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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TSZ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245434**
2.STATE VENDOR OR MEDICAID NO.
(L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

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 **05/08/2012** (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 IMR	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 **83** (L18)

13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	83			
(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):
Please see attached.

17. SURVEYOR SIGNATURE Date :
Christy Johnson, Unit Supervisor 05/10/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Nicole Steege, Program Specialist 05/10/2012 (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
Posted 5/11/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/16/2012
(L33)

DETERMINATION APPROVAL

A standard survey was completed at this facility on March 1, 2012. Deficiencies were found, the most serious were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). The facility was given an opportunity to correct before remedies were imposed.

On March 29, 2012 an abbreviated standard survey was conducted and deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Since the facility was not found in substantial compliance at the time of the survey, we recommended the following to the CMS RO:

- Mandatory DOPNA, effective June 1, 2012

On April 5, 2012, a LSC Post Certification Revisit (PCR) was conducted and on April 16, 2012, and May 8, 2012, health PCR's were conducted. The facility was found in substantial compliance as of May 8, 2012. We are therefore recommending the following to CMS:

- Mandatory DOPNA, effective June 1, 2012 be rescinded

Since DOPNA did not go into effect, the facility is also not subject to NATCEP loss.

See attached CMS-2567Bs for the results of the April 5, 2012, April 16, 2012, and May 8, 2012 revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5434

May 10, 2012

Ms. Carol Kvidt, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

Dear Ms. Kvidt:

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 May 8, 2012 the above facility is recommended for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 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,

Nicole Steege

Nicole Steege, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone #: (651) 201-4124 Fax #: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

May 10, 2012

Ms. Carol Kvidt, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

RE: Project Number S5434021 & H5434011

Dear Ms. Kvidt:

On March 15, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 29, 2012, the Minnesota Department of Health, Office of Health Facility Complaints completed an abbreviated standard survey 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 to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), whereby corrections were required. Due to continued noncompliance, we informed you in our letter dated April 13, 2012 that the following enforcement remedy was being imposed:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 1, 2012. (42 CFR 488.417 (b))

We also informed you on April 13, 2012 that in accordance with Federal law, as specified in the Act at Sections 1819(f)(2)(B), your facility is prohibited from conducting a Nurse Assistant Training/ Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 1, 2012.

On April 5, 2012 the Department of Public Safety, on April 16, 2012 (by review of the Plan of Correction) the Licensing and Certification Program, and on May 8, 2012 the Office of Health Facility Complaints completed Post Certification Revisits. We have determined, based on our visits, that your facility has corrected the deficiencies issued pursuant to our standard survey completed on March 1, 2012, and the abbreviated standard survey, completed March 29, 2012, as of May 8, 2012.

As a result of the revisit findings, the Department is recommending the following enforcement action:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 1, 2012 be rescinded as of May 8, 2012. (42 CFR 488.417 (b))

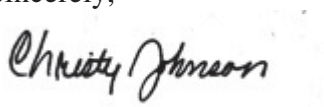
The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 9062

April 13, 2012

Ms. Carol Kvidt, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

RE: Project Number S5434021 & H5434011

Dear Ms. Kvidt:

On March 15, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 29, 2012, the Minnesota Department of Health, Office of Health Facility Complaints completed an abbreviated standard survey to determine if your facility was in complinace with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicatid programs. This survey found the most serious deficiencies to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached Statement of Deficiencies (CMS-2567), whereby corrections are required.

In addition, sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the Department is recommended the following remedy for imposition to the CMS Region V Office:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 1, 2012. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 1, 2012. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 1, 2012. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Bethany Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective June 1, 2012. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) from this visit is enclosed.

DEPARTMENT CONTACT

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

Kris Lohrke, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, Minnesota 55164-0970

Telephone: (651) 201-4215 Fax: (651) 281-9796

General Information: (651) 201-4201 1-800-369-7994

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 1, 2012 (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 1, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

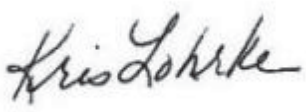
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,



Kris Lohrke, Assistant Director
Office of Health Facility Complaints
Division of Compliance Monitoring
Telephone: (651) 201-4215 Fax: (651) 281-9796

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245434	A. Building B. Wing	4/16/2012

Name of Facility	Street Address, City, State, Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/09/2012**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **04/10/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **03/26/2012**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/10/2012**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/26/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/10/2012**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/26/2012**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/03/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By** CJ/NCS	**Date:** 5/10/12	**Signature of Surveyor:** 12828	**Date:** 4/16/12
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/1/2012	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245434	A. Building B. Wing 01 - NURSING HOME	4/5/2012

