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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: T759
Facility ID: 00792

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245427**

2. STATE VENDOR OR MEDICAID NO. (L2) **516240800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA**
(L4) **901 SOUTHEAST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

4. TYPE OF ACTION: 7 (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/14/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **248** (L18)

13.Total Certified Beds **248** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	248			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE
Brenda Fischer, Unit Supervisor
Date : 05/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
Michaelyn Bruer, Enforcement Specialist
Date: 05/30/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

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
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
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/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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Facility ID: 00792

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(L3) **BETHESDA**
(L4) **901 SOUTHEAST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **03/22/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NE II 04/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/30/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)
29. INTERMEDIARY/CARRIER NO. **03001** (L31)
30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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

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

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	03/22/2018

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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with Centers for Medicare and Medicaid (CMS) Appendix Z, Emergency Preparedness Requirements, was conducted 3/19/18, through 3/2/18, during a recertification survey. The facility was in full compliance with these requirements, and no deficiencies are issued.	E 000		
F 000	INITIAL COMMENTS On 3/19/18 to 3/22/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take	F 565		4/27/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	03/22/2018

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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 565	Continued From page 1 reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents who resided on the short-term unit were provided opportunity to be involved in Resident Council Activities. This had the potential to affect 22 short term rehab residents of 212 residents who resided in the facility. The facility also had not promptly	F 565	Corrective Action For Residents Affected By Deficient Practice: Resident #34 and Resident #168 were interviewed regarding the temperature of their food and provided information about our plan to prevent reoccurrence. Resident Dining Committee meeting was held on 04/10/2018 with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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F 565	Continued From page 2 addressed resident council concerns regarding cold food temperatures and food palatability for 2 of 12 residents (R34, R168)who voiced concerns at resident council meetings. In addition, the facility had not address resident grievances of missing clothing for 1 of 1 residents, who voiced concerns during a resident group meeting. Findings include: RESIDENT COUNCIL MEETING: A review of the past three resident council meeting minutes identified the meetings were held quarterly, with the last meeting occurring on 2/14/18. The facility calendars and neighborhood meetings for the past four months were reviewed and identified the following: December 2017: Bethesda Club Suites: No scheduled resident council or neighborhood meeting identified. 1 South Recreation Calendar: Neighborhood meeting scheduled for 12/19/17. 2 South Recreation Calendar: Neighborhood meeting scheduled for 12/19/17. 1 North Recreation Calendar: Neighborhood meeting scheduled for 12/19/17. 2 North Recreation Calendar:Neighborhood meeting scheduled for 12/19/17. MCN Recreation Calendar: No documented neighborhood meeting identified on the calendar. E & F Activity Program Calendar: No documented neighborhood meeting identified on the calendar. G & H Program Calendar: No documented neighborhood meeting identified on the calendar. West Activity Program Calendar: No documented neighborhood meeting identified on the calendar.	F 565	discussion on food temperatures. Resident #218 has since discharged from the facility. Follow-up has been attempted to help resolve the concern of missing clothing. Neighborhood Resident Council meetings have been scheduled for all neighborhoods in April 2017 including in the short-term rehab unit. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: All residents who had desire to attend the resident council meetings or wished to express concerns had the potential to be affected by this deficient practice. Meetings will now be held in each neighborhood on a monthly basis. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Training and re-education was provided to all Licensed Social Workers on April 11, 2018 regarding all residents right to be involved in Resident Council activities including on the short-term unit and promptly addressing resident council concerns and grievances. Facility's policy and procedure on Resident Council was reviewed and revised. Meetings will now be held in each neighborhood on a monthly basis. Residents will be informed of their Resident Council rights at their next neighborhood meeting.	

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F 565	Continued From page 3 January 2018: Bethesda Club Suites: No scheduled resident council or neighborhood meeting identified. 1 South Recreation Calendar: No scheduled resident council or neighborhood meeting identified. 2 South Recreation Calendar: No scheduled resident council or neighborhood meeting identified. 1 North Recreation Calendar: No scheduled resident council or neighborhood meeting identified. 2 North Recreation Calendar: No scheduled resident council or neighborhood meeting identified. MCN Recreation Calendar: No scheduled resident council or neighborhood meeting identified. E & F Activity Program Calendar: No scheduled resident council or neighborhood meeting identified. G & H Program Calendar: Neighborhood meeting scheduled for 1/29/18. West Activity Program Calendar: No scheduled resident council or neighborhood meeting identified. February 2018: A facility residnets council meeting was scheduled for 2/14/18 and was identified on all unit calendars with the exception of the memory care unit and West D Hall meetings were held. March 2018: Bethesda Club Suites: No neighborhood meeting identified. 1 South Recreation Calendar: A neighborhood meeting was scheduled for 3/21/18. 2 South Recreation Calendar: A neighborhood	F 565	How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Administrator will review neighborhood meeting/resident council minutes to verify appropriate and prompt follow-up of noted concerns. All minutes will be reviewed monthly x 4 months beginning May 1, 2018. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 565	Continued From page 4 meeting was scheduled for 3/21/18 1 North Recreation Calendar: A neighborhood meeting was scheduled for 3/21/18. 2 North Recreation Calendar: A neighborhood meeting was scheduled for 3/21/18. West D Hall: No scheduled neighborhood meeting identified. West A Hall: No scheduled resident council or neighborhood meeting identified. MCN Recreation Calendar: No neighborhood meeting identified. E & F Activity Program Calendar: No neighborhood meeting identified. G & H Program Calendar: No neighborhood meeting identified. On 3/21/18, at 10:26 a.m. a resident group meeting was held with surveyors from residents who lives on various floors of the facility. R168 stated the units have "neighbor hood meetings" on occasion, however, this had not occurred every month. R169 stated the "large resident council" was held every three months. R169 added the meetings are "smaller meetings and they come together" with neighborhoods (units). The meeting was attended by the following residents; R168, R218, R34, R59, R102, R121, R73, R20, R84,R170, R38, and R13 R218 stated the resident meetings were "news to me", adding she had resided in the Club Suites for rehabilitation for less than a month and knew nothing about any meetings. R34 added they had also resided in the therapy suites since admission before transferring to the long term care and "was never invited to meetings". During interview on 3/22/18, at 1:04 p.m. the activity director (AD) stated the facility wide	F 565		

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F 565	Continued From page 5 resident council meetings were completed on a quarterly basis but added neighborhood meetings are held more frequently. The neighborhood meeting occur on a monthly basis and address any concerns, requests for changes, and suggestions for activities. The concerns from these meetings are brought to the attention of the appropriate individual or department for follow through. If there was a formal concern or grievance form completed, these are routed through the appropriate parties. The neighborhood meetings do not have any documentation that addressed what was covered in these meetings, concerns or issues. The Club Suites rehabilitate unit residents do not meet on a routine basis because they are not here very long, and are focused on rehab. They are invited to participate in the facility wide quarterly resident council meetings. During interview on 3/22/18, at 1:54 p.m. social worker (SW)-B stated the facility wide resident council meetings were held on a quarterly basis as modeled after the process from Heritage. In the interim, there are neighborhood meetings, however, the neighborhood meetings are not held in the Club Suites rehab unit. SW-B stated information gathered from neighborhood meetings may be shared at the quarterly resident meetings, however, there are no minutes to review to determine if there are similar concerns within the neighborhoods. SW-B stated the 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	F 565		

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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 identified to work on the evening menus with resident representative input. A review of the meeting minutes of 11/18/17 idenfied menu planning for the upcoming holidays. It did not revisit old business or address status with concerns of the evening meals. The next meeting was scheduled for the beginning of January, however, there were no additional meeting

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minutes following the meeting of 11/18/17.

During the resident group meeting held with surveyors on 3/21/18, at 10:26 a.m. the residents had additional concerns regarding the dining experience and food served. R34 expressed a main topic of concerns was "food preparations," stating some of the food had been served cold when it should have been hot. R34 stated this has been a long standing problem and was not related to recent remodeling of kitchen/dining areas. R34 provided an example of lasagna served with the top being hot, however the lower layers were "not hot at all". R168 offered an example of scrambled eggs being served cold. Additionally, other unidentified residents expressed concerns with pancakes and waffles being cold, and difficult to cut. They felt communication was the key word, adding often times they are told "we'll look into it and nothing gets done."

On 3/20/18 at 3:00 p.m. the dietary director stated the food committee meeting was not held in December 2017 because it was a busy holiday month. Additionally, the January meeting was not held due to a member passing away, two members hospitalized and illness in the facility. The next food committee meeting was scheduled for the first week in April, however, no date had been determined.

The Resident Council policy dated 12/17 identified following the resident council meeting the staff liaison will involve other departments as needed to resolve concerns/issues brought forth by the council.

MISSING CLOTHING

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R218's admission Minimum Data Set (MDS) dated 3/3/18, indicated she was admitted to the facility on 3/2/18. The MDS also indicated R218 was cognitively intact.

