 68		2's care pdated Having eficient pleted to ssure	4/27/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245427	B. WING		03/2	22/2018	
NAME OF PROVIDER OR SUPPLIER BETHESDA			STREET ADDRESS, CITY, STATE, ZIP (901 SOUTHEAST WILLMAR AVENUM WILLMAR, MN 56201	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 686	Nursing Admissio indicated R2 was (cm) by 5 cm moi from the previous caused by rubbing implemented were heeled, and to cle Telfa and Kerlix d. The Long-Term C Assessment Instructed 10/17, defir "Partial thickness shallow open ulce without slough. Mopen/ ruptured bli R2's Braden Scale Sore Risk comple indicated R2 was ulcers. R2's progress not - 3/14/18, indicated include provolone right foot at "all tin - 3/19/19, the dresd discontinued to the were apply Reme R2's Individual Redated 3/13/18, idented include provolone right foot at "all tin - 3/19/19, the dresd discontinued to the were apply Reme R2's Individual Redated 3/13/18, idented include provolone right foot at "all tin - 3/19/19, the dresd discontinued to the were apply Reme R2's Individual Redated 3/13/18, idented in his order and monitor During observation was seated in his	n Assessment dated 3/13/18, admitted with a 6 centimeter st area to the right heel. Report facility indicated it was a blister g against his shoe. Interventions e no shoes until right heel was an the right heel daily and apply ressing. are Facility Resident ument 3.0 User 's Manual nes a Stage 2 pressure ulcer as loss of dermis presenting as a er with a red-pink wound bed, ay also present as an intact or ster." be for Prediction of Pressure sted 3/13/18 and 3/20/18, at risk to develop pressure des identified the following: det an interventions was added to boot (pressure relieving) to the nes." ssing of Telfa and Kerlix was e right heel. Interventions added dy cream and check daily. esident Care Plan (baseline) entified a wound to the right was from a popped blister. uded: dressings per nursing	F 6	Measures Or Systemic Chaensure That Deficient Prace Recur: RNs were provided proper care planning and trecords on April 10, 2018. Training and re-education all nursing staff beginning A and will be completed by completed by completed by completed by completed by complete range of the present of the presen	etice Will Not leducation on reatment was provided to April 10, 2018 completion date. tor e That ON, ADON, or dom audits of ers to ensure cord are mpleted ning May 1, sented to the ommittee to		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		245427	B. WING _		03	/22/2018
NAME OF PROVIDER OR SUPPLIER BETHESDA				STREET ADDRESS, CITY, STATE, ZIP CO 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	On 3/21/18, at 9:53 wheelchair in his reslippers to both fee boot sitting on his not sure what the lawho was still seate had the blue provoce During interview or assistant (NA)-C sput on when R2 was Further, there was care sheet directin worn. R2's undated Resi interventions of no of two persons for one for personal carecliner in the day and he had the provolone boot on a recliner in the day and he had the provolone boot on a recliner in the day and he had the provolone boot on a recliner in the day and he had the provolone boot on a recliner in the day and he had the provolone boot on a recliner in the day and he had the provolone boot on a recliner in the day and he had the provolone stated the provolor right foot at night in recliner sleeping. nurse (LPN)-B state heeled and he had	volone boot to his right foot. 3 a.m. R2 was seated in his bom. R2 had socks and et. R2 had a blue provolone night stand. R2 stated he was boot was for. At 10:55 a.m. R2, et d in his wheelchair in his room blone boot on his right foot. 1 3/21/18, at 3:22 p.m. nursing tated the provolone boot was as going to bed for the night. The information on the resident g when the boot was to be 1 dent Care Sheet included shoes and required an assist transfers and assistance of	F 68	36		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 686	provolone boots we times. At 1:43 p.m. registe had not been consiboot and noticed the updated the reside provolone boot to the evening before. At 1:47 p.m. R2's reskin was intact and circled area about theeling skin with so out edge. RN-D state the continued need times. R2's Treatments Ac 3/22/18 directed "Ptimes", with a start had an area to sign day, evening, and resigned off every should be developed within changes would be direct care staff wo plan interventions. The facility's Bethed Documentation Pol 11/17, included a dulcers as a partial the presenting as a shared-pink wound because the sould be developed within the staff worth and the staff worth	ere supposed to be on at all ered nurse (RN)-D stated R2 istently wearing the provolone at the day before and just int care sheet to include the he right heel at all times the light heel at all times the sight heel was observed. The blanchable. There was a 5 cm's by 5 cm's of fresh pink ome dry hard flaking skin at the lated she needed to assess for lof the provolone boots at all date of 3/14/18. The record in off the boot was in place for nigh shifts. The record was	F 68	6		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245427	B. WING		03/22/2018	
NAME OF PROVIDER OR SUPPLIER BETHESDA				STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201		
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F 686	documented in the the residents plan of	ventative measures should be progress notes and added to of care and communicate	F 686			
			F 697	,	4/27/18	
	provided to resident consistent with profit the comprehensive and the residents' go This REQUIREMENT by: Based on observation review the facility facomprehensive pair resident (R111) in the second	isure that pain management is the who require such services, ressional standards of practice, person-centered care plan, goals and preferences. No is not met as evidenced stion, interview and document		Corrective Action For Residents Affect By Deficient Practice: Resident #111 helphad a pain assessment completed and working with Physical Therapy in relation to his chronic knee pain.	as d is	
	osteoarthritis, and a knee replacement s Minimum Data Set R111 was cognitive moderate to excess activities of daily liv pain, was on sched medication regime. occupational therap	andated, identified diagnosis of a history of artificial hip and surgery. R111's quarterly (MDS) of 1/26/18 identified ly intact, and needed sive assistance of one for ing. R111 had occasional mild uled and as needed pain He also had physical and by from 12/19/17 to 1/11/18.		Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed ensure all residents who indicated on a last MDS to have moderate or higher in pain intensity have a pain goal and management program. These identified residents were interviewed in regard to their satisfaction of their current pain management program. Measures Or Systemic Changes Made Ensure That Deficient Practice Will Not Recur: Nursing staff will be educated	ent d to cheir n ed o	
	his room sitting in the	on 03/21/18 at 10:08 a.m. in the recliner and complained of stated he fell awhile ago and		reporting pain to RN. Training and re-education was provide	d to	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHES	DA				01 SOUTHEAST WILLMAR AVENUE VILLMAR, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	rubbing his left knewassistant (NA)-F enhe wanted to go to At 10:19 a.m. NA-F mechanical lift that transferring. NA-F garound R111 and his stand and started lift to transfer him into approximately stand suddenly yelled out up. NA-F stopped to us know when we obecause of his knew full standing position NA-F transferred R wheelchair. NA-F umechanical lift and his left knee, and uphere. NA-F stated (pain when we transfer knee. NA-F stated (R111) and does the bike, and some other exemals of this. In an interview on Licensed Practical had a few falls in the to be independent to needing more staff but refused to particulated.	e pain since he fell and began e. At 10:18 a.m. nursing stered the room asking R111 if an activity which he accepted. Treturned with an EZ stand, assists residents with proceeded to place the sling pooked the sling to the EZ fting R11 up from his recliner his wheel chair. R111 was ding at a 45 degree angle, and for NA-F to stop lifting him the transfer saying (R111) lets can not lift him up any higher e pain. He usually is not in a n when he tells us to stop. 111 in the EZ stand to his nhooked R111 from the he immediately started to rub pper thigh saying it hurts right R111) complaints of left kneeder him and at times he will ack pain. R111 reported he was not for his pain but was unsure if whe took a lot of medication. To goes to nursing rehabilitation arm pedals, 2 pound leg lifts ercises for strengthening. Thas been complaining of his or awhile and the nurses are	F	697	all nursing staff beginning April 10, and will be completed by completed. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, AD designee will complete random au residents who have a pain manage program. Residents will be intervirge arding their current satisfaction pain management program. 8 ran audits will be completed monthly xmonths beginning May 1, 2018. The will be presented to the facility Quance Assurance committee to verify the compliance has been attained.	ON, or dits on ement ewed of their dom	

PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 697 Continued From page 27 LPN-D also stated (R111) received Tylenol 1,000 mg (milligrams) twice a day (analgesic), and has an order for 650 mg additional milligrams if he needed more. R111 was observed on 03/22/18 7:02 a.m. sitting at the dining room table for breakfast. His head was down, and hunched over filling out his breakfast choices. LPN-E asked R111 about his pain level, and he rated it a 3, (out of a 1-10 scale, with 10 being the worst). He complained about pain in his left leg, but this was no more		T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER BETHESDA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 697 Continued From page 27 LPN-D also stated (R111) received Tylenol 1,000 mg (milligrams) twice a day (analgesic), and has an order for 650 mg additional milligrams if he needed more. R111 was observed on 03/22/18 7:02 a.m. sitting at the dining room table for breakfast. His head was down, and hunched over filling out his breakfast choices. LPN-E asked R111 about his pain level, and he rated it a 3, (out of a 1-10 scale, with 10 being the worst). He complained about pain in his left leg, but this was no more			245427	B. WING		03	3/22/2018
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 697 Continued From page 27 LPN-D also stated (R111) received Tylenol 1,000 mg (milligrams) twice a day (analgesic), and has an order for 650 mg additional milligrams if he needed more. R111 was observed on 03/22/18 7:02 a.m. sitting at the dining room table for breakfast. His head was down, and hunched over filling out his breakfast choices. LPN-E asked R111 about his pain level, and he rated it a 3, (out of a 1-10 scale, with 10 being the worst). He complained about pain in his left leg, but this was no more					901 SOUTHEAST WILLMAR AVEN	CODE	
LPN-D also stated (R111) received Tylenol 1,000 mg (milligrams) twice a day (analgesic), and has an order for 650 mg additional milligrams if he needed more. R111 was observed on 03/22/18 7:02 a.m. sitting at the dining room table for breakfast. His head was down, and hunched over filling out his breakfast choices. LPN-E asked R111 about his pain level, and he rated it a 3, (out of a 1-10 scale, with 10 being the worst). He complained about pain in his left leg, but this was no more	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
than he usually had. At 7:10 a.m. LPN-E stated (R111) uses medication, cream, heat and ice for his pain and has been seen in therapy for strengthening, but they discharged him because he would not do the exercises. During interview on 03/22/18 07:22 a.m. R111 stated he had pain in his left knee, mornings are the worst. He could maybe use something stronger in the morning than the rest of the day because he had less pain later in the day. Physical Therapy discharge notes 1/11/2018 identified R111 was seen in therapy from 12/19/17 to 1/11/18 for strengthening, increased shortness of breath, and increased back pain. The note identified R111 was non compliant with therapy exercises and had reached his maximal potential because of his refusals and was discharged from therapy. There was no indication if other therapy modallities were used for his back pain besides exercise. There was no mention of any knee or leg pain. R111's Pain Assessment 1/26/18 identified R111 had mild, aching pain with movement. He had low	F 697	LPN-D also stated mg (milligrams) twan order for 650 m needed more. R111 was observed at the dining room was down, and hubreakfast choices pain level, and he scale, with 10 being about pain in his letthan he usually ha (R111) uses medich his pain and has bestrengthening, but he would not do the During interview of stated he had pain the worst. He could stronger in the mode because he had letter appears of breat the note identified the rapy exercises potential because discharged from the indication if other the for his back pain be mention of any known and the state of t	I (R111) received Tylenol 1,000 vice a day (analgesic), and has a additional milligrams if he and on 03/22/18 7:02 a.m. sitting table for breakfast. His head anched over filling out his LPN-E asked R111 about his rated it a 3, (out of a 1-10 ag the worst). He complained aft leg, but this was no more and. At 7:10 a.m. LPN-E stated cation, cream, heat and ice for been seen in therapy for they discharged him because are exercises. In 03/22/18 07:22 a.m. R111 in his left knee, mornings are d maybe use something bring than the rest of the day ass pain later in the day. Idischarge notes 1/11/2018 is seen in therapy from 8 for strengthening, increased th, and increased back pain. If R111 was non compliant with and had reached his maximal of his refusals and was merapy. There was no therapy modalities were used besides exercise. There was no see or leg pain.	F6	97		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		NSTRUCTION		E SURVEY MPLETED
		245427	B. WING			03/	22/2018
NAME OF F	PROVIDER OR SUPPLIER	2		901 SC	T ADDRESS, CITY, STATE, ZIP CODE DUTHEAST WILLMAR AVENUE MAR, MN 56201	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 697	back period. Plan identified as non-pand prescribed megoal of one or less identify R111 kneed address his kneed R111 care plan las problem with pain replacement. The a 1/10 pain scale. administer pain megeriods, observe sinform staff if expechange, massage packs. Review of R111 phidentified two anti Naproxen 375 mg on 10/20/17, and 8:00 a.m. and 8:00 The facility used a system, to determ worst pain and 1 be R111 identified the Medication Admini 12/17/17 to 1/16/1 days and rated pain as 2/17/18 to 3/22/18 days, and rated pain as 2/17/18 to 3/22/18 days, which identified the days, which identified the days, which identified pain as 2/17/18 to 3/22/18 days, and rated pain as 2/17/18 to 3/22/18 days, which identified the days and rated pain as 2/17/18 to 3/22/18 days, which identified the days are days, which identified the days are days, which identified the days are days.	d PRN Tylenol once in the look for addressing pain was charmacological interventions edication with a pain intensity in the assessment did not a pain or any interventions to pain. St revised on 2/5/18 identified a related to knee and hip joint goal of pain control was 1-2 on Staff were directed to edication, encourage rest signs of pain, remind him to eriencing pain and use position, distraction, warm and cold envision orders, undated, inflammatory medications of once a day, which was started fylenol 1000 mg twice a day, at 0 p.m. started on 2/5/18. Inumerical 1-10 pain scale ine pain levels of 10 being the being least amount of pain. In following pain scale on the	F 6	97			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		
		245427	B. WING _		03	/22/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201	ECTION (X5) HOULD BE COMPLETIC	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION
F 697	2/5/18. Review of the prog 3/22/18 identified or complained of pain afternoon and ever of 10. Scheduled T 8:00 p.m. and was p.m. During interview on physical therapist (sound equipment in last seen R111 in J for strengthening a do the exercise so therapy. She had modality for R111, awas unaware R111 knee pain. She stat R111's pain level. On 03/22/18 01:55 used Tylenol but he each day, and they help with his pain. During interview on stated she had not pain assessment for he was having left movement. She stated of background the property of	ress notes from 1/1/18 to ne note on 3/2/18 that R111 in "left leg (thigh) area" this sing and rated the pain 6-7 out ylenol 1,000 mg was given at resting quietly in bed at 9:00 a 3/22/18 at 12:00 p.m. PT)-A stated they had ultra in their department. She had anuary 2018 and did exercises and pain, but R111 refused to the was discharged from not used ultra sound as a land thought this may work and was having complaints of the ted they could re-evaluate p.m. LPN-F stated (R111) and still rated his pain level 3-4 could do something else to a 03/22/18 3:31 p.m. RN-C completed a comprehensive or R111 pain, and was unaware knee and leg pain with lated she was aware R111 had a pain and the facility had used the preferred the recliner which	F 69	07		
F 804 SS=D		ear, Palatable/Prefer Temp 1)(2)	F 80	04		4/27/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		E SURVEY PLETED
		245427	B. WING		03/2	22/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 901 SOUTHEAST WILLMAR AV WILLMAR, MN 56201	ZIP CODE	
(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 X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 804	Continued From pa	nd drink	F 8	504		
	§483.60(d)(1) Food conserve nutritive with sample of the s	d prepared by methods that value, flavor, and appearance; d and drink that is palatable, safe and appetizing NT is not met as evidenced tion, interview and document tiled to ensure food was served erature for palatability for 2 of and R156) whom complained arm to taste on the second		Corrective Action For R By Deficient Practice: D. re-education regarding p temperatures and how t improper food temperatures and Resident #156 were regarding the palatability provided information ab- prevent reoccurrence. Identification Of Other R the Potential To Be Affect Practice: Meal Food Te were reviewed for all ne the dates of 03/21/2018 Food temperatures were Resident Dining Commi on 04/10/2018. Food temperatures will I the Resident Neighborh scheduled in April.	A-A was provided balatable food o address ures. Resident #6 e interviewed y of their food and out our plan to Residents Having cted By Deficient mperature Logs ighborhoods for -03/31/2018. e discussed at the ttee meeting held be brought up at	
	and left the area. At 12:23 p.m. DA-A	A returned and placed the food		Measures Or Systemic Ensure That Deficient P Recur: "Preparing and C	ractice Will Not	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		E SURVEY PLETED
		245427	B. WING _		03/2	22/2018
NAME OF BETHES	PROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP (901 SOUTHEAST WILLMAR AVENUM WILLMAR, MN 56201	CODE	
(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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 804	in the five serving very temperature. DA-Acorn which read 16 barbeque chicken 147 degrees F; pur 136 degrees F and degrees F. At 12:33 p.m. DA-Atheir noon meal, lewarmers and food while serving reside the meal until 12:40 meal service. A testime and temperature for palatability by Darbeque chicken warm to taste, pot degrees F and wardegree F and sligh stated the food couchicken, the potato for temperature. At 12:50 p.m. reside the food couchicken, the potato for temperature. At 12:50 p.m. reside the food couchicken, the potato for temperature. At 12:50 p.m. reside the food couchicken, the food couchicken, the potato for temperature. At 12:50 p.m. reside the food couchicken, the food couchicken according to the dietate the food couchies the second floor No. 2018 to March 20, temperatures range. The resident concessor 3/21/18 at 12:58	warmers to maintain the food A obtained temperatures of the A degree Ferenheiht (F), 153 degrees F; Salisbury steak reed corn 161 degrees F, gravy mashed potatoes 157 A started to serve the residents ft the covers off the serving leaving the food open to air ents. DA-A continues to serve 6 p.m. when she completed at tray was requested at this are were obtained and tested A-A and surveyor. The was 128 degree F and slightly atoes and gravy was 131 m to taste, corn was 125 tly warm to taste. The DA-A all dbe warmer especially the les and corn were ok to taste lents were interviewed about a the food was not warm at all, the corn was not hot, chicken just warm. Both residents all dbe much warmer and this	F 80	Foods" and "Holding Hot an Potentially Hazardous Food reviewed and updated. Tra re-education will be provide staff starting April 17, 2018 proper food temperatures, preferences of food temper be completed by completion. How The Facility Will Monit Performance To Make Sure Solutions Are Sustained: C Manager or Dietician will concept temperature and proper food temp	d" policies were ining and ed to all culinary regarding palatability and ratures and will n date. tor e That ertified Dietary onduct 8 and x 4 months alatability ertified Dietary onitor meal being served 8 s beginning ighborhoods ese audits will Quality erify that	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY PLETED
		245427	B. WING		03/	22/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
F 804	they needed to wor served warmer.	k on making sure the food was y census sheet identified 21 n the 2nd floor north dining	F8	04		