Name of Facility	Street Address, City, State, Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	03/02/2012	ID Prefix Reg. # NFPA 101 LSC K0130	03/02/2012	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/NCS	**Date:** 5/10/12	**Signature of Surveyor:** 27200	**Date:** 4/5/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 3/1/2012		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245434	A. Building B. Wing 02 - SUB ACUTE	4/5/2012

Name of Facility	Street Address, City, State, Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 03/02/2012	ID Prefix Reg. # NFPA 101 LSC K0130	Correction Completed 03/02/2012	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/NCS	Date: 5/10/12	Signature of Surveyor: 27200	Date: 4/5/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/1/2012		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: TSZ9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245434**
2.STATE VENDOR OR MEDICAID NO.
(L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

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1. Initial 2. Recertification
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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 **03/01/2012** (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
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03 SNF/NF/Distinct	07 X-Ray	11 IMR	15 ASC	
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FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **83** (L18)

13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	83			
(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):

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

17. SURVEYOR SIGNATURE — Date :
Jonathan T. Hill, HFE NE II 04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Colleen B. Leach, Program Specialist 04/13/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
Posted 4/16/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 8898

March 15, 2012

Ms. Carol Kvidt, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

RE: Project Number S5434021

Dear Ms. Kvidt:

On March 1, 2012, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Christy Johnson
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933

Telephone: (218) 308-2114

Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 10, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 1, 2012 (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 1, 2012 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

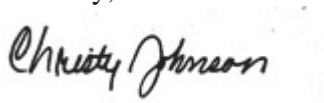
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure

cc: Licensing and Certification File 5434s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	03/01/2012

RECEIVED
APR 02 2012
Minnesota Department of Health
Regulation

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE 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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure the resident environment, including the doors and floors, was kept in good repair for 8 of 40 residents (R23, R92, R32, R21, R99, R42, R191 & R56) in the sample. Findings include: An environmental tour was conducted on 3/1/12, at 9:00 a.m. with the coordinator of maintenance (CM), the coordinator of housekeeping (CH) and the director of finance and operations (DFO).	F 253	**F253** It is the policy of Bethany Community to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. A. Items identified needing repair during survey have been completed. B. A walkthrough has been conducted of all rooms. Work orders have been issued for any repairs needed. C. Quarterly maintenance walkthrough has been developed. Education to all staff regarding expectation to report to maintenance anything that is not in good repair. D. Results from monthly audits will be reported to CQI team quarterly. Maintenance Coordinator is responsible. **April 9, 2012**	4/9/12

4/2/12 cf

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

Carol Knott — Executive Director — 3/29/12

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
	245434	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 253	Continued From page 1 The following was observed and verified by all staff present during the tour: On the floor next to R23's bed were four non skid strips measuring approximately two to three feet long and two inches wide. One strip was rolled up approximately three inches and another was rolled up approximately one inch. R92's bathroom door was scuffed at the bottom. The plastic door protector on the bottom of the bathroom door was secured at the bottom inner edge with gray tape and the door jam was scuffed. R32 had five of the non skid strips on the floor in the bathroom with one peeling up approximately an inch. The bathroom door in R21's room was scuffed with rough edges on the left corner. The plastic door protector at the bottom of the bathroom door was peeling up and away from the door. The edge was sharp and at ankle level. R99 had four non skid strips on the floor in front of the toilet. The edges of the strips were peeling up. R42's bathroom door on the right corner was heavily scuffed with rough edges on the wood. The plastic door protector was peeling up and away from the door. The edge was sharp and at ankle height. The door frame to R42's bathroom was heavily scuffed and scraped on the left side of the frame. The floor at R42's bedside had black scuff marks in the area of the non skid strips. R191's (admitted 2/21/12) bathroom door was scuffed at the bottom and the plastic door protector was lifting away from the door at the inner lower edge.	F 253		

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F 253	Continued From page 2 R56's bathroom floor appeared dirty and dull and had black scuff marks in the center of the floor. The walls next to the sink and the toilet were scuffed and dirty. On 3/1/12, at 9:05 a.m. the CM indicated the facility was in the process of developing a program for doing monthly maintenance rounds. The CM also indicated at currently the rooms were cleaned and repaired after a resident left the facility. For any other areas of concern, the staff was expected to fill out a work order slip. On 3/1/12, at 9:10 a.m. the CH indicated she would expect her staff to report scuffs and areas needing repair. The CH indicated the housekeeping staff had check lists each day. The check lists included each room in their assigned section. If an area was not included in the check list the staff were instructed to write a note on the check list. The check lists were then turned into the CH at the end of each day and the CH then puts in a request to maintenance if needed. All rooms were done daily. On 3/1/12, at 10:20 a.m. the director of nursing indicated the work order for maintenance repairs was on the computer at each desk. All staff including nursing assistants and housekeepers had been trained on how to use the request form to notify maintenance of any repairs needed. On 3/1/12, at 10:30 a.m. nursing assistant (NA)-D indicated she had been trained and was aware of how to use the computer system to contact maintenance for repairs. The CH provided a sheet the facility used to	F 253		