During interview on 3/20/18, at 9:45 a.m., R218 told the surveyor she had numerous items of clothing missing since her admission to the facility. R218 stated she had one gray and one burgundy-colored sweatshirt she had just purchased, and was taken to wash "and never came back." R218 pointed to a sign in her room that read "Family will do my Laundry" and stated she also lost two capris, two pairs of jeans, two bras. R218 stated "I don't know what to do." R218 again stated she "told everybody" and she was also "sick and tired" of losing her clothes. During a subsequent interview on 3/21/18, at 11:15 a.m. R218 stated she has just attended a resident meeting to let them know about my clothes. R218 stated she also had a pair of PJ (pajamas) she wore one time, gave to the facility laundry, and "they were gone, too, brand new." R218 stated she reported the PJs missing "a while ago" and wanted to know what has happening with the missing items.

A facility document, Lost/Found/Damaged Resident Property Report, dated 3/6/18, indicated R218 lost one pair of Teal-green PJs, with "No Problem" in Spanish on them. The document indicated R218 reported the item missing to a staff member. In the section When and where last seen was written: "She said she wore them here one time and that was the last time she saw them." Under Places searched/by whom: (nursing assistant)-NA-C; resident room, laundry room. Under Interview Staff involved, was a "-".

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"No" was circled following "Was item found?" The pre-printed form also had additional lines/questions, all of which were blank, and included: Item found when/where; found by; Family contacted and by whom; Did they seem satisfied with resolution?; and Comments/Additional information.

When interviewed on 3/21/18 at 4:02 p.m., assistant director of nursing (ADON)-A stated we knew about R218's missing PJs, and there was a report on those filled out on the 6th (3/6/18) and R218 reported more items missing today. ADON-A stated when residents are admitted to the facility, there was no clothing inventory completed, but the facility marked resident clothing, "hopefully before" it gets done in laundry. ADON-A stated all resident, personal items on this unit, (the short-term stay) was laundered in house, on the unit. ADON-A also stated they were still looking for R218's PJs, as well the other items she had lost.

When interviewed on 3/22/18, at 12:53 p.m. social worker (SW)-A stated R218's PJ were missing on the (March) sixth, and added that R218 came to me "yesterday" to express she was missing more items. SW-A stated at R218's care conference, which was on (March)13th R218 and her family were told we were still actively looking for the PJs. SW-A stated the missing PJs "was still open" and she would need to have a conversation with R218 and the family and "try to get a resolution."

When interviewed on 3/22/18 at 3:08 p.m. the facility administrator stated the facility was looking for R218's missing items, and stated she felt this was not a "grievance" because of ongoing efforts

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F 565	Continued From page 10 to find them. The administrator stated missing resident clothing had been a facility quality improvement focus, and the facility evaluated and made changes to its process to reduce and eliminate missing clothing. The administrator acknowledged R218's PJs were missing since the 6th, and also understood why this was unresolved for R218. The administrator stated it was the facility policy to resolve grievances promptly and also it would be nice to see R218's concern come to a resolution, and would follow up to make sure the clothing issues were addressed for R218. Although R218 had reported her PJs missing on 3/6/18, and still lost for sixteen days, the case was still unresolved for R218, who expressed frustration during the survey, and had reported additional missing clothing items. A facility document, Our Grievance Procedure, undated, indicated Residents or resident representative have a right to file a grievance orally, in writing,and/or anonymously if desired. The document indicated it is the facility intent to meet resident and family needs and desire to the fullest extent possible. The document also indicted, "Within a reasonable timeframe of receiving the concern not to exceed 10 business days, a facility representative will meet with all parties involved in he matter, seek resolution to the concern, and respond tot he individual expressing the concern, in writing, if requested.	F 565		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		4/27/18

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F 684	Continued From page 11 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote good posture and positioning for 2 of 8 residents (R96, R28) reviewed for wheelchair positioning. In addition the facility failed to ensure consistent clinical monitoring was completed for 1 of 1 resident (R97) whom had a low pulse rate and a history of cardiac problems. Findings include: R96's quarterly Minimum Data Set (MDS) dated 1/26/18, identified R96 had severe cognitive impairment, required supervision with locomotion on and off the unit, and used a wheelchair for mobility. R96's care plan revised 11/2/17, identified R96 had an activities of daily living (ADL) impairment and ambulated in the hallway pushing a wheelchair. R96 was recorded as, "may agree to a push in [wheelchair] for longer distances." However, the care plan lacked any dictation regarding what type of wheelchair R96 used, nor information on how often R96 used her wheelchair for sitting or rest. During observation on 3/22/18, at 8:25 a.m. R96 was seated in the dining room with her wheelchair	F 684	Corrective Action For Residents Affected By Deficient Practice: Resident #96 is under the care of Occupational Therapy to obtain a proper fitting wheelchair that she is agreeable to. Resident #28 has had her foot pedals modified so her feet sit properly and are supported while she sits in her wheelchair. She is also being seen by Occupational Therapy for proper wheelchair positioning. Resident #97 heart rate has been monitored, MD has been notified of results and no treatment is indicated. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit will be completed by April 25, 2018 on all residents who use a wheelchair to ensure all residents' wheelchairs are appropriate and resident is well supported. A facility audit was completed to ensure all residents heart rates are being monitored and are within appropriate parameters. Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: Nursing staff will be educated on	

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with a bedside table placed in front of her. R96 had been served a breakfast meal which consisted of eggs and pancakes. R96 was centered on the seat of the wheelchair with several inches of spacing on each side of her hips, and the arm rest(s) of the chair extending upwards and nearly level with R96's shoulders. R96 had to lift her arms up and over the arm rest(s) of the wheelchair, resting her inner arm on the arm rest while picking up her pancakes to eat them using her hands. R96 stated she had no concerns about her wheelchair, however, added "[I] never sit in it long enough to notice."

When interviewed on 3/22/18, at 8:40 a.m. nursing assistant (NA)-A stated R96 had the same wheelchair for the past several years and often used it to sit in during meals, in her room and during activities. NA-A observed R96 sitting in her wheelchair in the dining room and stated she looked "tiny in it," and the chair was "too big." NA-A stated she was not aware if occupational therapy (OT) or the nurse had ever reviewed R96's positioning in the chair before. Further, NA-A stated R96 had never complained about shoulder or arm pain to her before.

R96's medical record was reviewed and lacked any evidence R96 had ever been screened or reviewed by nursing or OT for her wheelchair use; despite using the same chair for several years and her having to lift her arms up and over the rests to eat.

During subsequent observation on 3/22/18, at 9:26 a.m. R96 remained seated in the same wheelchair, however, was now in the commons area with several other residents listening to an activity. R96's arms were down in her lap,

F 684

identifying wheelchair positioning and heart rate parameters.
Training and re-education was provided to all nursing staff beginning April 10, 2018 and will be completed by completion date.

How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Occupational Therapist or designee will complete 8 random wheelchair positioning audits monthly x 4 months beginning May 1, 2018. DON, ADON, or designee will complete random audits on resident's heart rate for 8 residents monthly x 4 months beginning May 1, 2018. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.

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however, she continued to have several inches on both side(s) of her body between her buttocks and chair sides.

When interviewed on 3/22/18, at 9:32 a.m. registered nurse (RN)-B stated R96 was independent with her mobility, however, sits in her wheelchair for most of the meals. RN-B observed R96 seated in the commons area in her wheelchair and stated R96 "needs a smaller wheelchair." RN-B stated R96 had never been referred to OT for her wheelchair positioning in the past, however, one should be completed to ensure R96 had good posture and was comfortable in her chair.

On 3/22/18, at 11:27 a.m. certified occupational therapy assistant (COTA)-A observed R96 eating the lunch meal in her wheelchair. When interviewed immediately following, COTA-A stated R96 voiced she was happy with her wheelchair, however, COTA-A expressed R96 had approximately four inches (4") of space on each side of her while seated in the wheelchair adding it should be 2", not 4" in size, for positioning. COTA-A stated she was going to notify the OT and obtain her input on R96's wheelchair as "maybe she could use a more narrow chair." Further, COTA-A explained their department had never been approached before about R96's wheelchair or positioning and if floor staff were seeing these things, "they're supposed to contact OT and get an assessment," to see if better options could be found or provided.

R28'S quarterly MDS dated 12/22/17 indicated R28 had moderate cognitive impairment, required total assistance with mobility, and used a

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wheelchair for mobility.

R28's Resident Face Sheet, undated, indicated R28 had chronic gout (inflammation of joints), difficulty in walking, dependence on wheelchair, and mononeuropathy (a nerve disorder which can cause increased pain or weakness).

R28's care plan initiated 9/13/16, identified resident had musculoskeletal (injuries and disorders that affect the human body's movement) impairment related to neuropathic pain and arthritis. The care plan also identified R28 required assistance with ADL's related to weakness and decreased mobility. The care plan directed the staff to provide total assistance with the use of her wheelchair.