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245427 B. WING 03/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA** WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) ID (X4) ID COMPLÉTION (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 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, State Fire Marshal Division, on March 23, 2018. At the time of this survey, Building 01 of Bethesda Nursing Home Pleasant View was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. IF OPTING TO USE AN EPOC, A PAPER COPY **EPOC** OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** (K-TAGS) TO: LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Electronically Signed

TITLE

(X6) DATE 04/12/2018

NG 01 COMPLETED
03/20/2018
CITY, STATE, ZIP CODE WILLMAR AVENUE 56201
ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
DEFICIENCY
(V

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245427 B. WING 03/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (X4) ID COMPLÉTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 Continued From page 2 K 000 the east end. Due to the lack of a 2 hour fire barrier between the two types of construction. building 01 was downgraded to a type V (111) as allowed by NFPA 101 (12) section 8.2.1.3 (3). The building is fully sprinkled per NFPA 13 and has a fire alarm system with smoke detectors in the corridors and spaces open to the corridors. The facility has a capacity of 248 beds and had a census of 229 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 4/9/18 K 321 Hazardous Areas - Enclosure K 321 SS=D | CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons)

PRINTED: 04/13/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245427 B. WING 03/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA** WILLMAR, MN 56201 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL. (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 321 | Continued From page 3 K 321 e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the Corrective Action For The Deficiency: facility failed to maintain one hazardous storage Closure was installed on the identified room and one combustible storage room in door on 03/22/2018. Facility audit was accordance with the 2012 Life Safety Code completed on 04/09/2018 and revealed no (NFPA 101) section 19.3.2.1.3. This deficient other instances of this deficient practice. condition could allow smoke or fire to enter the corridor making it untenable and affect the quick Completion Date: March 22, 2018 and efficient exiting for 20 of the 248 residents and an undetermined amount of staff and visitors. Name and Title Of Person Responsible For Correction And Monitoring To Prevent Findings include: Recurrence: Ross Brandt, Facilities Director On the facility tour between 1:00 pm to 4:00 pm on 03/20/2018 observations and staff interview revealed the storage room behind the nurses station on the west side (combustible storage) did not have a closer. This deficient condition was confirmed by the Facility Maintenance Director.

PRINTED: 04/13/2018 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING 02 - MEMORY UNIT 245427 B. WING 03/20/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE **BETHESDA** WILLMAR, MN 56201 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 23, 2018. At the time of this survey, Building 01 of Bethesda Nursing Home Pleasant View was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Building 02 of Bethesda Nursing Home Pleasant View consists of one structure of type II (111) construction that was added on in 2014. It is a 3 story 84 bed unit that is separated from the original building by a 2 hour fire barrier. The building is fully sprinkled and has a fire alarm system with smoke detectors in the resident rooms, corridors and spaces open to the corridors. The facility has a capacity of 248 beds and had a census of 229 at time of the survey. EPOC The requirement at 42 CFR, Subpart 483.70(a) is MET. LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Electronically Signed

(X6) DATE

04/12/2018

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 4, 2018

Ms. Ashley Bormann, Administrator Bethesda 901 Southeast Willmar Avenue Willmar, MN 56201

Re: State Nursing Home Licensing Orders - Project Number S5427029

Dear Ms. Bormann:

The above facility was surveyed on March 19, 2018 through March 22, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

Bethesda April 4, 2018 Page 2

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Brenda Fischer, Unit Supervisor at (320) 223-7338 or at brenda.fischer@state.mn.us.

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,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kamala Fishe Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00792	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BETHES	DA		THEAST WIL R, MN 56201	LMAR AVENUE		
(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) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the corrected requires of the number and MN Ruwhen a rule contain	nether a violation has been				
	lack of compliance. re-inspection with a result in the assess	Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

04/12/18 **Electronically Signed**

TITLE

STATE FORM 6899 T75911 If continuation sheet 1 of 35

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00792	B. WING		03/	22/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BETHES	SDA		THEAST WILL R, MN 56201	MAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 000	Department of Hea you electronically, is necessary for Sta enter the word "context. You must then State licensure procompletion date, the corrected prior to el Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department's staff, the following correction that you and identify the date. Minnesota Department State Licensing federal software. The State Licensing federal software. The assigned to Minnesota Department State Licensing federal software. The state state is the "Summer column and replaced the correction order the findings which a statute after the state as evidence by." For are the Suggested Time period for Corpusted Time period for Corpusted Time period for Corpusted Time State State State The Suggested Time Period for Corpusted The State Sta	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. The 3/22/18, surveyors of this visited the above provider and tion orders are issued. Our electronic plan of have reviewed these orders, e when they will be completed. The east of Health is documenting. Correction Orders using ag numbers have been ota state statutes/rules for the assigned tag number efft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" as the "To Comply" portion of the state tement, "This Rule is not met ollowing the surveyors findings method of Correction and trection. ARD THE HEADING OF THE	2 000			

Minnesota Department of Health

STATE FORM 6899 T75911 If continuation sheet 2 of 35

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00792	B. WING		03/2	2/2018	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BETHES	DA		THEAST WIL R, MN 56201	LMAR AVENUE			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	MINNESOTA STATE STATUTES/RULES.						
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train		2 302			4/27/18	
	ALZHEIMER'S DIS DISORDER TRAIN MN St. Statute 144						
	Alzheimer's disease or related of	ity serves persons with disorders, whether in a					
	care staff	eral unit, the facility's direct					
	related disorders; (2) assistance with	ed training include: of Alzheimer's disease and activities of daily living; with challenging behaviors;					
	written or electronic training program, the	provide to consumers in form a description of the ne categories of employees					
	topics covered.	ncy of training, and the basic					
	by:	ent is not met as evidenced					
	facilty failed to ensu	and document review the ure 3 of 8 newly hired staff b) had completed the required		Corrected			

Minnesota Department of Health

STATE FORM 6899 T75911 If continuation sheet 3 of 35

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BETHES	DA		THEAST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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)	LD BE	(X5) COMPLETE DATE	
2 302	Continued From pa	ge 3	2 302				
		mentia care training program. ial to affect all residents in the					
	Findings include:						
	was hired on 12/15 that DA-C complete	C's personal file identified she /17. There was no indication ed the facility mandatory er and dementia care.					
	1/11/18. There was	e identified she was hired on no indication that DA-D ity mandatory training for lentia care.					
	she was hired on 2 that NA-M complete	NA)-M's personal file identified /5/18. There was no indication ed the facility mandatory er and dementia care.					
	Resource (HR)-As each month there is new employees. Ea Team sheet, that in for this general orientation they cor	3/21/18 at 4:00 p.m., Human tated the forth Tuesday of s mandatory training for all ach of them get a Welcome to forms them of date and time entation. During this general implete the staff training for tentia care, which is imployees.					
	stated, she was not had not attended the was no system in provientation has been these employee do dementia unit, but the residents throughout the statement of the was not attended to the was not attended to the was not attended	3/22/18 at 11:30 p.m. HR-A t aware these three employees te training. Currently there lace to follow to ensure this n completed. She stated not work on the locked hey do have contact with ut the facility who have tentia. We need to change or					