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F 253	Continued From page 3 direct them in housekeeping and facility maintenance. The sheet consisted of the state and federal guidelines. Policies regarding routine facility maintenance were requested, but none were provided.	F 253	F272 It is the policy of Bethany Community that the immediate needs of a resident are addressed at admission. A comprehensive assessment is completed for each resident in accordance with state and federal law and professional standard of practice. A. Because resident R126 discharged on 12-24-11, we were unable to complete a comprehensive skin assessment; pressure area was healed by 11-14-11. B. We have audited all residing residents that were admitted within the last 3 months, to assure a comprehensive skin assessment has been completed. C. Nurse managers have been re-educated re: IDT Assessment. Licensed staff were re-educated on the Assessment IDT policy and procedure including time lines for completion of assessments. A laminated copy of the assessment check list has been placed in the front of each assessment book for a guideline for staff reference. D. Will audit new admissions for completion of comprehensive skin assessments x4 weeks to assure a comprehensive skin assessment has been completed fully. Further audits will be completed if indicated. Audits will be conducted and results reported to the CQI team.	4/10/12
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272		

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 272	Continued From page 4 Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to complete a comprehensive assessment that included an assessment of the skin's tolerance to pressure in order to determine an individualized repositioning schedule for 1 of 3 residents (R126) with pressure ulcers. Findings include: R126 had diagnoses including acute renal failure, history of colon cancer, history of gastrostomy tube placement and history of stroke. R126 had been admitted to the facility on 10/27/11, and was discharged on 12/24/11. The Resident Admission assessment dated 10/27/11, identified R126 had multiple scabs on his body upon admission including scabs on his left heel. The initial Minimum Data Set dated 11/3/11, identified R126 with cognitive impairments and as requiring extensive assistance with all activities of daily living. In addition, R126 was identified with a Stage one (redness) pressure ulcer on his right hip. The Activities of Daily Living Care Area Assessment (CAA) dated 11/9/11, revealed R126 had a red area on his right hip and was receiving a foam dressing treatment (Allevyn) to the area.	F 272	Clinical Director is responsible. Completion date 4-10-2012	

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F 272	Continued From page 5 The CAA did not identify any other area of redness or open skin. The Braden Score (tool for predicting pressure ulcer risk) dated 10/27/11, identified R126 as being at risk for the development of pressure ulcers. The Skin Assessment dated 11/9/11, identified the area on R126's right hip and directed the staff to reposition the resident every two hours. However, the skin assessment was not comprehensive and did not identify how the repositioning schedule was determined. Information related to the skin's ability to tolerate pressure for R126 was lacking. The policy Skin Assessment and Care dated May 2011, indicated that within 14 days after admission, a comprehensive skin assessment would be completed that included an evaluation of the "skin integrity and tissue tolerance (ability of the skin to tolerate pressure). At 3:00 p.m. on 3/1/12, the director of nursing verified the facility had not completed a comprehensive skin assessment according to the facility policy.	F 272		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess	F 276		