During observation on 3/21/18, at 11:29 a.m. R28 was receiving passive range of motion (PROM) to her lower extremities from the restorative aide (RA)-A. R28 was wearing support hose and non-skid slippers. At this time R28 was seated in her wheelchair with her leg rests in place on both sides, with her calves resting on the leg rests. R28's toes touched the foot rest, however, the resident is unable to rest her foot on the full foot pedal.

During PROM by RA-A stated R28's leg rests and foot pedals have been positioned like this but it looked like the footrests should be adjusted by maintenance because just the toes are touching. RA-A stated R28 elevation of the leg rests would provide increased support to legs. While receiving PROM, R28 stated her legs and feet are "OK" for a while in unsupported position, but stated "they get tired".

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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.

During interview on 3/21/18, at 3:25 p.m. with licensed practical nurse (LPN)-A stated the leg rests had been adjusted for R28. LPN-A stated the adjustment to the appropriate length was important for both comfort and support.

During observation on 3/21/18, at 3:31 p.m. R28 was observed to be seated in her wheelchair with her left foot resting supported on her left foot pedal. R28's right foot pedal had approximately 1 inch foam block secured to the pedal to improve position, however, her right foot was dangling off the foot pedal.

On 3/22/18, at 1:26 p.m. registered nurse (RN)-C stated R28's leg rests were adjusted and supportive foam was placed on the right foot pedal, however stated she continues to demonstrate improper positioning and an evaluation by occupational therapy was needed. RN-C stated R28's leg rests were too long and needed to be adjusted 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.

A facility policy, titled Positioning in Chair Policy

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and Procedure, revised 2/2017 identified it was the responsibility of the nursing staff to ensure residents are positioned properly. The policy also indicated the staff was to consult with occupational Therapy (OT) and physical therapy (PT) when necessary.

CLINICAL MONITORING
R97's quarterly MDS dated 1/26/18 identified resident had moderate cognitive an required extensive assistance of two to complete ADL's. R97's medical diagnoses included hypertension (high blood pressure), diabetes, dementia and depression.

R97's Resident Face Sheet undated additionally identified diagnoses of chronic kidney disease, hypotension (low blood pressure), cerebrovascular disease (conditions that affect blood supply to the brain), hypothyroidism (decreased thyroid functioning), rheumatic mitral valve disease and tricuspid deficiency (alteration of heart function), hypertensive chronic kidney disease, and cardiomegaly (an enlarged heart), and somnolence (sleepiness).

During observation on 3/22/18, at 7:14 a.m. R97 was laying on his bed, under a sheet, with his eyes closed, relaxed facial expression and easy respirations. The bed was in a low position with a mat at bedside. At 8:40 a.m. R97 remained in bed, eyes closed, facial expression relaxed, and respirations easy.

On 3/22/18, at 12:31 p.m. R97 was observed in bed resting at this time, however his eyes were open, watching television. His bed was in the low position and mat at bedside. Resident mumbled

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in response to greeting and continued watching television.

The narrative notes identified on 1/15/18, R97 had been minimally responsive and did not open his eyes to questions, though did shake his head yes or no. R97's oxygen saturation levels (O2 sats-level of oxygen in the blood) were noted to be low at 88% on room air (normal saturation level 93-96%) and oxygen was started through a nasal cannula (provides oxygen through tubing from an oxygen source). At that time R97 was afebrile (without fever) at 97.5 degrees Fahrenheit, respiration (breathing) rate of 20 breaths per minute and a heart rate of 72 beats per minute which were all within normal limits. R97's blood pressure was high at 139/75. The narrative note of 1/15/18 written by RN-E identified a report was received from the hospital to inform the facilty R97 was admitted to the hospital with influenza B, dehydration, and a new second degree heart block.

R97 returned from the hospital on 1/19/18 with the diagnosis of a urinary tract infection (UTI) for which he was on antibiotic therapy. R97's discharge summary dated 1/19/18, identified R97 was dehydrated with hypoglycemia (low blood sugar) on admission. Resident was identified positive for influenza B, treated with Tamiflu (an antiviral treatment for influenza), and had stage four chronic kidney disease (advanced kidney damage with a severe decrease in the kidney function). The diagnosis of heart block was not addressed in the discharge summary. R97's discharge orders identified resident was to receive furosemide (a water pill) 40 mg by mouth daily and aspirin (as a blood thinner) 81 mg daily.

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A review of R97's care plan revised 2/14/18, initiated on 12/3/14 identified a cardiovascular impairment related to diagnoses including hypertension, mitral valve disease and tricuspid valve disease, a history of a myocardial infarction (heart attack), cerebral arrester occlusion/cerebrovascular disease (alteration in the circulatory systm/blood vessels) and history of a transient ischemic attacks (little strokes). The care plan directed the staff to administer medications as ordered. The care plan also directed the RN to asses changes in vital signs and update the physician or nurse practioner routinely and as needed. R97's care does not address heart block. The record did not identify the discrepancy or any clarification from the hospital report of a heart block, or the absence of this on R97's hospital discharge summary to ensure continuity of care.

R97 was seen by his physician on 1/25/18 for follow up of his hospitalization at which time the diagnoses of somnolence and lethargy was identified on the assessment. R97's care plan does not identify this or provide interventions as to cares to be provided.

A review of R97's routine heart rate as noted on the vitals report from 1/19/18 to 3/18/18 identified R97's heart rate ranged from 61 to 79 beats per minute with the exception of a decreased heart rate note on 3/12/18 at 8:32 p.m. by RN-F. A heart rate of 50 beats per minute was documented on 3/15/18 at 2:54 p.m. by licensed practical nurse (LPN)-C.

On 3/11/18, the electronic resident progress written by trained medical assistant B at 3:52 p.m. indicated R97 was not feeling well and VS were

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obtained with heart rate at 55, respirations at 18, no fever noted, and a blood pressure 144/66. R97 had a low blood sugar of 65 and a glass of orange juice was given. No subsequent heart rate monitored or documental on that date.

On 3/12/18, an electronic narrative note of 8:33 a.m. by RN-F indicated R97's family member did not think resident felt well and RN-F indicated resident has been sleepy today. RN-F "obtained vitals as follows: T[temperature]-98.1, R[respirations]-24, BP[blood pressure]-153/71, O2[oxygen saturation]-95% on RA [room air]room, P [pulse]-45, Blood sugar-245. Encouraged fluids. Attempted a second set of vitals an hour later and O2 was at 94% on RA and pulse 45. Resident began swearing and yelling and stated he wanted to be left alone to sleep." The medical record lacked further documentation of any additional vital signs for that date.

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.

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F 684	Continued From page 20 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 an apical pulse should be checked to assure accurate readings. RN-E also stated it would be her expectation that she be notified of 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 follow up log for the nurse practitioner dependent on symptoms presenting and with (R97s) history of lethargy and somnolence. During interview on 3/22/18, at 3:25 p.m. the director of nursing stated she would expect prior to notification of the primary care provider the staff would implement monitoring per nursing orders in order to provide accurate information to the primary care provider. The DON stated the physician or primary care provider should be contacted if the resident were symptomatic. A facility policy titled Change in Condition Policy and Procedure updated 12/17, identified it was the policy of Bethesda to consult with the resident's physician if there is a significant	F 684		

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F 684	Continued From page 21 change in the resident's physical, mental or psychosocial status. The policy indicates data should be gathered for a complete assessment, the DON/designee or nursing supervisor of condition and documentation should be completed with this information. The policy further states the follow up should continue until the resident stabilizes.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently implement interventions to prevent the reoccurrence of a pressure ulcer for 1 of 2 residents (R2) who had current pressure ulcers. Findings include: R2's undated Resident Face Sheet indicated R12 admitted to the facilty on 3/13/18. Diagnoses included dementia and type 2 diabetes. R2's	F 686	Corrective Action For Residents Affected By Deficient Practice: Resident #2's care plan and treatment record were updated with current interventions. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to ensure residents that have a pressure ulcer have a current care plan and treatment record.	4/27/18

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F 686	Continued From page 22 Nursing Admission Assessment dated 3/13/18, indicated R2 was admitted with a 6 centimeter (cm) by 5 cm moist area to the right heel. Report from the previous facility indicated it was a blister 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	F 686	Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: RNs were provided education on proper care planning and treatment records on April 10, 2018. Training and re-education was provided to all nursing staff beginning April 10, 2018 and will be completed by completion date. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will complete random audits of residents with pressure ulcers to ensure care plan and treatment record are current. 4 audits will be completed monthly X 4 months beginning May 1, 2018. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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did not have a provolone boot to his right foot.

On 3/21/18, at 9:53 a.m. R2 was seated in his wheelchair in his room. R2 had socks and slippers to both feet. R2 had a blue provolone boot sitting on his night stand. R2 stated he was not sure what the boot was for. At 10:55 a.m. R2, who was still seated in his wheelchair in his room had the blue provolone boot on his right foot.

During interview on 3/21/18, at 3:22 p.m. nursing assistant (NA)-C stated the provolone boot was put on when R2 was going to bed for the night. Further,there was no information on the resident care sheet directing when the boot was to be worn.

R2's undated Resident Care Sheet included interventions of no shoes and required an assist of two persons for transfers and assistance of one for personal cares.