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE A. BUILDING:					
		00792	B. WING		03/2	2/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00.2	
BETHES	DA		HEAST WIL	LMAR AVENUE		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 302	orientation process SUGGESTED MET designee could dev policies and proced Alzheimer's training quality assessment could perform rand compliance. TIME PERIOD FOR (21) days.	THOD: The administrator or relop/revise and implement lures related to the required program requirements. The and assurance committee om audits to ensure	2 302			4/27/19
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			4/27/18
	by: F684 F697 Based on observati review, the facility f	on, interview and document		Corrected		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00792	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE		
(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) COMPLETE DATE
2 830	(R96, R28) reviewed addition the facility clinical monitoring was resident (R97) who history of cardiac professional facility in the facility of cardiac professional facility. R96's quarterly Min 1/26/18, identified Frimpairment, requires on and off the unit, mobility.	positioning for 2 of 8 residents and for wheelchair positioning. In failed to ensure consistent was completed for 1 of 1 m had a low pulse rate and a roblems. Imum Data Set (MDS) dated R96 had severe cognitive and supervision with locomotion and used a wheelchair for rised 11/2/17, identified R96	2 830			
	had an activities of and ambulated in the wheelchair. R96 was a push in [wheelchathathathathathathathathathathathathath	daily living (ADL) impairment ne hallway pushing a as recorded as, "may agree to air] for longer distances." plan lacked any dictation of wheelchair R96 used, nor often R96 used her g or rest.				
	was seated in the d with a bedside table had been served a consisted of eggs a centered on the sea several inches of sp hips, and the arm re upwards and nearly R96 had to lift her a rest(s) of the wheel the arm rest while p them using her han concerns about her	on 3/22/18, at 8:25 a.m. R96 lining room with her wheelchair e placed in front of her. R96 breakfast meal which and pancakes. R96 was at of the wheelchair with pacing on each side of her est(s) of the chair extending a level with R96's shoulders. For arm and over the arm chair, resting her inner arm on picking up her pancakes to eat ds. R96 stated she had no sheelchair, however, addeding enough to notice."				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/22/2018	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	03/2	2/2010
BETHES	DA		HEAST WIL	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
	nursing assistant (N same wheelchair for often used it to sit in and during activities in her wheelchair in she looked "tiny in in NA-A stated she was therapy (OT) or the R96's positioning in NA-A stated R96 has shoulder or arm particular or arm particular shoulder or arm particular should be sh	on 3/22/18, at 8:40 a.m. NA)-A stated R96 had the or the past several years and on during meals, in her room is. NA-A observed R96 sitting the dining room and stated t," and the chair was "too big." as not aware if occupational nurse had ever reviewed in the chair before. Further, and never complained about in to her before. In the chair before. In the chair before about in the chair before. In the chair before are was reviewed and lacked and ever been screened or				
	reviewed by nursing despite using the sa	g or OT for her wheelchair use; ame chair for several years ft her arms up and over the				
	9:26 a.m. R96 rema wheelchair, howeve area with several of activity. R96's arm however, she contil	observation on 3/22/18, at ained seated in the same er, was now in the commons ther residents listening to an s were down in her lap, nued to have several inches er body between her buttocks				
	registered nurse (R independent with he wheelchair for most observed R96 seat wheelchair and state wheelchair." RN-B referred to OT for he past, however,	on 3/22/18, at 9:32 a.m. N)-B stated R96 was er mobility, however, sits in her t of the meals. RN-B ed in the commons area in her red R96 "needs a smaller stated R96 had never been her wheelchair positioning in one should be completed to od posture and was				

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STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF PROVIDE	ER OR SUPPLIER			STATE, ZIP CODE		
BETHESDA			HEAST WIL , MN 56201	LMAR AVENUE		
	EACH DEFICIENCY	TEMENT 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)	LD BE	(X5) COMPLETE DATE
comformation of the second of	py assistant (0 inch meal in heal in h	chair. 7 a.m. certified occupational COTA)-A observed R96 eating er wheelchair. When ately following, COTA-A stated is happy with her wheelchair, expressed R96 had inches (4") of space on each ated in the wheelchair adding 4" in size, for positioning. was going to notify the OT to n R96's wheelchair as use a more narrow chair." explained their department had ched before about R96's oning and if floor staff were as they're supposed to contact essment," to see if better und or provided. 9S dated 12/22/17 indicated cognitive impairment, required in mobility, and used a	2 830			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7. Boilbing.				
		00792	B. WING		03/2	2/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE			
(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) COMPLETE DATE	
2 830	the use of her wheel During observation was receiving pass to her lower extrem (RA)-A. R28 was where wheelchair with sides, with her calver R28's toes touched resident is unable to pedal. During PROM by R foot pedals have be looked like the foot maintenance becaute. RA-A stated R28 exprovide increased streceiving PROM, Rare "OK" for a while stated "they get tire. Upon observation of was noted to have left foot was able to when a towel was proport this. R28's and the length had R28's right leg was the leg rest. During interview on licensed practical notes had been adjutted adjustment to the important for both of the contract of the service of the contract of th	elchair. on 3/21/18, at 11:29 a.m. R28 ive range of motion (PROM) ities from the restorative aide vearing support hose and at this time R28 was seated in her leg rests in place on both es resting on the leg rests. the foot rest, however, the orest her foot on the full foot A-A stated R28's leg rests and the positioned like this but it rests should be adjusted by use just the toes are touching. It levation of the leg rests would support to legs. While 28 stated her legs and feet in unsupported position, but	2 830				
		e seated in her wheelchair with					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00792		B. WING		03/3	2/2018	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/2	2/2010	
				LMAR AVENUE			
BETHES	DA		R, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 9	2 830				
	her left foot resting pedal. R28's right fo inch foam block sec	supported on her left foot oot pedal had approximately 1 cured to the pedal to improve her right foot was dangling off					
	stated R28's leg res supportive foam wa pedal, however stat demonstrate improp evaluation by occup RN-C stated R28's	p.m. registered nurse (RN)-C sts were adjusted and as placed on the right foot ted she continues to per positioning and an pational therapy was needed. leg rests were too long and ted to provide proper support.					
	During interview on 3/22/18, at 3:23 p.m. the director of nursing (DON) stated proper positioning of leg rests and foot pedals was important to provide support and to prevent foot drop.						
	and Procedure, rev the responsibility of residents are position indicated the staff w	py (OT) and physical therapy					
	resident had moder extensive assistand R97's medical diag	ORING S dated 1/26/18 identified rate cognitive an required ce of two to complete ADL's. noses included hypertension re), diabetes, dementia and					
		ce Sheet undated additionally sof chronic kidney disease,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/	22/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	SDA		THEAST WIL R, MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	hypotension (low blocerebrovascular disblood supply to the (decreased thyroid valve disease and to fheart function), housease, and cardicand somnolence (some supply of the position was laying on his been eyes closed, relaxer respirations. The been mat at bedside. At 8 bed, eyes closed, farespirations easy. On 3/22/18, at 12:3 bed resting at this topen, watching tele position and mat at in response to gree television. The narrative notes had been minimally his eyes to question yes or no. R97's obstats-level of oxyger be low at 88% on relevel 93-96%) and consal cannula (prover from an oxygen some supplied in the perminute which we R97's blood pressure.	ood pressure), sease (conditions that affect brain), hypothyroidism functioning), rheumatic mitral ricuspid deficiency (alteration ypertensive chronic kidney megaly (an enlarged heart), leepiness). on 3/22/18, at 7:14 a.m. R97 ed, under a sheet, with his d facial expression and easy ed was in a low position with a 3:40 a.m. R97 remained in acial expression relaxed, and a sheet, with his defacial expression relaxed, and a sheet in acial expression relaxed, and a sheet in the low bedside. Resident mumbled ting and continued watching a sidentified on 1/15/18, R97 responsive and did not open as, though did shake his head a sygen saturation levels (O2 in the blood) were noted to bom air (normal saturation by ygen was started through a vides oxygen through tubing urce). At that time R97 was	2 830			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE			
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 830	to inform the facilty hospital with influer second degree head R97 returned from the diagnosis of a which he was on ar discharge summary was dehydrated with sugar) on admission positive for influenzing antiviral treatment of four chronic kidney damage with a seven function). The diagnaddressed in the didischarge orders id receive furosemide daily and aspirin (as A review of R97's conitiated on 12/3/14 impairment related hypertension, mitratival valve disease, a his (heart attack), cere occlusion/cerebrovathe circulatory systrata transient ischemic care plan directed the RN to a and update the phyroutinely and as neaddress heart block the discrepancy or hospital report of a	R97 was admitted to the iza B, dehydration, and a new rt block. the hospital on 1/19/18 with irinary tract infection (UTI) for ntibiotic therapy. R97's // dated 1/19/18, identified R97 h hypoglycemia (low blood in. Resident was identified a B, treated with Tamiflu (an or influenza), and had stage disease (advanced kidney ere decrease in the kidney nosis of heart block was not scharge summary. R97's entified resident was to (a water pill) 40 mg by mouth is a blood thinner) 81 mg daily. are plan revised 2/14/18, identified a cardiovascular to diagnoses including I valve disease and tricuspid story of a myocardial infarction bral arrester ascular disease (alteration in m/blood vessels) and history of a tatacks (little strokes). The he staff to administer ered. The care plan also asses changes in vital signs sician or nurse practioner eded. R97's care does not it. The record did not identify any clarification from the heart block, or the absence of tal discharge summary to	2 830				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHESE	DA		HEAST WIL , MN 56201	LMAR AVENUE		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	follow up of his hos diagnoses of somnoidentified on the assidoes not identify this to cares to be provided to care the vitals report from R97's heart rate and commented on 3/12/18 heart rate of 50 beard documented on 3/12 practical nurse (LPI). On 3/11/18, the elect written by trained mindicated R97 was a obtained with heart no fever noted, and R97 had a low blood orange juice was gimonitored or docum. On 3/12/18, an elecand think resident for esident has been so vitals as follows: T[IR[respirations]-24, IR[respirations]-24, IR[respiration	is physician on 1/25/18 for pitalization at which time the plence and lethargy was sessment. R97's care plan is or provide interventions as ded. Dutine heart rate as noted on in 1/19/18 to 3/18/18 identified inged from 61 to 79 beats per eption of a decreased heart at 8:32 p.m. by RN-F. A at sper minute was 5/18 at 2:54 p.m. by licensed N)-C. Detronic resident progress redical assistant B at 3:52 p.m. not feeling well and VS were rate at 55, respirations at 18, a blood pressure 144/66. It is a blood pressure 144/66. It	2 830			