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 276	Continued From page 6 bladder function following increased urinary incontinence for 1 of 3 residents (R107) in the sample reviewed for urinary incontinence. Findings include: R107's diagnoses included dementia, depression, hypertension, muscle weakness and lack of coordination. The admission Minimum Data Set, dated 10/31/11, indicated R107 was occasionally incontinent of urine (less then 7 episodes of incontinence), and required extensive assistance of 1 staff to walk in room and to use the toilet. The Care Area Assessment (CAA) dated 11/1/11, indicated R107's need for assistance with activities of daily living (ADLs) caused an increase in risk for urinary incontinence, and nursing was to assist with toileting as needed. The comprehensive bowel and bladder assessment dated 10/27/11, indicated R107 was able to recognize the appropriate time/place to urinate, had problems with mobility, had no apparent voiding pattern, and had a diagnosis of functional incontinence (incontinence due to cognitive or physical impairment, and/or environmental barriers). The analysis indicated R107 had some urinary dribbling, but generally voided on the toilet and remained dry with only occasional bladder incontinence. The quarterly MDS, dated 1/25/12, indicated R107 was cognitively intact and frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least 1 episode of continent voiding), and required extensive assistance of 1 staff to walk in room and to use the toilet. The	F 276	F276 It is the policy of Bethany Community that assessments are reviewed and updated as needed e.g. hospitalization, acute illness, change in status and at least quarterly. A quarterly review of assessments at a minimum contains a summary statement of the resident's functioning in the area being assessed since the last review. A. A new comprehensive bladder assessment was completed for Resident R107 with new interventions implemented. B. An audit was completed to identify any residents with a decline in urinary functioning in the past 3 months. New comprehensive assessments were completed for any resident in this finding. C. Nurse managers were re-educated on IDT Assessment.Education provided to Nurse Managers on accuracy of quarterly assessments, and documenting a summary statement of the resident's functioning since the last review. If changes are noted to assess further to find the reason for the change and document why, or complete a comprehensive assessment if needed. D. Audits will be completed x 3 months on quarterly assessment to assure accuracy of assessment. Audits will be conducted and	3/26/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(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 276	Continued From page 7 bowel and bladder assessment dated 1/25/12, indicated incontinence of bladder was frequent, had increased from the previous assessment, and the increased incontinence was due to a toilet that filled high with water (wetting the back of R107's legs), and increased incontinence at night. The assessment lacked R107's voiding patterns. On 2/29/12, at 3:03 p.m. the registered nurse (RN) clinical manager-B (CM-B) was interviewed and stated urinary incontinence data was entered from the facility care tracker system with data entered by the nursing assistants. CM-B stated if there was a decline in a resident's urinary incontinence, they would do a root cause analysis of why they are more incontinent. CM-B added they then adjust the resident's toileting time and schedule. On 3/1/12, at 9:45 p.m., CM-B stated they did not track R107's voiding patterns when they identified the decline, but added they should have. On 3/1/12, at 8:26 a.m., RN-C was interviewed and verified she had completed the quarterly MDS, and the MDS was accurate. On 3/1/12, at 8:34 a.m., RN-D was interviewed and stated the quarterly assessment for urinary incontinence did not include tracking a resident's voiding patterns. RN-D stated the facility did not document the time of day R107 toileted, or if R107 was continent or incontinent. RN information was documented at the end of the shift on the number of incontinent episodes R107 had that shift. RN-D stated she had not reassessed R107's incontinence.	F 276	results reported to the CQI team quarterly. Clinical Director is responsible. Completed 3-26-12	

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	245434	A. BUILDING _____ B. WING _____	03/01/2012

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F 276	Continued From page 8 On 3/1/12, at 9:51 a.m., RN-B was interviewed and verified she had completed the MDS in October, and the MDS was accurate. The facility was unable to provide a policy and procedure on urinary incontinence or toileting programs.	F 276	F279 Bethany Community policy states: The care planning process begins during pre-admission/intake and continues on a regular and periodic basis throughout the resident/patient stay. The resident and/or their representative, along with the entire care team are involved in the care planning process. Care is planned to help attain or maintain the resident's/patient's highest practicable physical, mental and psychosocial well being. A. Because R126 has been discharged, we were unable to complete a comprehensive plan of care. B. Chart audits on residing residents in short stay that have been in the facility longer than 21 days were completed to assure there is a complete comprehensive plan of care in place. C. Re-education of Care Planning IDT was completed with the Nurse Managers. Staff education has been done on the Care Planning IDT policy for all licensed staff. The care plan template has been moved from the resident chart to the daily charting book. The charting guidelines were updated to include review and update the plan of care. The plan of care will be reviewed by each nurse with daily charting and updated to reflect the resident's current status. Items not on the template will also be included on	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that addressed gastrostomy site treatments,	F 279		2/10/12

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F 279	Continued From page 9 colostomy cares, the use of antipsychotic medication, and the resident's diet and eating ability for 1 of 1 resident (R126) who required a comprehensive care plan to include these areas. Findings include: R126 had diagnoses including acute renal failure, history of colon cancer, anxiety, history of gastrostomy tube placement and history of stroke. R126 had been admitted to the facility on 10/27/11, and was discharged on 12/24/11. The initial Minimum Data Set dated 11/3/11, identified R126 with cognitive impairments, as requiring extensive assistance with all activities of daily living, and use of an antipsychotic medication daily. The Behavioral Symptoms Care Area Assessment dated 11/9/11, identified R126 received an antipsychotic medication related to agitation while at dialysis. Review of the Short Term Care Plan check sheet initiated on 10/28/11, identified minimal cares for R126. The clinical record identified several areas which had not been added to the care plan. The following items were identified: -A physician progress note dated 11/10/11 identified R126's gastrostomy site as being red and swollen with a small amount of drainage. The physician had ordered a treatment for the gastrostomy site. The short term care plan indicated R126 had a gastrostomy tube but did not include any sort of treatments for the area. -A nurse's note dated 10/31/11, revealed R126 had a colostomy bag which was to be changed	F 279	the plan of care, IE dialysis, and a temporary plan of care may be used for problems expected to resolve within a few weeks. D. Audits will be done on all new admissions that remain in the facility longer than 21 days, x8 weeks to assure compliance for completion of a comprehensive plan of care. Further audits will be completed if indicated. Audits will be reviewed with the CQI team quarterly. Clinical Director is responsible. Complete by 4-10-12	