On 3/22/18, at 6:55 a.m. R2 was seated in a recliner in the day room. His feet were elevated and he had the provolone boot on his right foot. At 8:22 a.m. R2 was seated in his wheelchair at the dining room table and only had socks and slippers to both feet. R2 did not have the provolone boot on. At 8:52 a.m. R2 was seated in a recliner in the day room, his feet were elevated and he had the provolone boot on his right foot.

During interview on 3/22/18, at 1:39 p.m. NA-D stated the provolone boot was placed on R2's right foot at night in bed or if he was in the recliner sleeping. At 1:40 p.m. licensed practical nurse (LPN)-B stated R2's pressure ulcer was heeled and he had some dry peeling skin and the nurses were monitoring it daily. Further the

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provolone boots were supposed to be on at all times.

At 1:43 p.m. registered nurse (RN)-D stated R2 had not been consistently wearing the provolone boot and noticed that the day before and just updated the resident care sheet to include the provolone boot to the right heel at all times the evening before.

At 1:47 p.m. R2's right heel was observed. The skin was intact and blanchable. There was a circled area about 5 cm's by 5 cm's of fresh pink heeling skin with some dry hard flaking skin at the out edge. RN-D stated she needed to assess for the continued need of the provolone boots at all times.

R2's Treatments Adminstration History 3/13/18-3/22/18 directed "Provolone Boot right foot at all times", with a start date of 3/14/18. The record had an area to sign off the boot was in place for day, evening, and nigh shifts. The record was signed off every shift as completed.

The facility's Bethesda Baseline Care Plan Policy dated 11/17, included a baseline care plan would be developed within 48 hours of admission and changes would be made as necessary. Further, direct care staff would be educated about care plan interventions.

The facility's Bethesda Pressure Ulcer/Wound Documentation Policy and Procedure revised 11/17, included a definition of a Stage 2 pressure ulcers as a 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. An

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F 686	Continued From page 25 evaluation and preventative measures should be documented in the progress notes and added to the residents plan of care and communicate interventions to the appropriate staff.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to conduct a comprehensive pain assessment for 1 of 1 resident (R111) in the sample who complained of ongoing pain and discomfort with movement. Findings include: R111's facesheet, undated, identified diagnosis of osteoarthritis, and a history of artificial hip and knee replacement surgery. R111's quarterly Minimum Data Set (MDS) of 1/26/18 identified R111 was cognitively intact, and needed moderate to excessive assistance of one for activities of daily living. R111 had occasional mild pain, was on scheduled and as needed pain medication regime. He also had physical and occupational therapy from 12/19/17 to 1/11/18. R111 was observed on 03/21/18 at 10:08 a.m. in his room sitting in the recliner and complained of left knee pain. He stated he fell awhile ago and	F 697	Corrective Action For Residents Affected By Deficient Practice: Resident #111 has had a pain assessment completed and is working with Physical Therapy in relation to his chronic knee pain. Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: A facility audit was completed to ensure all residents who indicated on their 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 To Ensure That Deficient Practice Will Not Recur: Nursing staff will be educated on reporting pain to RN. Training and re-education was provided to	4/27/18

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F 697	Continued From page 26 has had some knee pain since he fell and began rubbing his left knee. At 10:18 a.m. nursing assistant (NA)-F entered the room asking R111 if he wanted to go to an activity which he accepted. At 10:19 a.m. NA-F returned with an EZ stand, mechanical lift that assists residents with transferring. NA-F proceeded to place the sling around R111 and hooked the sling to the EZ stand and started lifting R11 up from his recliner to transfer him into his wheel chair. R111 was approximately standing at a 45 degree angle, and suddenly yelled out, for NA-F to stop lifting him up. NA-F stopped the transfer saying (R111) lets us know when we can not lift him up any higher because of his knee pain. He usually is not in a full standing position when he tells us to stop. NA-F transferred R111 in the EZ stand to his wheelchair. NA-F unhooked R111 from the mechanical lift and he immediately started to rub his left knee, and upper thigh saying it hurts right here. NA-F stated (R111) complaints of left knee pain when we transfer him and at times he will also complain of back pain. R111 reported he was on some medication for his pain but was unsure if this helped but knew he took a lot of medication. NA-F stated (R111) goes to nursing rehabilitation and does the bike, arm pedals, 2 pound leg lifts and some other exercises for strengthening. NA-F stated (R111) has been complaining of his left knee, leg pain for awhile and the nurses are aware of this. In an interview on 03/21/18 at 3:57 p.m. Licensed Practical Nurse (LPN)-D stated (R111) had a few falls in the past few months. He used to be independent but has becoming weaker and needing more staff help. He had gone to therapy but refused to participate in the program so he was discharged from therapy in January 2018.	F 697	all nursing staff beginning April 10, 2018 and will be completed by completion date. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: DON, ADON, or designee will complete random audits on residents who have a pain management program. Residents will be interviewed regarding their current satisfaction of their pain management program. 8 random audits will be completed monthly X 4 months beginning May 1, 2018. The audit will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 27	F 697		

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 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 modalities 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 back pain and blames this on his bed, he takes

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	245427	A. BUILDING ______ B. WING ______	03/22/2018

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F 697	Continued From page 28	F 697		

Naproxen daily and PRN Tylenol once in the look back period. Plan for addressing pain was identified as non-pharmacological interventions and prescribed medication with a pain intensity goal of one or less. The assessment did not identify R111 knee pain or any interventions to address his knee pain.

R111 care plan last revised on 2/5/18 identified a problem with pain related to knee and hip joint replacement. The goal of pain control was 1-2 on a 1/10 pain scale. Staff were directed to administer pain medication, encourage rest periods, observe signs of pain, remind him to inform staff if experiencing pain and use position change, massage, distraction, warm and cold packs.

Review of R111 physician orders, undated, identified two anti inflammatory medications of Naproxen 375 mg once a day, which was started on 10/20/17, and Tylenol 1000 mg twice a day, at 8:00 a.m. and 8:00 p.m. started on 2/5/18.

The facility used a numerical 1-10 pain scale system, to determine pain levels of 10 being the worst pain and 1 being least amount of pain. R111 identified the following pain scale on the Medication Administration Record:
12/17/17 to 1/16/18: rated pain 1-3 for 6 of 31 days and rated pain 4-7.5 for 13 out of 31 days.

1/17 to 2/16/18: rated pain 1-3; for 14 of 31 days, and rated pain as a 4-5; for 4 out of 31 days

2/17/18 to 3/22/18: rated pain 1-3 for 5 out of 33 days, and rated pain as a 4-6 for 13 out of 33 days, which identified an increase in pain levels than R111 had previously identified even though

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	245427	A. BUILDING ____ B. WING ____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 697	Continued From page 29 Tylenol 1,000 mg was added twice a day on 2/5/18. Review of the progress notes from 1/1/18 to 3/22/18 identified one note on 3/2/18 that R111 complained of pain in "left leg (thigh) area" this afternoon and evening and rated the pain 6-7 out of 10. Scheduled Tylenol 1,000 mg was given at 8:00 p.m. and was resting quietly in bed at 9:00 p.m. During interview on 3/22/18 at 12:00 p.m. physical therapist (PT)-A stated they had ultra sound equipment in their department. She had last seen R111 in January 2018 and did exercises for strengthening and pain, but R111 refused to do the exercise so he was discharged from therapy. She had not used ultra sound as a modality for R111, and thought this may work and was unaware R111 was having complaints of knee pain. She stated they could re-evaluate R111's pain level. On 03/22/18 01:55 p.m. LPN-F stated (R111) used Tylenol but had still rated his pain level 3-4 each day, and they could do something else to help with his pain. During interview on 03/22/18 3:31 p.m. RN-C stated she had not completed a comprehensive pain assessment for R111 pain, and was unaware he was having left knee and leg pain with movement. She stated she was aware R111 had complained of back pain and the facility had used different beds but he preferred the recliner which he used at home.	F 697		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2)	F 804		4/27/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 804 Continued From page 30

§483.60(d) Food and drink
Each resident receives and the facility provides-

§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;

§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.
This 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 and R156) whom complained the food was not warm to taste on the second floor north dining area.

Findings include:

During observation on 3/21/18 at 12:02 p.m. on the second floor north dining area dietary aide (DA)-A was in the kitchenette and had turned all five food warmers on high and was waiting for the food to be delivered. 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 served for the noon meal.

At 12:15 p.m. the food had not yet arrived, and residents were asking where the food was. DA-A called the kitchen and was told she was responsible to get the food from the main kitchen and left the area.

At 12:23 p.m. DA-A returned and placed the food

F 804

Corrective Action For Residents Affected By Deficient Practice: DA-A was provided re-education regarding palatable food temperatures and how to address improper food temperatures. Resident #6 and Resident #156 were interviewed regarding the palatability of their food and provided information about our plan to prevent reoccurrence.

Identification Of Other Residents Having the Potential To Be Affected By Deficient Practice: Meal Food Temperature Logs were reviewed for all neighborhoods for the dates of 03/21/2018-03/31/2018.