Minnesota Department of Health STATE FORM

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 [PACH DEPICENCY MUST BE PRECEDED BY FULL RESULATORY OR LS CIDENTIFYING INFORMATION) 10 SUMMARY STATEMENT OF DEFICIENCESS 10 COntinued From page 13 12 830 Continued From page 13 13 The next electronic entries in the Resident Progress Notes on 3/13/18 and 3/14/18 did not indicate a follow up on R97's low heart rate. On 3/15/18, a narrative noted of LPN-C at 2:50 p.m. indicated R97's family member informed staff R97 was not feeling well. LPN-C to obtained a temperature, pulse and respiratory count and noted a heart rate of 50. R97 told LPN-C "I feel fine." A subsequent note at 8:39 p.m. indicated R97 ate little for supper and addressed his blood sugar but no additional vital signs were recorded either in the electronic progress notes or vitals report indicates R97's heart rate was next documented on 3/16/18 at 91.75 p.m., two days later. There was no indication a physician had been contacted about R97's low heart rate and symptoms. On 3/22/18, at 12:37 p.m. RN-E stated the information regarding R97's heart block was provided verbally via a report from the hospital. RN-E stated the standard for monitoring residents vital signs was on a weekly basis, with vital signs to be checked additionally if there were other concerns. RN-E stated when a resident was noted to have a low heart rate, she would expect staff to be monitoring the residents vitals, skin color and oxygen level in addition to monitoring for chest pain. RN-E stated it would be important to monitor this if there was a decrease in pulse range outside the normal perimeter, indicating anything below 50 would warrant monitoring. RN-E stated to a pical pulse should be checked to a ssure accurate readings. RN-E also stated it would be her expectation that she be notified of		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER BETHESDA STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 [X4] ID PREETIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG ZAMMARY STATEMENT OF DEFICIENCIES TAG [EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 830 Continued From page 13 The next electronic entries in the Resident Progress Notes on 3/13/18 and 3/14/18 did not indicate a follow up on R97's low heart rate. On 3/15/18, a narrative noted of LPN-C at 2:50 p.m. indicated R97's family member informed staff R97 was not feeling well. LPN-C obtained a temperature, pulse and respiratory count and noted a heart rate of 50. R97 told LPN-C" If feel fine." A subsequent note at 8:39 p.m. indicated R97 ate little for supper and addressed his blood sugar but no additional vital signs were recorded either in the electronic progress notes or vitals report. A review of the electronic vitals report indicates R97's heart rate was next documented on 3/16/18 at 9:15 p.m., two days later. There was no indication a physician had been contacted about R97's low heart rate and symptoms. On 3/22/18, at 12:37 p.m. RN-E stated the information regarding R97's heart block was provided verbally via a report from the hospital. RN-E stated the standard for monitoring residents vital signs was on a weekly basis, with vital signs to be checked additionally if there were other concerns. RN-E stated with a resident was noted to have a low heart rate, she would expect staff to be monitoring the residents vitals, skin color and oxygen level in addition to monitoring for chest pain. RN-E stated the indication and the provided verbally of the provided verbally in the reward of the provided verbally in the reward of the provided verbally in the reward of the provided verbally via a report from the hospital. RN-E stated the standard for monitoring for chest pain. RN-E stated the indication anything below 50 would warrant monitoring. RN-E stated an apical pulse should be				A. BUILDING:			
SUMMARY STATEMENT OF DEFICIENCIES TAGE PREFIX TAGE PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPOPRIATE DATE DATE			00792	B. WING		03/2	2/2018
X41 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (ACCOMPLETE TAG) CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED FOR HEAPPROPRIATE DIFFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG CROSS-REFERENCED FOR HEAPPROPRIATE DIFFICIENCY 2 830 Continued From page 13 2 830 The next electronic entries in the Resident Progress Notes on 3/13/18 and 3/14/18 did not indicate a follow up on R97's low heart rate. On 3/15/16, a narrative note of L PN-C obtained a temperature, pulse and respiratory count and noted a heart rate of 50. R97 told LPN-C "If feel fine." A subsequent note at 8.39 p.m. indicated R97 ate little for supper and addressed his blood sugar but no additional vital signs were recorded either in the electronic progress notes or vitals report. A review of the electronic vitals report indicates R97's heart rate was next documented on 3/16/18 at 9:15 p.m., two days later. There was no indication a physician had been contacted about R97's low heart rate and symptoms. On 3/22/18, at 12:37 p.m. RN-E stated the information regarding R97's heart block was provided verbally via a report from the hospital. RN-E stated the standard for monitoring residents vital signs was on a weekly basis, with vital signs to be checked additionally if there were other concerns. RN-E stated when a resident was noted to have a low heart rate, she would expect staff to be monitoring the residents vitals, skin color and oxygen level in addition to monitoring for chest pain. RN-E stated it would be important to monitor this if there was a decrease in pulse range outside the normal perimeter, indicating anything below 50 would warrant monitoring. RN-E stated a a pical pulse should be checked to assure accurate readings. RN-E also stated it	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFEIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) 2 830 Continued From page 13 The next electronic entries in the Resident Progress Notes on 3/13/18 and 3/14/18 did not indicate a follow up on R97's low heart rate. On 3/15/18, a narrative noted of LPN-C at 2:50 p.m. indicated R97's family member informed staff R97 was not feeling well. LPN-C obtained a temperature, pulse and respiratory count and noted a heart rate of 50. R97 told LPN-C" lfeel fine." A subsequent note at 8:39 p.m. indicated R97 at little for super and addressed his blood sugar but no additional vital signs were recorded either in the electronic progress notes or vitals report. A review of the electronic vitals report indicates R97's heart rate was next documented on 3/16/18 at 9:15 p.m., two days later. There was no indication a physician had been contacted about R97's low heart rate and symptoms. On 3/22/18, at 12:37 p.m. RN-E stated the information regarding R97's heart block was provided verbally via a report from the hospital. RN-E stated the standard for monitoring residents vital signs was on a weekly basis, with vital signs to be checked additionally if there were other concerns. RN-E stated when a resident was noted to have a low heart rate, she would expect staff to be monitoring the residents vitals, skin color and oxygen level in addition to monitoring for chest pain. RN-E stated in would be important to monitor this if there was a decrease in pulse range outside the normal perimeter, indicating anything below 50 would warrant monitoring. RN-E stated in be important to monitor the if there was a decrease in pulse range outside the normal perimeter, indicating anything below 50 would warrant monitoring. RN-E stated the normal perimeter, indicating anything below 50 would warrant monitoring.	BETHES	DA			LMAR AVENUE		
The next electronic entries in the Resident Progress Notes on 3/13/18 and 3/14/18 did not indicate a follow up on R97's low heart rate. On 3/15/18, a narrative noted of LPN-C at 2:50 p.m. indicated R97's family member informed staff R97 was not feeling well. LPN-C obtained a temperature, pulse and respiratory count and noted a heart rate of 50. R97 told LPN-C" I feel fine." A subsequent note at 8:39 p.m. indicated R97 ate little for supper and addressed his blood sugar but no additional vital signs were recorded either in the electronic progress notes or vitals report. A review of the electronic vitals report indicates R97's heart rate was next documented on 3/16/18 at 9:15 p.m., two days later. There was no indication a physician had been contacted about R97's low heart rate and symptoms. On 3/22/18, at 12:37 p.m. RN-E stated the information regarding R97's hearb block was provided verbally via a report from the hospital. RN-E stated the standard for monitoring residents vital signs was on a weekly basis, with vital signs to be checked additionally if there were other concerns. RN-E stated when a resident was noted to have a low heart rate, she would expect staff to be monitoring the residents vitals, skin color and oxygen level in addition to monitoring for chest pain. RN-E stated it would be important to monitor this if there was a decrease in pulse range outside the normal perimeter, indicating anything below 50 would warrant monitoring. RN-E stated an apical pulse should be checked to assure accurate readings. RN-E also stated it	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
any abnormalities. RN-E stated she had not aware of R97's heart rate being so low and not feeling well. RN-E stated it would be indicated to advise the physician, either via fax, phone or	2 830	The next electronic Progress Notes on indicate a follow up 3/15/18, a narrative indicated R97's fam R97 was not feeling temperature, pulse noted a heart rate of fine." A subsequent R97 ate little for sup sugar but no addition either in the electron report. A review of indicates R97's hear on 3/16/18 at 9:15 p.m., two days later physician had been heart rate and symportic of the state of the s	entries in the Resident 3/13/18 and 3/14/18 did not on R97's low heart rate. On a noted of LPN-C at 2:50 p.m. nily member informed staff g well. LPN-C obtained a and respiratory count and of 50. R97 told LPN-C "I feel a note at 8:39 p.m. indicated oper and addressed his blood onal vital signs were recorded nic progress notes or vitals the electronic vitals report art rate was next documented at the contacted about R97's low otoms. 7 p.m. RN-E stated the ng R97's heart block was a a report from the hospital. andard for monitoring residents a weekly basis, with vital signs tionally if there were other atted when a resident was a heart rate, she would expect ng the residents vitals, skin evel in addition to monitoring. E stated it would be important ere was a decrease in pulse ormal perimeter, indicating would warrant monitoring. Cal pulse should be checked readings. RN-E also stated it cation that she be notified of RN-E stated she had not art rate being so low and not stated it would be indicated to	2 830			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/2	2/2010
BETHES		901 SOUT		LMAR AVENUE		
(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 SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	on symptoms prese of lethargy and som During interview on director of nursing sto notification of the staff would impleme orders in order to pthe primary care prophysician or primar contacted if the results A facility policy titled and Procedure upd the policy of Bethes resident's physician change in the resident's physician change in the resident's physician change in the resident by physician change in the resident by physician change in the resident by the DON/designee condition and document of the policy of the DON/designee condition and document of the policy of the policy of Bethes resident's physician change in the resident stabilizes. SUGGESTED MET The director of nurse could review and/or education for staff reand change in vital designee could aud positioning, and inspositioning concern them. The Quality A	e nurse practitioner dependent enting and with (R97s) history molence. 3/22/18, at 3:25 p.m. the stated she would expect prior primary care provider the ent monitoring per nursing rovide accurate information to ovider. The DON stated the y care provider should be ident were symptomatic. d Change in Condition Policy ated 12/17, identified it was a significant ent's physical, mental or a complete assessment, or nursing supervisor of mentation should be information. The policy further should continue until the THOD FOR CORRECTION: sing (DON) and/or designee develop policies and provide regarding pain assessments signs. In addition the DON/ lit residents for proper ervice staff on identifying is and how to correct ssessment and Assurance ould do random audits to	2 830			
	TIME PERIOD FOR	CORRECTION: Twenty-one				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BETHES	DA		THEAST WIL R, MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	(21) days.					
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			4/27/18
	comprehensive resident of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to event infection, and prevent yeloping.				
	by: Based on observati review, the facility fa interventions to pre-	ent is not met as evidenced on, interview and document ailed to consistently implement vent the reoccurrence of a of 2 residents (R2) who had cers.		Corrected		
	Findings include:					
	admitted to the facilincluded dementia a Nursing Admission indicated R2 was admission.	lent Face Sheet indicated R12 lty on 3/13/18. Diagnoses and type 2 diabetes. R2's Assessment dated 3/13/18, dmitted with a 6 centimeter area to the right heel. Report				