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F 279	Continued From page 10 twice a week and as needed if leaking. The short term care plan indicated R126 had a colostomy, but did not include interventions related to the care of the colostomy. -The physicians orders dated 10/27/11, included an order for Zyprexa 2.5 mg (antipsychotic medication) to be given as needed at bedtime for agitation. The short term care plan did not identify any problems with agitation and did not identify R126 was receiving any antipsychotic medication. In addition, non-pharmacological interventions which could be attempted prior to the use of the medication had not been identified. -The short term plan of care identified R126 as unable to tolerate anything by mouth. The nurses note dated 11/17/11, (21 days from admission) indicated R126 had a swallowing study completed and had been advanced to receive an oral diet. The policy Care Planning IDT (interdisciplinary team) dated May 2011, directed staff to complete a comprehensive care plan within 7 days after a comprehensive assessment, but no later than 21 days after admission. At 1:30 p.m. on 3/1/12, registered nurse (RN)-E stated R126 had resided on the short term acute stay unit in the facility. RN-E added the facility did not complete comprehensive care plans for the residents on the short term unit until they had been at the facility for ninety days. She stated they had never completed comprehensive care plans for residents in the short term stay. She verified R126 had been at the facility for 59 days and the facility had not completed a comprehensive care plan for the resident. She	F 279		

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F 279	Continued From page 11 verified the treatments for the gastrostomy and colostomy sites were not on the plan of care. She also verified the short term care plan did not address the diet orders or the use of an antipsychotic medication. At 3:00 p.m. on 3/1/12, the director of nurses verified the facility had not been completing comprehensive care plans for residents who were in the facility greater than 21 days.	F 279	**F309** It is the policy of Bethany Community to assure that all supportive/comfort measures are taken when a resident is at an end stage disease process. A. To ensure coordination of hospice services for resident R23 a meeting was held with RN's from Hospice and Clinical Director to review the comfort care policy and F309. B. An audit of current residents on hospice was completed. C. Hospice of Douglas County will provide Bethany Community with a schedule of days that the support staff will visit Bethany. Hospice will provide an aide assignment sheet that will indicate specific areas of care the aide will provide. The aide assignment sheet will be in each resident's chart and in the care plan book for staff reference. Hospice will continue to communicate with the Nurse Manager and the station nurse at each visit to make them aware of how the visit went and any change made to the residents plan of care. Hospice will initiate changes, along with the nurse or nurse manager, to the plan of care as needed. Education of Comfort Care policy and F309 was completed with the Nurse Managers. Per Hospice of Douglas County contract, pages 2 and 3, Hospice responsibilities will	3/26/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure coordination of hospice services to identify the services to be provided by the hospice aide and the time frame of those services for 1 of 1 resident (R23) in the sample reviewed that received hospice services. Findings include: R23's diagnoses included failure to thrive, hypertension, atrial fibrillation, anemia and late effects of cerebrovascular disease. The significant change Minimum Data Set (MDS) dated 2/2/12, indicated R23 required extensive	F 309		

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F 309	Continued From page 12 assist of 1 staff for dressing, personal hygiene, toileting and eating, and was totally dependent on 1 staff for bathing. On 1/23/12, R23 began hospice services for the terminal diagnosis of failure to thrive. On 1/23/12, the hospice registered nurse (RN) met with R23 and family. In a report dated 1/25/12, the hospice RN indicated the need for hospice aide services. The report also identified the hospice aide cares would be coordinated with the facility, and the hospice aide would see R23 once a week for personal cares. The hospice plan of care dated 1/23/12, indicated hospice aide once a week to help with personal cares, but lacked specific cares that would be provided. The facility plan of care dated 1/27/12, indicated hospice aide once a week, but lacked what cares the hospice aide would provide. On 2/29/12, at 9:28 a.m., the registered nurse clinical manager (CM-B) was interviewed and stated the hospice provider was supposed to fax the hospice aide's schedule and what cares would be provided, but they had not done this yet. CM-B was unsure of the date or time of the hospice aide's next visit, or what personal cares were to be completed with the weekly visit. CM-B stated the hospice aide does not do personal cares for R23, so dressing, personal hygiene, toileting and eating are completed by facility staff. CM-B stated the hospice aide will soak and message R23's feet, and apply lotion to her legs. CM-B verified the hospice aide assignment sheet was not in the facility chart, and the plans of care of the hospice provider and the facility did not identify what cares the hospice aide would	F 309	be attached to the comfort care policy. Copies of Hospice of Douglas County responsibilities were given to the Nurse Managers for reference. Staff education has been provided to all licensed staff as to where this information can be referenced. D. Will audit the next 5 admissions to hospice services to assure a schedule of visits an aide assignment sheet and the care plan is current in each chart and aide assignment sheet is in care plan book. Audit results will be reported to the CQI team quarterly. Clinical Director is responsible. Completed 3-26-12	