Food temperatures were discussed at the Resident Dining Committee meeting held on 04/10/2018.

Food temperatures will be brought up at the Resident Neighborhood Meetings scheduled in April.

Measures Or Systemic Changes Made To Ensure That Deficient Practice Will Not Recur: “Preparing and Cooking Hot

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F 804	Continued From page 31 in the five serving warmers to maintain the food temperature. DA-A obtained temperatures of the corn which read 164 degree Ferenheiht (F), barbeque chicken 153 degrees F; Salisbury steak 147 degrees F; pureed corn 161 degrees F, gravy 136 degrees F and mashed potatoes 157 degrees F. At 12:33 p.m. DA-A started to serve the residents their noon meal, left the covers off the serving warmers and food leaving the food open to air while serving residents. DA-A continues to serve the meal until 12:46 p.m. when she completed meal service. A test tray was requested at this time and temperature were obtained and tested for palatability by DA-A and surveyor. The barbeque chicken was 128 degree F and slightly warm to taste, potatoes and gravy was 131 degrees F and warm to taste, corn was 125 degree F and slightly warm to taste. The DA-A stated the food could be warmer especially the chicken, the potatoes and corn were ok to taste for temperature. At 12:50 p.m. residents were interviewed about the food, R6 stated the food was not warm at all, and R156 stated the corn was not hot, chicken and potatoes were just warm. Both residents stated the food could be much warmer and this had been a concern previously. Review of the dietary temperature sheets logs for the second floor North kitchenette from February 2018 to March 20, 2018 identified food temperatures ranged from 147 to 165 degrees F. The resident concerns were discussed with DA-A on 3/21/18 at 12:55 p.m. and indicated the kitchen was being currently being remodeled, but	F 804	Foods" and "Holding Hot and Cold Potentially Hazardous Food" policies were reviewed and updated. Training and re-education will be provided to all culinary staff starting April 17, 2018 regarding proper food temperatures, palatability and preferences of food temperatures and will be completed by completion date. How The Facility Will Monitor Performance To Make Sure That Solutions Are Sustained: Certified Dietary Manager or Dietician will conduct 8 resident interviews per month x 4 months on food temperature and palatability beginning May 1, 2018. Certified Dietary Manager or Dietician will monitor meal temperatures prior to meal being served 8 times per month x 4 months beginning May 1, 2018 in different neighborhoods throughout the facility. These audits will be presented to the facility Quality Assurance committee to verify that compliance has been attained.	

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F 804	Continued From page 32 they needed to work on making sure the food was served warmer. Review of the facility census sheet identified 21 residents resided on the 2nd floor north dining area who received food from the north kitchenette.	F 804		

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

F5427029

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, 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 OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(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.

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	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/20/2018**

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K 000	Continued From page 1	K 000		

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St Paul, MN 55101-5145, or

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

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

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

2. The actual, or proposed, completion date.

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

Building 01 of Bethesda Nursing Home Pleasant View is a one story building with a full basement that was constructed as type II (111) in 1979. In 1994 two gazebos of type II (111) construction were added to the original building at the common areas adjacent to the east and west resident wings. In 1999 a link was constructed between the memory care wings which was constructed as type II (111). In 2014 two additions were added off the south ends of the two North/South wings that was constructed as type V (111), one was a 6 bed addition and the other was a dining area, and one 36 bed single story with a partial basement of type V (111) was added on

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

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

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	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/20/2018**

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K 000	Continued From page 2 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:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure 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)	K 321		4/9/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/20/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 321	Continued From page 3 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 facility failed to maintain one hazardous storage room and one combustible storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for 20 of the 248 residents and an undetermined amount of staff and visitors. Findings include: 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.	K 321	Corrective Action For The Deficiency: Closure was installed on the identified door on 03/22/2018. Facility audit was completed on 04/09/2018 and revealed no other instances of this deficient practice. Completion Date: March 22, 2018 Name and Title Of Person Responsible For Correction And Monitoring To Prevent Recurrence: Ross Brandt, Facilities Director	

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

F5427029

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING ______	**03/20/2018**

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K 000	INITIAL COMMENTS 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. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(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.

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

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
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
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cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00792	A. BUILDING: ____ B. WING ____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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 attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 3/19/18, through 3/22/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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	2 000		

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facilty failed to ensure 3 of 8 newly hired staff (NA-M, DA-C, DA-D) had completed the required	2 302	Corrected	4/27/18

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2 302	Continued From page 3 Alzheimers and dementia care training program. This had the potential to affect all residents in the facilty. Findings include: Dietary Aide (DA)-C's personal file identified she was hired on 12/15/17. There was no indication that DA-C completed the facility mandatory training for Alzheimer and dementia care. DA-D's personal file identified she was hired on 1/11/18. There was no indication that DA-D completed the facility mandatory training for Alzheimer and dementia care. Nursing Assistant (NA)-M's personal file identified she was hired on 2/5/18. There was no indication that NA-M completed the facility mandatory training for Alzheimer and dementia care. During interview on 3/21/18 at 4:00 p.m., Human Resource (HR)-A stated the forth Tuesday of each month there is mandatory training for all new employees. Each of them get a Welcome to Team sheet, that informs them of date and time for this general orientation. During this general orientation they complete the staff training for Alzheimer and dementia care, which is mandatory for all employees. During interview on 3/22/18 at 11:30 p.m. HR-A stated, she was not aware these three employees had not attended the training. Currently there was no system in place to follow to ensure this orientation has been completed. She stated these employee do not work on the locked dementia unit, but they do have contact with residents throughout the facility who have Alzheimer and dementia. We need to change or	2 302		

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2 302	Continued From page 4 orientation process. SUGGESTED METHOD: The administrator or designee could develop/revise and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: F684 F697 Based on observation, interview and document review, the facility failed to comprehensively assess and develop interventions to promote	2 830	Corrected	4/27/18

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good posture and positioning for 2 of 8 residents (R96, R28) reviewed for wheelchair positioning. In addition the facility failed to ensure consistent clinical monitoring was completed for 1 of 1 resident (R97) whom had a low pulse rate and a history of cardiac problems.

Findings include:

R96's quarterly Minimum Data Set (MDS) dated 1/26/18, identified R96 had severe cognitive impairment, required supervision with locomotion on and off the unit, and used a wheelchair for mobility.

R96's care plan revised 11/2/17, identified R96 had an activities of daily living (ADL) impairment and ambulated in the hallway pushing a wheelchair. R96 was recorded as, "may agree to a push in [wheelchair] for longer distances." However, the care plan lacked any dictation regarding what type of wheelchair R96 used, nor information on how often R96 used her wheelchair for sitting or rest.

During observation on 3/22/18, at 8:25 a.m. R96 was seated in the dining room with her wheelchair with a bedside table placed in front of her. R96 had been served a breakfast meal which consisted of eggs and pancakes. R96 was centered on the seat of the wheelchair with several inches of spacing on each side of her hips, and the arm rest(s) of the chair extending upwards and nearly level with R96's shoulders. R96 had to lift her arms up and over the arm rest(s) of the wheelchair, resting her inner arm on the arm rest while picking up her pancakes to eat them using her hands. R96 stated she had no concerns about her wheelchair, however, added "[I] never sit in it long enough to notice."

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When interviewed on 3/22/18, at 8:40 a.m. nursing assistant (NA)-A stated R96 had the same wheelchair for the past several years and often used it to sit in during meals, in her room and during activities. NA-A observed R96 sitting in her wheelchair in the dining room and stated she looked "tiny in it," and the chair was "too big." NA-A stated she was not aware if occupational therapy (OT) or the nurse had ever reviewed R96's positioning in the chair before. Further, NA-A stated R96 had never complained about shoulder or arm pain to her before.

R96's medical record was reviewed and lacked any evidence R96 had ever been screened or reviewed by nursing or OT for her wheelchair use; despite using the same chair for several years and her having to lift her arms up and over the rests to eat.

During subsequent observation on 3/22/18, at 9:26 a.m. R96 remained seated in the same wheelchair, however, was now in the commons area with several other residents listening to an activity. R96's arms were down in her lap, however, she continued to have several inches on both side(s) of her body between her buttocks and chair sides.

When interviewed on 3/22/18, at 9:32 a.m. registered nurse (RN)-B stated R96 was independent with her mobility, however, sits in her wheelchair for most of the meals. RN-B observed R96 seated in the commons area in her wheelchair and stated R96 "needs a smaller wheelchair." RN-B stated R96 had never been referred to OT for her wheelchair positioning in the past, however, one should be completed to ensure R96 had good posture and was

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comfortable in her chair.

On 3/22/18, at 11:27 a.m. certified occupational therapy assistant (COTA)-A observed R96 eating the lunch meal in her wheelchair. When interviewed immediately following, COTA-A stated R96 voiced she was happy with her wheelchair, however, COTA-A expressed R96 had approximately four inches (4") of space on each side of her while seated in the wheelchair adding it should be 2", not 4" in size, for positioning. COTA-A stated she was going to notify the OT and obtain her input on R96's wheelchair as "maybe she could use a more narrow chair." Further, COTA-A explained their department had never been approached before about R96's wheelchair or positioning and if floor staff were seeing these things, "they're supposed to contact OT and get an assessment," to see if better options could be found or provided.