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 900 Continued From page 16 from the previous facility indicated it was a blister	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION		SURVEY PLETED
BETHESDA 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 16 from the previous facility indicated it was a blister	00792		B. WING		03/	22/2018	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 900 Continued From page 16 from the previous facility indicated it was a blister					,		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 2 900 Continued From page 16 from the previous facility indicated it was a blister	I BETHESDA						
from the previous facility indicated it was a blister	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	OULD BE	(X5) COMPLETE DATE
caused by rubbing against his shoe. Interventions implemented were no shoes until right heel was heeled, and to clean the right heel daily and apply Telfa and Kerlix dressing. The Long-Term Care Facility Resident Assessment Instrument 3.0 User 's Manual dated 10/17, defines a Stage 2 pressure ulcer as "Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister." R2's Braden Scale for Prediction of Pressure Sore Risk completed 3/13/18 and 3/20/18, indicated R2 was at risk to develop pressure ulcers. R2's progress notes identified the following: - 3/14/18, indicated an interventions was added to include provolone boot (pressure relieving) to the right foot at "all times." - 3/19/19, the dressing of Telfa and Kerlix was discontinued to the right heel. Interventions added were apply Remedy cream and check daily. R2's Individual Resident Care Plan (baseline) dated 3/13/18, identified a wound to the right heel, indicating it was from a popped blister. Interventions included: dressings per nursing order and monitor daily. During observation on 3/20/18, at 10:41 a.m. R2 was seated in his wheelchair at the dining room table. Both feet had socks on with slippers. R2 did not have a provolone boot to his right foot. On 3/21/18, at 9:53 a.m. R2 was seated in his	2 900	from the previous facaused by rubbing implemented were heeled, and to clea Telfa and Kerlix dre The Long-Term Car Assessment Instrurdated 10/17, define "Partial thickness loshallow open ulcer without slough. May open/ ruptured blist R2's Braden Scale Sore Risk complete indicated R2 was a ulcers. R2's progress note: - 3/14/18, indicated include provolone bright foot at "all time: - 3/19/19, the dress discontinued to the were apply Remedy R2's Individual Res dated 3/13/18, iden heel, indicating it we Interventions include order and monitor of During observation was seated in his we table. Both feet had did not have a proventions included in the province of the control of the were apply Remedy R2's Individual Res dated 3/13/18, iden heel, indicating it we little the control of	acility indicated it was a blister against his shoe. Interventions no shoes until right heel was in the right heel daily and apply essing. The Facility Resident ment 3.0 User 's Manual es a Stage 2 pressure ulcer as the sos of dermis presenting as a with a red-pink wound bed, y also present as an intact or ter." The Prediction of Pressure ed 3/13/18 and 3/20/18, at risk to develop pressure is identified the following: If an interventions was added to boot (pressure relieving) to the es." The sing of Telfa and Kerlix was right heel. Interventions added by cream and check daily. The sident Care Plan (baseline) of the estimate of the right ras from a popped blister. The dediction of the right ras from a popped blister rate of the right ras from a popped blister. The right rate of the right ra	2 900			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00792		B. WING		03/2	22/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	, , ,	
BETHESDA		THEAST WIL R, MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	slippers to both fee boot sitting on his root sure what the boot who was still seated had the blue provoled. During interview on assistant (NA)-C stoput on when R2 was ruther, there was rushed the care sheet directing worn. R2's undated Residinterventions of no of two persons for toone for personal cases of the case	t. R2 had a blue provolone hight stand. R2 stated he was not was for. At 10:55 a.m. R2, d in his wheelchair in his room one boot on his right foot. 3/21/18, at 3:22 p.m. nursing ated the provolone boot was as going to bed for the night. The information on the resident g when the boot was to be dent Care Sheet included shoes and required an assist transfers and assistance of	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00792		B. WING		03/2	2/2018
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
BETHESDA			HEAST WIL R, MN 56201	LMAR AVENUE		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	updated the resider provolone boot to the evening before. At 1:47 p.m. R2's riskin was intact and circled area about the heeling skin with so out edge. RN-D state the continued need times. R2's Treatments Ac 3/22/18 directed "Pitimes", with a start had an area to sign day, evening, and misgned off every ship the developed within changes would be redirect care staff wor plan interventions. The facility's Bethes double to direct care staff wor plan interventions. The facility's Bethes Documentation Pol 11/17, included a deulcers as a partial the presenting as a shared-pink wound become present as an intactive valuation and previous mented in the	at the day before and just and care sheet to include the me right heel at all times the ght heel was observed. The blanchable. There was a com's by 5 cm's of fresh pink and dry hard flaking skin at the ted she needed to assess for of the provolone boots at all date of 3/14/18. The record off the boot was in place for high shifts. The record was fit as completed. Sada Baseline Care Plan Policy and a baseline care plan would a 48 hours of admission and made as necessary. Further, all be educated about care sada Pressure Ulcer/Wound icy and Procedure revised definition of a Stage 2 pressure hickness loss of dermis allow open ulcer with a dry without slough. May also to open/ ruptured blister. An ventative measures should be progress notes and added to of care and communicate	2 900			
	SUGGESTED METHOD OF CORRECTION:					