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F 309	Continued From page 13 provide. On 3/1/12, at 2:18 p.m., the RN hospice coordinator (RN-F) was interviewed by telephone, and stated their protocol was to fax the hospice aide's schedule to the facility, along with the hospice aide assignment sheet. The facility was unable to provide a policy and procedure on hospice services.	F 309	**F314:** It is the policy of Bethany Community for a registered nurse to complete a new comprehensive skin assessment when there is a development of a new pressure ulcer. The assessment must include a review of the resident's tissue tolerance to pressure (ability of the skin and its supporting structures to endure the effects of pressure without adverse effects).	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure necessary treatment interventions were implemented including an appropriate repositioning schedule following the development of a pressure ulcer for 1 of 3 residents (R126) who had pressure ulcers. Findings include: R126 had diagnoses including acute renal failure, history of colon cancer, history of gastrostomy tube placement and history of stroke. R126 had	F 314	A. Because R 126 discharged from the facility on 12-24-11, we were not able to complete a comprehensive skin assessment; pressure area was healed by 11-14-11. B. An audit was completed on all residents currently residing at Bethany, who have or had pressure ulcers in the past 6 months to assure a comprehensive skin assessment has been completed. C. A wound guideline was developed; this will be laminated and kept with the MAR for quick reference to staff, providing instructions and protocol to follow in the event of a new pressure ulcer. Review/education of Skin Assessment and care was completed with the Nurse Managers. Staff education has been provided to all licensed staff on Ulcer/Wound guidelines, change of condition charting, green skin flow sheet and Policy and	4/10/12

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F 314	Continued From page 14 been admitted to the facility on 10/27/11, and was discharged on 12/24/11. The Resident Admission assessment dated 10/27/11, identified R126 had multiple scabs on his body upon admission including scabs on his left heel. The initial Minimum Data Set dated 11/3/11, identified R126 with cognitive impairments and as requiring extensive assistance with all activities of daily living. In addition, R126 was identified with a Stage one (redness) pressure ulcer on his right hip. The Activities of Daily Living Care Area Assessment (CAA) dated 11/9/11, revealed R126 had a red area on his right hip and was receiving a foam dressing treatment (Allevyn) to the area. The CAA did not identify any other area of redness or open skin. The Braden Score (tool for predicting pressure ulcer risk) dated 10/27/11, identified R126 as being at risk for the development of pressure ulcers. The Skin Assessment dated 11/9/11, identified the area on R126's right hip and directed the staff to reposition the resident every two hours. However, the skin assessment was not comprehensive and did not identify how the repositioning schedule was determined. Information related to the skin's ability to tolerate pressure for R126 was lacking. A nurse's note dated 12/4/11, revealed R126 had developed an open blister (pressure ulcer) on his left heel which was 1.25 cm wide and 2 cm long. Review of further nurse's notes included a nutritional assessment on 12/6/11, which identified the open area on R126's left heel. A Skin Assessment flow sheet dated 12/4/11, identified the open area on the left heel and	F 314	Procedure for Skin Assessment and Care. D. Audits on any newly reported pressure ulcers will be conducted x 4 months to assure compliance of completion of new comprehensive skin assessment. Audits will be conducted and reviewed by the CQI team. Clinical Director is responsible. Completion date 4-10-2012	

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F 314	Continued From page 15 indicated a treatment of Bacitracin Zinc Ointment and dressing was started for R126. Monitoring notes on 12/6/11, 12/14/11, and 12/20/11, indicated the area decreased in size. However, the record did not contain a comprehensive assessment after the development of R126's new open area on the left heel which would include possible interventions to assist in wound healing and the prevention of further pressure ulcers. Information related to the skin's ability to tolerate pressure for R126 was lacking. The policy Skin Assessment and Care dated May 2011, indicated that within 14 days after admission, a comprehensive skin assessment would be completed that included an evaluation of the "skin integrity and tissue tolerance (ability of the skin to tolerate pressure). In addition, the policy read, "A registered nurse must complete a skin assessment if a new pressure ulcer develops. The assessment must include a review of the resident's tissue tolerance to pressure." At 1:05 p.m. on 3/1/12, registered nurse (RN)-E reviewed the closed record. She verified the left heel blister had developed while R126 was in the facility and a comprehensive skin assessment had not been completed at the time the area had been identified. At 3:00 p.m. on 3/1/12, the director of nursing verified the facility had not completed a comprehensive skin assessment following the development of an ulcer according to the facility policy.	F 314		