R28'S quarterly MDS dated 12/22/17 indicated R28 had moderate cognitive impairment, required total assistance with mobility, and used a wheelchair for mobility.

R28's Resident Face Sheet, undated, indicated R28 had chronic gout (inflammation of joints), difficulty in walking, dependence on wheelchair, and mononeuropathy (a nerve disorder which can cause increased pain or weakness).

R28's care plan initiated 9/13/16, identified resident had musculoskeletal (injuries and disorders that affect the human body's movement) impairment related to neuropathic pain and arthritis. The care plan also identified R28 required assistance with ADL's related to weakness and decreased mobility. The care plan directed the staff to provide total assistance with

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the use of her wheelchair.

During observation on 3/21/18, at 11:29 a.m. R28 was receiving passive range of motion (PROM) to her lower extremities from the restorative aide (RA)-A. R28 was wearing support hose and non-skid slippers. At this time R28 was seated in her wheelchair with her leg rests in place on both sides, with her calves resting on the leg rests. R28's toes touched the foot rest, however, the resident is unable to rest her foot on the full foot pedal.

During PROM by RA-A stated R28's leg rests and foot pedals have been positioned like this but it looked like the footrests should be adjusted by maintenance because just the toes are touching. RA-A stated R28 elevation of the leg rests would provide increased support to legs. While receiving PROM, R28 stated her legs and feet are "OK" for a while in unsupported position, but stated "they get tired".

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.

During interview on 3/21/18, at 3:25 p.m. with licensed practical nurse (LPN)-A stated the leg rests had been adjusted for R28. LPN-A stated the adjustment to the appropriate length was important for both comfort and support.

During observation on 3/21/18, at 3:31 p.m. R28 was observed to be seated in her wheelchair with

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her left foot resting supported on her left foot pedal. R28's right foot pedal had approximately 1 inch foam block secured to the pedal to improve position, however, her right foot was dangling off the foot pedal.

On 3/22/18, at 1:26 p.m. registered nurse (RN)-C stated R28's leg rests were adjusted and supportive foam was placed on the right foot pedal, however stated she continues to demonstrate improper positioning and an evaluation by occupational therapy was needed. RN-C stated R28's leg rests were too long and needed to be adjusted 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.

A facility policy, titled Positioning in Chair Policy and Procedure, revised 2/2017 identified it was the responsibility of the nursing staff to ensure residents are positioned properly. The policy also indicated the staff was to consult with occupational Therapy (OT) and physical therapy (PT) when necessary.

CLINICAL MONITORING
R97's quarterly MDS dated 1/26/18 identified resident had moderate cognitive an required extensive assistance of two to complete ADL's. R97's medical diagnoses included hypertension (high blood pressure), diabetes, dementia and depression.

R97's Resident Face Sheet undated additionally identified diagnoses of chronic kidney disease,

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hypotension (low blood pressure), cerebrovascular disease (conditions that affect blood supply to the brain), hypothyroidism (decreased thyroid functioning), rheumatic mitral valve disease and tricuspid deficiency (alteration of heart function), hypertensive chronic kidney disease, and cardiomegaly (an enlarged heart), and somnolence (sleepiness).

During observation on 3/22/18, at 7:14 a.m. R97 was laying on his bed, under a sheet, with his eyes closed, relaxed facial expression and easy respirations. The bed was in a low position with a mat at bedside. At 8:40 a.m. R97 remained in bed, eyes closed, facial expression relaxed, and respirations easy.

On 3/22/18, at 12:31 p.m. R97 was observed in bed resting at this time, however his eyes were open, watching television. His bed was in the low position and mat at bedside. Resident mumbled in response to greeting and continued watching television.

The narrative notes identified on 1/15/18, R97 had been minimally responsive and did not open his eyes to questions, though did shake his head yes or no. R97's oxygen saturation levels (O2 sats-level of oxygen in the blood) were noted to be low at 88% on room air (normal saturation level 93-96%) and oxygen was started through a nasal cannula (provides oxygen through tubing from an oxygen source). At that time R97 was afebrile (without fever) at 97.5 degrees Fahrenheit, respiration (breathing) rate of 20 breaths per minute and a heart rate of 72 beats per minute which were all within normal limits. R97's blood pressure was high at 139/75. The narrative note of 1/15/18 written by RN-E identified a report was received from the hospital

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to inform the facilty R97 was admitted to the hospital with influenza B, dehydration, and a new second degree heart block.

R97 returned from the hospital on 1/19/18 with the diagnosis of a urinary tract infection (UTI) for which he was on antibiotic therapy. R97's discharge summary dated 1/19/18, identified R97 was dehydrated with hypoglycemia (low blood sugar) on admission. Resident was identified positive for influenza B, treated with Tamiflu (an antiviral treatment for influenza), and had stage four chronic kidney disease (advanced kidney damage with a severe decrease in the kidney function). The diagnosis of heart block was not addressed in the discharge summary. R97's discharge orders identified resident was to receive furosemide (a water pill) 40 mg by mouth daily and aspirin (as a blood thinner) 81 mg daily.

A review of R97's care plan revised 2/14/18, initiated on 12/3/14 identified a cardiovascular impairment related to diagnoses including hypertension, mitral valve disease and tricuspid valve disease, a history of a myocardial infarction (heart attack), cerebral arrester occlusion/cerebrovascular disease (alteration in the circulatory systm/blood vessels) and history of a transient ischemic attacks (little strokes). The care plan directed the staff to administer medications as ordered. The care plan also directed the RN to asses changes in vital signs and update the physician or nurse practioner routinely and as needed. R97's care does not address heart block. The record did not identify the discrepancy or any clarification from the hospital report of a heart block, or the absence of this on R97's hospital discharge summary to ensure continuity of care.

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R97 was seen by his physician on 1/25/18 for follow up of his hospitalization at which time the diagnoses of somnolence and lethargy was identified on the assessment. R97's care plan does not identify this or provide interventions as to cares to be provided.

A review of R97's routine heart rate as noted on the vitals report from 1/19/18 to 3/18/18 identified R97's heart rate ranged from 61 to 79 beats per minute with the exception of a decreased heart rate note on 3/12/18 at 8:32 p.m. by RN-F. A heart rate of 50 beats per minute was documented on 3/15/18 at 2:54 p.m. by licensed practical nurse (LPN)-C.

On 3/11/18, the electronic resident progress written by trained medical assistant B at 3:52 p.m. indicated R97 was not feeling well and VS were obtained with heart rate at 55, respirations at 18, no fever noted, and a blood pressure 144/66. R97 had a low blood sugar of 65 and a glass of orange juice was given. No subsequent heart rate monitored or documental on that date.

On 3/12/18, an electronic narrative note of 8:33 a.m. by RN-F indicated R97's family member did not think resident felt well and RN-F indicated resident has been sleepy today. RN-F "obtained vitals as follows: T[temperature]-98.1, R[respirations]-24, BP[blood pressure]-153/71, O2[oxygen saturation]-95% on RA [room air]room, P [pulse]-45, Blood sugar-245. Encouraged fluids. Attempted a second set of vitals an hour later and O2 was at 94% on RA and pulse 45. Resident began swearing and yelling and stated he wanted to be left alone to sleep." The medical record lacked further documentation of any additional vital signs for that date.

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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 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 an apical pulse should be checked to assure accurate readings. RN-E also stated it would be her expectation that she be notified of 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

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follow up log for the nurse practitioner dependent on symptoms presenting and with (R97s) history of lethargy and somnolence.

During interview on 3/22/18, at 3:25 p.m. the director of nursing stated she would expect prior to notification of the primary care provider the staff would implement monitoring per nursing orders in order to provide accurate information to the primary care provider. The DON stated the physician or primary care provider should be contacted if the resident were symptomatic.

A facility policy titled Change in Condition Policy and Procedure updated 12/17, identified it was the policy of Bethesda to consult with the resident's physician if there is a significant change in the resident's physical, mental or psychosocial status. The policy indicates data should be gathered for a complete assessment, the DON/designee or nursing supervisor of condition and documentation should be completed with this information. The policy further states the follow up should continue until the resident stabilizes.

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review and/or develop policies and provide education for staff regarding pain assessments and change in vital signs. In addition the DON/ designee could audit residents for proper positioning, and inservice staff on identifying positioning concerns and how to correct them.The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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2 830	Continued From page 15 (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently implement interventions to prevent the reoccurrence of a pressure ulcer for 1 of 2 residents (R2) who had current pressure ulcers. Findings include: R2's undated Resident Face Sheet indicated R12 admitted to the facilty on 3/13/18. Diagnoses included dementia and type 2 diabetes. R2's Nursing Admission Assessment dated 3/13/18, indicated R2 was admitted with a 6 centimeter (cm) by 5 cm moist area to the right heel. Report	2 900	Corrected	4/27/18

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from the previous facility indicated it was a blister 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 wheelchair in his room. R2 had socks and

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slippers to both feet. R2 had a blue provolone boot sitting on his night stand. R2 stated he was not sure what the boot was for. At 10:55 a.m. R2, who was still seated in his wheelchair in his room had the blue provolone boot on his right foot.