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00792		B. WING		03/2	2/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
I BETHESDA			HEAST WIL , MN 56201	LMAR AVENUE		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From page 19 The director of nursing (DON) or designee could review/revise policies/procedures for pressure ulcer prevention and care, educate staff, and then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.		2 900			
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facilty failed to ensure food was served at the proper temperature for palatability for 2 of 21 residents (R6, R156) whom complained the food was not warm to taste on the second floor north dining kitchenette. Findings include: During observation on 3/21/18 at 12:02 p.m. on the second floor north kitchenette dietary aide (DA)-A was in the kitchenette and had turned on all five food warmers on high and was waiting for the food to be delivered to the 2nd floor. During this time nursing assistants were serving residents fluids, and cold vegetable salad while they waited for the meal to be delivered. The menu identified barbeque chicken, Salisbury steak; potatoes/gravy, and corn were being		2 960	Corrected		4/27/18

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00792		B. WING		03/2	2/2018
				STATE, ZIP CODE		
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OULD BE COMPLETE	
2 960	At 12:15 p.m. the foresidents were askicalled the kitchen a responsible to get to for the 2nd floor and the five serving with temperature. DA-Acorn which read 16 barbeque chicken 147 degrees F; pur 136 degrees F and degrees F. At 12:33 p.m. DA-Atheir noon meal, lef warmers and food I while serving reside the meal until 12:46 meal service. A testime and temperature for palatability by Disarbeque chicken warm to taste, potadegrees F and warm degrees F and slight stated the food colochicken, and the potate for temperature At 12:50 p.m. reside the food, R6 stated and R156 stated the and potatoes were stated the food could been a concern.	ood had not yet arrived, and ing where the food was. DA-A nd was told she was he food from the main kitchen d left the area. A returned and placed the food warmers to maintain the food work obtained temperatures of the 4 degree Ferenheiht (F), 153 degrees F; Salisbury steak eed corn 161 degrees F, gravy mashed potatoes 157 A started to serve the residents it the covers off the serving eaving the food open to air ents. DA-A continues to serve in period part of the serving eaving the food open to air ents. DA-A continues to serve in period and tested A-A and surveyor. The was 128 degree F and slightly atoes and gravy was 131 m to taste, corn was 125 mly warm to taste. The DA-A may be warmer especially the obtatoes and corn were ok to re. The triangle of the food was not warm at all, the corn was not hot, chicken just warm. Both residents lid be much warmer and this	2 960			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00792		B. WING		03/22/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 960	2018 to March 20, 2 temperatures range The resident conce on 3/21/18 at 12:55 kitchen was being of they needed to work served warmer. Review of the facility residents resided of received food from SUGGESTED MET certified dietary man could identify and dining experience a staff education regaincluded temperature and Assurance (QA random audits to er	2018 identified food ed from 147 to 165 degrees F. rns were discussed with DA-A p.m. and indicated the currently being remodeled, but k on making sure the food was by census sheet identified 21 in the 2nd floor north area who the north kitchenette. CHOD OF CORRECTION: The mager (CDM) and/or designee evelop a more palatable and could provide appropriate arding food preparation, res. The Quality Assessment A) committee could do	2 960			
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla	A.04 Subd. 3 Tuberculosis ntrol e provider must establish and nensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of action, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis n that covers all paid and contractors, students,	21426			4/27/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		THEAST WIL R, MN 56201	LMAR AVENUE		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	residents, and volue Health shall provide regarding implemen	nteers. The Department of e technical assistance ntation of the guidelines.	21426			
	by: Based on interview facility failed to ens symptoms screen a (tuberculin skin tes employees (E3 and were reviewed. In a document the resul induration of TSTs	and document review, the ure tuberculosis (TB) and second-step TST at) were completed for 2 of 6 (E6) whose personnel records addition, the facility failed to tant millimeters (mm) of for 2 of 5 residents (R198, admission tuberculosis		Corrected		
	Employee Mantoux given a first-step TS	of 2/5/18. A facility document, Record, indicated E3 was ST on 2/5/18, and on 2/8/17. The record lacked				
	Mantoux Record in step TST on 11/29/12/1/17; and a second	of 11/29/18. The Employee dicated E6 was given a first 17, which was read on ond-step TST was /11/17 and read on 12/13/17.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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) COMPLETE DATE
21426	E6's record lacked completed for E6. When interviewed oregistered nurse (Roto find evidence as E3. When interview on human resources of should have completed it was facility polyprior to getting the was not able to find screen was completed. A facility policy, Tubber Guidelines for Empindicated "All emplotation to the screen was completed to the screen was completed. The policy further in the screen was admitted administration records.	evidence a TB symptoms was on 3/22/18 at 1:22 p.m., th)-A stated she was not able second TST was completed for 3/22/18 at 2:47 p.m., the lirector (HRD) stated E6 eted the TB symptoms screen, icy to complete the screen TST. The HRD stated she documentation E6 symptoms eted. Derculosis Screening aloyees, revised 12/2017, byees shall be screened for a skin test (TST) and a written and disease using a skin test (TST) and a written are current symptoms of TB. Indicated the TST will be read and the reaction should be eters of induration (palpable, rea or swelling). REENING:	21426			
	the first and secon 2/4/18 and 2/19/18, recorded as "neg" (indicate the degree R87 was admitted of	e MAR indicated the results of d-step TSTs were read on respectively, and were negative). The results did not of induration in millimeters. on 4/4/17. R87's MAR for April . The MAR indicated the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	results of the first a read on 4/9/17 and were recorded as "I did not indicate the millimeters. When interviewed of director of nursing results were record residents' MARs, at consistency in char. A facility policy, Tub. Guidelines-Residen "The facility will scretuberculosis (TB) in policy also indicated documented negati months will receive admission.	and second-step TSTs were 4/24/17, respectively, and neg" (negative). The results degree of induration in on 3/22/18 at 3:12 p.m., the (DON) acknowledged the TST ed as negative in the nd stated there should be ting the TST results. Derculosis Screening nts, revised 11/2017, indicated een all residents for affection and disease. The dall residents with a ve TST within the previous 3 a two-step TST upon	21426			
	The Director of Nur could monitor to as procedures for resideveloped and impl					
21870	Residents of HC Fa Subd. 18. Respor residents shall have	.651 Subd. 18 Patients & ac.Bill of Rights nsive service. Patients and e the right to a prompt and se to their questions and	21870			4/27/18

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		HEAST WIL	LMAR AVENUE		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21870	Continued From pa	ge 25	21870			
	by: Based on interview facility failed to ense the short-term unit to be involved in Resid had the potential to residents of 212 res facility. The facility addressed resident cold food temperate of 12 residents (R3 concerns at the res the facility had not a missing clothing for	and document review, the ure residents who resided on were provided opportunity to dent Council Activities which affect 22 short term rehab sidents who resided in the also had not promptly council concerns regarding ures and food palatability for 2 4, R168) who voiced ident meetings. In addition, address resident grievances of 1 of 1 residents (R218), who uring a resident group meeting.		Corrected		
	meeting minutes identified quarterly, with 2/14/18. The facility calendar for the past four movidentified the follow December 2017: Bethesda Club Suit council or neighbor 1 South Recreation meeting scheduled 2 South Recreation meeting scheduled	t three resident council entified the meetings were the last meeting occurring on ars and neighborhood meetings onths were reviewed and ing: tes: No scheduled resident hood meeting identified. a Calendar: Neighborhood for 12/19/17. b Calendar: Neighborhood for 12/19/17. Calendar: Neighborhood				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00792	B. WING		03/2	2/2018
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHESDA			HEAST WIL , MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
m M ne E ne G ne W ne E ne E ne G ne W ne E	eighborhood meet & F Activity Progreighborhood meet is & H Program Cal eighborhood meet is & H Program Cal eighborhood meet is eighborhood meet is eighborhood meet anuary 2018: entified. North Recreation eighborhood eighborhood meet entified. North Recreation eighborhood eighborhood meet entified. North Recreation eighborhood eighborhood eighborhood eighborhood entified. North Recreation eighborhood eighb	for 12/19/17. alendar: No documented ing identified on the calendar. am Calendar: No documented ing identified on the calendar. endar: No documented ing identified on the calendar. am Calendar: No documented ing identified on the calendar. am Calendar: No documented ing identified on the calendar. es: No scheduled resident hood meeting identified. Calendar: No scheduled neighborhood meeting alendar: No scheduled neighborhood meeting am Calendar: No scheduled neighborhood meeting	21870			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00792	B. WING		03/2	2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		THEAST WIL R, MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21870	unit calendars with care unit and West March 2018: Bethesda Club Suit identified. 1 South Recreation meeting was sched 2 South Recreation meeting was sched 1 North Recreation meeting was sched 2 North Recreation meeting was sched 2 North Recreation meeting was sched West D Hall: No scheeting identified. West A Hall: No scheeting identified. West A Hall: No scheeting identified. E & F Activity Programeeting identified. E & F Activity Programeeting identified. On 3/21/18, at 10:2 meeting was held who lives on various stated the units havon occasion, howevery month. R169 council" was held e added the meetings they come together The meeting was a	the exception of the memory D Hall meetings were held. es: No neighborhood meeting Calendar: A neighborhood uled for 3/21/18. Calendar: A neighborhood uled for 3/21/18 Calendar: A neighborhood uled for 3/21/18. Calendar: A neighborhood uled for 3/21/18. Calendar: A neighborhood uled for 3/21/18. heduled neighborhood meduled resident council or cing identified. alendar: No neighborhood am Calendar: No	21870			
		sident meetings were "news to d resided in the Club Suites				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		00792	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHES	DA		, MN 56201	LMAR AVENUE		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21870	for rehabilitation for nothing about any ralso resided in the before transferring never invited to me During interview on activity director (AD resident council me quarterly basis but are held more frequenceting occur on a any concerns, requesuggestions for act these meetings are appropriate individuational. If there was grievance form conthrough the appropneighborhood meet documentation that in these meetings, Suites rehabilitate to routine basis becausiong, and are focus to participate in the council meetings. During interview on worker (SW)-B state council meetings was modeled after the interim, there are however, the neight in the Club Suites reneetings may be someetings, however review to determine	less than a month and knew neetings. R34 added they had therapy suites since admission to the long term care and "was etings". 3/22/18, at 1:04 p.m. the objection of the facility wide setings were completed on a padded neighborhood meetings sently. The neighborhood monthly basis and address ests for changes, and divities. The concerns from brought to the attention of the sal or department for follow is a formal concern or inpleted, these are routed	21870			