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the necessary toileting services were provided to minimize urinary incontinence for 1 of 3 residents (R107) in the sample reviewed for urinary incontinence. Findings include: R107's diagnoses included dementia, depression, hypertension, muscle weakness and lack of coordination. The admission Minimum Data Set, dated 10/31/11, indicated R107 was occasionally incontinent of urine (less then 7 episodes of incontinence), and required extensive assistance of 1 staff to walk in room and to use the toilet. The Care Area Assessment (CAA) dated 11/1/11, indicated R107's need for assistance with activities of daily living (ADLs) caused an increase in risk for urinary incontinence, and nursing was to assist with toileting as needed.	F 315	**F315** It is the policy of Bethany Community to assist residents to achieve their highest level of urinary continence. A. A new comprehensive bladder assessment was completed for R107 immediately with new interventions implemented. B. Any resident that showed a decline in bladder function within the past 6 months has been reassessed by completing a comprehensive bladder assessment. C. Review/education of Urinary Incontinence Assessment was completed with the Nurse Managers. The urinary incontinence policy was reviewed with all Nurse Managers. All Nurse Managers were re-trained on how to complete a quarterly assessment comparing the results from previous MDS's to look for any declines in urinary functioning. Look for root cause of the decline and analyze the results, is it avoidable or unavoidable, and all findings are documented, with MD referrals as needed and new interventions implemented as needed. D. Audits will be done x 3 months on any resident that shows a decline in urinary incontinence to assure reasoning is documented or a comprehensive assessment was	3/26/12

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F 315	Continued From page 17 The comprehensive bowel and bladder assessment dated 10/27/11, indicated R107 was able to recognize the appropriate time/place to urinate, had problems with mobility, had no apparent voiding pattern, and had a diagnosis of functional incontinence (incontinence due to cognitive or physical impairment, and/or environmental barriers). The analysis indicated R107 had some urinary dribbling, but generally voided on the toilet and remained dry with only occasional bladder incontinence. The quarterly MDS, dated 1/25/12, indicated R107 was cognitively intact and frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least 1 episode of continent voiding), and required extensive assistance of 1 staff to walk in room and to use the toilet. The bowel and bladder assessment dated 1/25/12, indicated incontinence of bladder was frequent, had increased from the previous assessment, and the increased incontinence was due to a toilet that filled high with water (wetting the back of R107's legs), and increased incontinence at night. The assessment lacked R107's voiding patterns. A trial toileting program of waking R107 up every 2 hours at night to toilet was started 1/27/12, and discontinued after 2 nights when R107 refused the toileting program. The plan of care dated 11/3/11, indicated R107 could use the toilet independently at times, but was able to ask staff for assistance if needed. Staff were also to assist with brief changes and pericares. The plan of care lacked R107's voiding patterns and a toileting plan to assist with	F 315	completed if needed. Audits will be conducted and results reported to the CQI team quarterly. Clinical Director is responsible. Completed 3-26-12	

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F 315	Continued From page 18 maintaining continence. On 2/29/12, at 3:03 p.m. the registered nurse (RN) clinical manager-B (CM-B) was interviewed and stated urinary incontinence data was entered from the facility care tracker system with data entered by the nursing assistants. CM-B stated if there was a decline in a resident's urinary incontinence, they would do a root cause analysis of why they are more incontinent. CM-B added they then adjust the resident's toileting time and schedule. On 3/1/12, at 9:45 p.m., CM-B stated they did not track R107's voiding patterns when they identified the decline, but added they should have. CM-B verified R107 did not have a toileting plan in place. On 3/1/12, at 8:26 a.m., RN-C was interviewed and verified she had completed the quarterly MDS, and the MDS was accurate. On 3/1/12, at 8:34 a.m., RN-D was interviewed and stated the quarterly assessment for urinary incontinence did not include tracking a resident's voiding patterns. RN-D stated the facility did not document the time of day R107 toileted, or if R107 was continent or incontinent. RN information was documented at the end of the shift on the number of incontinent episodes R107 had that shift. RN-D stated she had not reassessed R107's incontinence now that the toilet was fixed, or since R107's refusal to do a night toileting program. RN-D verified R107 did not have a toileting program. On 3/1/12, at 9:51 a.m., RN-B was interviewed	F 315		

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	245434	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(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 315	Continued From page 19 and verified she had completed the MDS in October, and the MDS was accurate. The facility was unable to provide a policy and procedure on urinary incontinence or toileting programs.	F 315	**F371** A. Issues identified related to sanitation were immediately addressed through 1:1 staff education of those involved and cleaning. Thermometers were immediately placed in the freezer compartments identified. The dome lids and tilting braiser were cleaned and dried. The chemical sanitizer is in use until repairs have been completed and temperatures maintained. Dishwasher manufacturer has been alerted to the problem. They will visit facility and check accuracy of machine's water temp thermometer. Vendor has been called to repair the booster heater. B. All dietary staff will be re-educated on proper food handling procedure and sanitary conditions. Dietary staff will begin using a new butter product which eliminates handling the bread to butter it. Policies and procedures will be reviewed with staff at education on glove usage, proper cleaning methods and timetables, maintaining proper freezer temps, equipment dry storage, and maintaining proper hot water temps in the dishwasher. C. Quality review sheets will be developed and maintained. Spot checks will be done weekly by supervisors to observe staff practice as well as check cleaning and	4/3/12
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve breads in a sanitary manner, and failed to maintain a sanitary kitchen related to coffee machines, freezers, plate covers, the soup kettle, and dishwasher temperatures. This practice had the potential to affect 68 of 69 residents residing in the facility. Findings include: Main Dining Room On 2/27/12, at 5:28 p.m. during the supper meal in the main dining room, cook-B (C-B) was observed to wash her hands and don clean gloves. C-B began to prepare the food trays, and	F 371		