During interview on 3/21/18, at 3:22 p.m. nursing assistant (NA)-C stated the provolone boot was put on when R2 was going to bed for the night. Further,there was no information on the resident care sheet directing when the boot was to be worn.

R2's undated Resident Care Sheet included interventions of no shoes and required an assist of two persons for transfers and assistance of one for personal cares.

On 3/22/18, at 6:55 a.m. R2 was seated in a recliner in the day room. His feet were elevated and he had the provolone boot on his right foot. At 8:22 a.m. R2 was seated in his wheelchair at the dining room table and only had socks and slippers to both feet. R2 did not have the provolone boot on. At 8:52 a.m. R2 was seated in a recliner in the day room, his feet were elevated and he had the provolone boot on his right foot.

During interview on 3/22/18, at 1:39 p.m. NA-D stated the provolone boot was placed on R2's right foot at night in bed or if he was in the recliner sleeping. At 1:40 p.m. licensed practical nurse (LPN)-B stated R2's pressure ulcer was heeled and he had some dry peeling skin and the nurses were monitoring it daily. Further the provolone boots were supposed to be on at all times.

At 1:43 p.m. registered nurse (RN)-D stated R2 had not been consistently wearing the provolone

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boot and noticed that the day before and just updated the resident care sheet to include the provolone boot to the right heel at all times the evening before.

At 1:47 p.m. R2's right heel was observed. The skin was intact and blanchable. There was a circled area about 5 cm's by 5 cm's of fresh pink heeling skin with some dry hard flaking skin at the out edge. RN-D stated she needed to assess for the continued need of the provolone boots at all times.

R2's Treatments Adminstration History 3/13/18-3/22/18 directed "Provolone Boot right foot at all times", with a start date of 3/14/18. The record had an area to sign off the boot was in place for day, evening, and nigh shifts. The record was signed off every shift as completed.

The facility's Bethesda Baseline Care Plan Policy dated 11/17, included a baseline care plan would be developed within 48 hours of admission and changes would be made as necessary. Further, direct care staff would be educated about care plan interventions.

The facility's Bethesda Pressure Ulcer/Wound Documentation Policy and Procedure revised 11/17, included a definition of a Stage 2 pressure ulcers as a 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. An evaluation and preventative measures should be documented in the progress notes and added to the residents plan of care and communicate interventions to the appropriate staff.

SUGGESTED METHOD OF CORRECTION:

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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 served for the noon meal.	2 960	Corrected	4/27/18

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At 12:15 p.m. the food had not yet arrived, and residents were asking where the food was. DA-A called the kitchen and was told she was responsible to get the food from the main kitchen for the 2nd floor and left the area.

At 12:23 p.m. DA-A returned and placed the food in the five serving warmers to maintain the food temperature. DA-A obtained temperatures of the corn which read 164 degree Ferenheiht (F), barbeque chicken 153 degrees F; Salisbury steak 147 degrees F; pureed corn 161 degrees F, gravy 136 degrees F and mashed potatoes 157 degrees F.

At 12:33 p.m. DA-A started to serve the residents their noon meal, left the covers off the serving warmers and food leaving the food open to air while serving residents. DA-A continues to serve the meal until 12:46 p.m. when she completed meal service. A test tray was requested at this time and temperature were obtained and tested for palatability by DA-A and surveyor. The barbeque chicken was 128 degree F and slightly warm to taste, potatoes and gravy was 131 degrees F and warm to taste, corn was 125 degree F and slightly warm to taste. The DA-A stated the food cold be warmer especially the chicken, and the potatoes and corn were ok to taste for temperature.

At 12:50 p.m. residents were interviewed about the food, R6 stated the food was not warm at all, and R156 stated the corn was not hot, chicken and potatoes were just warm. Both residents stated the food could be much warmer and this had been a concern before.

Review of the dietary temperature sheets logs for the second floor North kitchenette from February

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2 960	Continued From page 21 2018 to March 20, 2018 identified food temperatures ranged from 147 to 165 degrees F. The resident concerns were discussed with DA-A on 3/21/18 at 12:55 p.m. and indicated the kitchen was being currently being remodeled, but they needed to work on making sure the food was served warmer. Review of the facility census sheet identified 21 residents resided on the 2nd floor north area who received food from the north kitchenette. SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) and/or designee could identify and develop a more palatable dining experience and could provide appropriate staff education regarding food preparation, included temperatures. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students,	21426		4/27/18

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21426	Continued From page 22 residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) symptoms screen and second-step TST (tuberculin skin test) were completed for 2 of 6 employees (E3 and E6) whose personnel records were reviewed. In addition, the facility failed to document the resultant millimeters (mm) of induration of TSTs for 2 of 5 residents (R198, R87) reviewed for admission tuberculosis screening. Findings include: EMPLOYEE TB SCREENING: E3 had a hire date of 2/5/18. A facility document, Employee Mantoux Record, indicated E3 was given a first-step TST on 2/5/18, and subsequently read on 2/8/17. The record lacked evidence of a second TST. E6 had a hire date of 11/29/18. The Employee Mantoux Record indicated E6 was given a first step TST on 11/29/17, which was read on 12/1/17; and a second-step TST was administered on 12/11/17 and read on 12/13/17.	21426	Corrected	

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E6's record lacked evidence a TB symptoms was completed for E6.

When interviewed on 3/22/18 at 1:22 p.m., registered nurse (RN)-A stated she was not able to find evidence a second TST was completed for E3.

When interview on 3/22/18 at 2:47 p.m., the human resources director (HRD) stated E6 should have completed the TB symptoms screen, as it was facility policy to complete the screen prior to getting the TST. The HRD stated she was not able to find documentation E6 symptoms screen was completed.

A facility policy, Tuberculosis Screening Guidelines for Employees, revised 12/2017, indicated "All employees shall be screened for tuberculosis (TB) infection and disease using a two-step tuberculin skin test (TST) and a written assessment for any current symptoms of TB. The policy further indicated the TST will be read by a licensed nurse, and the reaction should be measured in millimeters of induration (palpable, raised, hardened area or swelling).

RESIDENT TB SCREENING:

R198 was admitted 2/2/18. R198's medication administration record (MAR) for February 2018 was reviewed. The MAR indicated the results of the first and second-step TSTs were read on 2/4/18 and 2/19/18, respectively, and were recorded as "neg" (negative). The results did not indicate the degree of induration in millimeters.

R87 was admitted on 4/4/17. R87's MAR for April 2017 was reviewed. The MAR indicated the

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21426	Continued From page 24 results of the first and second-step TSTs were read on 4/9/17 and 4/24/17, respectively, and were recorded as "neg" (negative). The results did not indicate the degree of induration in millimeters. When interviewed on 3/22/18 at 3:12 p.m., the director of nursing (DON) acknowledged the TST results were recorded as negative in the residents' MARs, and stated there should be consistency in charting the TST results. A facility policy, Tuberculosis Screening Guidelines-Residents, revised 11/2017, indicated "The facility will screen all residents for tuberculosis (TB) infection and disease. The policy also indicated all residents with a documented negative TST within the previous 3 months will receive a two-step TST upon admission. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) and/or designee could monitor to assure tuberculosis screening procedures for residents and staff were developed and implemented to ensure a tuberculosis-free living and working environment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests.	21870		4/27/18

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This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure residents who resided on the short-term unit were provided opportunity to be involved in Resident Council Activities which had the potential to affect 22 short term rehab residents of 212 residents who resided in the facility. The facility also had not promptly addressed resident council concerns regarding cold food temperatures and food palatability for 2 of 12 residents (R34, R168) who voiced concerns at the resident meetings. In addition, the facility had not address resident grievances of missing clothing for 1 of 1 residents (R218), who voiced concerns during a resident group meeting.

Corrected

Findings include:

RESIDENT COUNCIL MEETING:
A review of the past three resident council meeting minutes identified the meetings were held quarterly, with the last meeting occurring on 2/14/18.

The facility calendars and neighborhood meetings for the past four months were reviewed and identified the following:
December 2017:
Bethesda Club Suites: No scheduled resident council or neighborhood meeting identified.
1 South Recreation Calendar: Neighborhood meeting scheduled for 12/19/17.
2 South Recreation Calendar: Neighborhood meeting scheduled for 12/19/17.
1 North Recreation Calendar: Neighborhood meeting scheduled for 12/19/17.
2 North Recreation Calendar:Neighborhood

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meeting scheduled for 12/19/17.
MCN Recreation Calendar: No documented neighborhood meeting identified on the calendar.
E & F Activity Program Calendar: No documented neighborhood meeting identified on the calendar.
G & H Program Calendar: No documented neighborhood meeting identified on the calendar.
West Activity Program Calendar: No documented neighborhood meeting identified on the calendar.