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NAME OF PROVIDER OR SUPPLIER BETHESDA B. WING O3/22/2018 STREET ADDRESS, CITY, STATE, ZIP CODE 901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
BETHESDA 901 SOUTHEAST WILLMAR AVENUE			00792	B. WING		03/2	22/2018
BETHESDA	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	BETHES	SDA			LMAR AVENUE		
	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETE DATE
21870 Continued From page 29 residents from Club Suites are invited to participate in the quarterly facility wide resident council meetings. On 3/22/18, at 3:31 p.m. the administrator stated the frequency of resident council is resident directed however, was unsure when this was initiated or if the frequency was reviewed with current residents. The facility policy titled Resident Council dated 12/17, identified the purpose of the resident council was to ensure that residents at Bethesda can exercise their right to forma and hold resident council meetings on a regular basis. DINING CONCERNS FOOD PALATABILITY: Review of the quarterly facility side resident council meeting minutes of 8/16/17 proposed an idea of a dining council with a target date of implementation of October 2017. The facility wide resident council meeting minutes of 11/15/17 identified a Dining Committee had been formed with representatives from each neighborhood, with the next meeting on 11/17/17. The facility wide resident council minutes of 2/14/18 identified the Dining Committee will be meeting again near the end of February, however, provided no updates or any planning of menus, any suggestions or concerns. A review of the Dining Committee Minutes of 10/30/17 identified new menu suggestions, and identified satisfaction with the alternate menu. The minutes reflected there were concerns regarding the evening meal related to presentation, cooking, and choices. A plan was	21870	residents from Club participate in the question council meetings. On 3/22/18, at 3:31 the frequency of residents from current residents. The facility policy tit 12/17, identified the council was to ensure can exercise their recouncil meetings or DINING CONCERN Review of the quart council meeting miridea of a dining coulimplementation of Cowide resident council meeting miridea of a dining coulimplementation of Cowide resident council meeting miridea of a dining coulimplementation of Cowide resident council meeting and with represent eighborhood, with The facility wide resident council meeting again near however, provided menus, any suggest A review of the Dini 10/30/17 identified identified satisfaction The minutes reflect regarding the eveni	p.m. the administrator stated sident council is resident vas unsure when this was quency was reviewed with ded Resident Council dated purpose of the resident ure that residents at Bethesda ight to forma and hold resident aregular basis. IS FOOD PALATABILITY: early facility side resident nutes of 8/16/17 proposed an uncil with a target date of Doctober 2017. The facility cil meeting minutes of a Dining Committee had been entatives from each the next meeting on 11/17/17. Sident council minutes of the Dining Committee will be the end of February, no updates or any planning of the sident with the alternate menu. The end of the were concerns and on with the alternate menu.	21870			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS. CITY. S	STATE, ZIP CODE		
BETHESDA			HEAST WIL	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21870	meeting minutes of planning for the upor revisit old business concerns of the ever was scheduled for thowever, there were minutes following the During the resident surveyors on 3/21/1 additional concerns experience and foor main topic of concestating some of the when it should have been a long standing related to recent related with the top layers were "not how example of scramb Additionally, other understand the expressed concerns being cold, and difficommunication was times they are told gets done." On 3/20/18 at 3:00 the food committee December 2017 be month. Additionally, held due to a members hospitalized The next food committee of the first week in been determined. The Resident Countries of the planning of the first week in been determined.	ge 30 11/18/17 idenfied menu coming holidays. It did not or address status with ening meals. The next meeting the beginning of January, re no additional meeting he meeting of 11/18/17. group meeting held with 8, at 10:26 a.m. residents had regarding the dining diserved. R34 expressed a rns was "food preparations," food had been served cold been hot. R34 stated this has gip problem and was not modeling of kitchen/dining dian example of lasagna being hot, however the lower that at all". R168 offered an led eggs being served cold. Inidentified residents is with pancakes and waffles cult to cut. They felt is the key word, adding often we'll look into it and nothing p.m. the dietary director stated meeting was not held in cause it was a busy holiday the January meeting was not been passing away, two been passing away, two led and illness in the facility. The meeting was scheduled April, however, no date had cil policy dated 12/17 the resident council meeting	21870			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00792	B. WING		03/2	2/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		THEAST WIL R, MN 56201	LMAR AVENUE		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21870	Continued From pa	ge 31	21870			
		involve other departments as concerns/issues brought forth				
	MISSING CLOTHIN	NG				
	dated 3/3/18, indicated facility on 3/2/18. The was cognitively intaction of the surveyor structure of the survey of the surveyor structure of the survey of the surveyor structure of the survey of the sur	3/20/18, at 9:45 a.m., R218 ne had numerous items of nice her admission to the				
	burgundy-colored s purchased, and wa came back." R218 that read "Family w she also lost two ca bras. R218 stated R218 again stated s was also "sick and During a subseque 11:15 a.m. R218 stated resident meeting to clothes. R218 state (pajamas) she word laundry, and "they was	d she had one gray and one weatshirt she had just s taken to wash "and never pointed to a sign in her room ill do my Laundry" and stated apris, two pairs of jeans, two "I don't know what to do." she "told everybody" and she tired" of losing her clothes. In the tried of losing her clothes at let them know about my led she also had a pair of PJ e one time, gave to the facility were gone, too, brand new."				
		ported the PJs missing "a ited to know what has missing items.				
	Resident Property F R218 lost one pair of Problem" in Spanis indicated R218 repostaff member. In the	Lost/Found/Damaged Report, dated 3/6/18, indicated of Teal-green PJs, with "No h on them. The document orted the item missing to a ne section When and where en: "She said she wore them				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00792	B. WING		03/2	2/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BETHESDA			HEAST WIL , MN 56201	LMAR AVENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21870	here one time and to them." Under Place (nursing assistant)-room. Under Interviewed included: Item four Family contacted as satisfied with resolution Comments/Addition. When interviewed consistant director of knew about R218's report on those filler R218 reported more ADON-A stated whether facility, there was completed, but the clothing, "hopefully ADON-A stated all in this unit, (the shorthouse, on the unit, were still looking for items she had lost. When interviewed consocial worker (SW)-missing on the (Mar R218 came to me missing more items conference, which wher family were told for the PJs. SW-Astill open" and she was conversation with R get a resolution."	hat was the last time she saw es searched/by whom: NA-C; resident room, laundry iew Staff involved, was a "-". lowing "Was item found?" m also had additional of which were blank, and nd when/where; found by; nd by whom; Did they seem ition?; and	21870				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00792	B. WING		03/2	2/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHES	DA		HEAST WIL , MN 56201	LMAR AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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)	LD BE	(X5) COMPLETE DATE
21870	facility administrator for R218's missing was not a "grievand to find them. The aresident clothing has improvement focus and made changes eliminate missing cacknowledged R21 the 6th, and also ununresolved for R21 was the facility policy promptly and also inconcern come to a up to make sure the addressed for R218 Although R218 had 3/6/18, and still lost was still unresolved frustration during the additional missing of the concern to the c	r stated the facility was looking items, and stated she felt this ce" because of ongoing efforts administrator stated missing ad been a facility quality, and the facility evaluated to its process to reduce and lothing. The administrator 8's PJs were missing since aderstood why this was 8. The administrator stated it by to resolve grievances to would be nice to see R218's resolution, and would follow the clothing issues were 3. I reported her PJs missing on a for sixteen days, the case I for R218, who expressed are survey, and had reported	21870			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00792	B. WING		03/2	22/2018	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BETHESDA 901 SOUTHEAST WILLMAR AVENUE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	SHOULD BE COMPLETE		
21870	in the resident coun manner. The admin educate all appropr assurance (QAA) to systems to ensure of report those results for further recomme	ncil were addressed in a timely histrator or designee could liate staff. The quality eam could develop auditing longoing compliance and to the quality assurance team	21870				

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