January 2018:
Bethesda Club Suites: No scheduled resident council or neighborhood meeting identified.
1 South Recreation Calendar: No scheduled resident council or neighborhood meeting identified.
2 South Recreation Calendar: No scheduled resident council or neighborhood meeting identified.
1 North Recreation Calendar: No scheduled resident council or neighborhood meeting identified.
2 North Recreation Calendar: No scheduled resident council or neighborhood meeting identified.
MCN Recreation Calendar: No scheduled resident council or neighborhood meeting identified.
E & F Activity Program Calendar: No scheduled resident council or neighborhood meeting identified.
G & H Program Calendar: Neighborhood meeting scheduled for 1/29/18.
West Activity Program Calendar: No scheduled resident council or neighborhood meeting identified.

February 2018:
A facility residnets council meeting was scheduled for 2/14/18 and was identified on all

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	00792	A. BUILDING: ______ B. WING ______	03/22/2018

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BETHESDA	**901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201**

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unit calendars with the exception of the memory care unit and West D Hall meetings were held.

March 2018:
Bethesda Club Suites: No neighborhood meeting identified.
1 South Recreation Calendar: A neighborhood meeting was scheduled for 3/21/18.
2 South Recreation Calendar: A neighborhood meeting was scheduled for 3/21/18
1 North Recreation Calendar: A neighborhood meeting was scheduled for 3/21/18.
2 North Recreation Calendar: A neighborhood meeting was scheduled for 3/21/18.
West D Hall: No scheduled neighborhood meeting identified.
West A Hall: No scheduled resident council or neighborhood meeting identified.
MCN Recreation Calendar: No neighborhood meeting identified.
E & F Activity Program Calendar: No neighborhood meeting identified.
G & H Program Calendar: No neighborhood meeting identified.

On 3/21/18, at 10:26 a.m. a resident group meeting was held with surveyors from residents who lives on various floors of the facility. R168 stated the units have "neighbor hood meetings" on occasion, however, this had not occurred every month. R169 stated the "large resident council" was held every three months. R169 added the meetings are "smaller meetings and they come together" with neighborhoods (units). The meeting was attended by the following residents; R168, R218, R34, R59, R102, R121, R73, R20, R84,R170, R38, and R13

R218 stated the resident meetings were "news to me", adding she had resided in the Club Suites

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for rehabilitation for less than a month and knew nothing about any meetings. R34 added they had also resided in the therapy suites since admission before transferring to the long term care and "was never invited to meetings".

During interview on 3/22/18, at 1:04 p.m. the activity director (AD) stated the facility wide resident council meetings were completed on a quarterly basis but added neighborhood meetings are held more frequently. The neighborhood meeting occur on a monthly basis and address any concerns, requests for changes, and suggestions for activities. The concerns from these meetings are brought to the attention of the appropriate individual or department for follow through. If there was a formal concern or grievance form completed, these are routed through the appropriate parties. The neighborhood meetings do not have any documentation that addressed what was covered in these meetings, concerns or issues. The Club Suites rehabilitate unit residents do not meet on a routine basis because they are not here very long, and are focused on rehab. They are invited to participate in the facility wide quarterly resident council meetings.

During interview on 3/22/18, at 1:54 p.m. social worker (SW)-B stated the facility wide resident council meetings were held on a quarterly basis as modeled after the process from Heritage. In the interim, there are neighborhood meetings, however, the neighborhood meetings are not held in the Club Suites rehab unit. SW-B stated information gathered from neighborhood meetings may be shared at the quarterly resident meetings, however, there are no minutes to review to determine if there are similar concerns within the neighborhoods. SW-B stated the

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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 identified to work on the evening menus with resident representative input. A review of the

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meeting minutes of 11/18/17 idenfied menu planning for the upcoming holidays. It did not revisit old business or address status with concerns of the evening meals. The next meeting was scheduled for the beginning of January, however, there were no additional meeting minutes following the meeting of 11/18/17.

During the resident group meeting held with surveyors on 3/21/18, at 10:26 a.m. residents had additional concerns regarding the dining experience and food served. R34 expressed a main topic of concerns was "food preparations," stating some of the food had been served cold when it should have been hot. R34 stated this has been a long standing problem and was not related to recent remodeling of kitchen/dining areas. R34 provided an example of lasagna served with the top being hot, however the lower layers were "not hot at all". R168 offered an example of scrambled eggs being served cold. Additionally, other unidentified residents expressed concerns with pancakes and waffles being cold, and difficult to cut. They felt communication was the key word, adding often times they are told "we'll look into it and nothing gets done."

On 3/20/18 at 3:00 p.m. the dietary director stated the food committee meeting was not held in December 2017 because it was a busy holiday month. Additionally, the January meeting was not held due to a member passing away, two members hospitalized and illness in the facility. The next food committee meeting was scheduled for the first week in April, however, no date had been determined.

The Resident Council policy dated 12/17 identified following the resident council meeting

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the staff liaison will involve other departments as needed to resolve concerns/issues brought forth by the council.

MISSING CLOTHING

R218's admission Minimum Data Set (MDS) dated 3/3/18, indicated she was admitted to the facility on 3/2/18. The MDS also indicated R218 was cognitively intact.

During interview on 3/20/18, at 9:45 a.m., R218 told the surveyor she had numerous items of clothing missing since her admission to the facility. R218 stated she had one gray and one burgundy-colored sweatshirt she had just purchased, and was taken to wash "and never came back." R218 pointed to a sign in her room that read "Family will do my Laundry" and stated she also lost two capris, two pairs of jeans, two bras. R218 stated "I don't know what to do." R218 again stated she "told everybody" and she was also "sick and tired" of losing her clothes. During a subsequent interview on 3/21/18, at 11:15 a.m. R218 stated she has just attended a resident meeting to let them know about my clothes. R218 stated she also had a pair of PJ (pajamas) she wore one time, gave to the facility laundry, and "they were gone, too, brand new." R218 stated she reported the PJs missing "a while ago" and wanted to know what has happening with the missing items.

A facility document, Lost/Found/Damaged Resident Property Report, dated 3/6/18, indicated R218 lost one pair of Teal-green PJs, with "No Problem" in Spanish on them. The document indicated R218 reported the item missing to a staff member. In the section When and where last seen was written: "She said she wore them

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here one time and that was the last time she saw them." Under Places searched/by whom: (nursing assistant)-NA-C; resident room, laundry room. Under Interview Staff involved, was a "-". "No" was circled following "Was item found?" The pre-printed form also had additional lines/questions, all of which were blank, and included: Item found when/where; found by; Family contacted and by whom; Did they seem satisfied with resolution?; and Comments/Additional information.

When interviewed on 3/21/18 at 4:02 p.m., assistant director of nursing (ADON)-A stated we knew about R218's missing PJs, and there was a report on those filled out on the 6th (3/6/18) and R218 reported more items missing today. ADON-A stated when residents are admitted to the facility, there was no clothing inventory completed, but the facility marked resident clothing, "hopefully before" it gets done in laundry. ADON-A stated all resident, personal items on this unit, (the short-term stay) was laundered in house, on the unit. ADON-A also stated they were still looking for R218's PJs, as well the other items she had lost.

When interviewed on 3/22/18, at 12:53 p.m. social worker (SW)-A stated R218's PJ were missing on the (March) sixth, and added that R218 came to me "yesterday" to express she was missing more items. SW-A stated at R218's care conference, which was on (March)13th R218 and her family were told we were still actively looking for the PJs. SW-A stated the missing PJs "was still open" and she would need to have a conversation with R218 and the family and "try to get a resolution."

When interviewed on 3/22/18 at 3:08 p.m. the

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facility administrator stated the facility was looking for R218's missing items, and stated she felt this was not a "grievance" because of ongoing efforts to find them. The administrator stated missing resident clothing had been a facility quality improvement focus, and the facility evaluated and made changes to its process to reduce and eliminate missing clothing. The administrator acknowledged R218's PJs were missing since the 6th, and also understood why this was unresolved for R218. The administrator stated it was the facility policy to resolve grievances promptly and also it would be nice to see R218's concern come to a resolution, and would follow up to make sure the clothing issues were addressed for R218.

Although R218 had reported her PJs missing on 3/6/18, and still lost for sixteen days, the case was still unresolved for R218, who expressed frustration during the survey, and had reported additional missing clothing items.

A facility document, Our Grievance Procedure, undated, indicated Residents or resident representative have a right to file a grievance orally, in writing,and/or anonymously if desired. The document indicated it is the facility intent to meet resident and family needs and desire to the fullest extent possible. The document also indicted, "Within a reasonable timeframe of receiving the concern not to exceed 10 business days, a facility representative will meet with all parties involved in he matter, seek resolution to the concern, and respond tot he individual expressing the concern, in writing, if requested.

SUGGESTED METHOD OF CORRECTION:
The administrator or designee could review and revise facility systems, to ensure voiced concerns

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