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F 371	Continued From page 20 at 5:34 p.m. took 1 slice of bread out of the package, and buttered it with the same (soiled) gloves. At 5:35 p.m., C-B took 1 slice of bread out of the package and put it in the toaster, taking it out of the toaster and buttering it at 5:35. C-B was observed handling 19 slices of bread with gloves that were soiled from touching the counter, microwave, refrigerator and cupboards. This continued through the meal service, ending at 6:03 p.m. On 2/27/12, at 6:03 p.m. C-B was interviewed, and verified she had used soiled gloves to touch the bread. C-B stated the area around the serving table was considered clean, but she should have washed her hands and put on clean gloves after touching the microwave. When asked if she should touch the bread with clean gloves, and not gloves that are soiled, C-B stated, "We probably should be, but we don't," and added a utensil, such as a tongs, could be used. Short Term Rehabilitation Unit On 2/27/12, at 6:03 p.m. dietary aide (DA)-A was observed touching the handles to the coffee and hot water machine. DA-A then opened a cupboard and took a loaf of bread out. DA-A then handled the bread in the bag and touched the meal tickets with gloved hands. At 6:10 p.m. DA-A then reached into the bread bag with the same gloved hands and took out a slice of bread and placed it on a resident plate. At 6:12 p.m. the DA changed gloves without washing her hands. At 6:15 p.m. the DA opened the refrigerator with gloved hands and then changed the gloves	F 371	freezer temps and water temps. Documentation sheets will be maintained for review. D. Results from weekly audits will be summarized and reported to CQI team quarterly. Director of Dining Service is responsible. April 3, 2012	

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F 371	Continued From page 21 without washing her hands. The DA then touched the pizza with the gloved hand while trying to pull it apart from another piece. The DA then reached into the bread bag two more times with gloved hands and took out a slice of bread.The DA was then observed handling the meal tickets with gloved hands. The DA then reached into the bread bag and took out a slice of bread and placed it on a resident plate. DA-A was then observed to change the gloves without washing her hands. Following this, the DA touched the meal tickets, and then changed the gloves again without washing her hands. Following this, the DA again reached into the bread bag and took out a slice of bread and placed it on a resident plate. The DA was then observed handling the meal tickets, and then reached into the bread bag, took out a slice of bread and put it on a resident plate. The DA then opened a cupboard with the gloved hands, served some melon with a scoop, removed the gloves and answered the telephone. The DA then washed her hands and applied new gloves. The DA then handled the meal tickets, opened the refrigerator and then changed the gloves without washing her hands. The DA again handled the meal tickets, removed the gloves, used the telephone and put on new gloves without washing her hands. The DA again handled the meal tickets and then reached into the bread bag, took out a slice of bread and placed it on a plate and repeated this two more times. The DA then handled clear plastic wrap. The DA then changed her gloves without washing her hands. The DA then reached into the bread bag, took out a slice of bread and placed it on a resident plate.	F 371		

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F 371	Continued From page 22 During interview at 6:49 p.m. DA-A indicated she usually touched the food with gloved hands. The DA indicated there was not any tongs to use. At 12:00 p.m. on 2/29/12, the main kitchen noon meal was observed to be served by DA-B and cook-A. The nursing staff approached the serving window and ordered meals for the residents. The dietary staff were observed to dish up the plates as ordered, however, the dietary staff were observed to directly touch the bread with soiled gloves. At 12:12 p.m. cook-A donned gloves and then picked up a bag of bread and opened it. She then picked up a slice of bread with her gloved hands, placed it on a plate, touched the side of a butter container with her glove and then placed the butter on the bread while holding onto the side of the bread. When she was done buttering the bread, she handed the plate to a staff member and rested her hands on the counter. A few moments later, cook-A again reached into the bread bag, picked up a slice of bread and buttered it. She was again observed to hold onto the side of the butter dish and onto the bread while she buttered it. She handed the bread plate to the staff member and touched the front of her uniform with the gloved hands. She repeated this process during the meal service between 12:12 p.m. and 12:49 p.m. Dietary aide (DA)-B was also observed to assist with the meal service and butter bread for the residents upon request. She also wore gloves, but was observed to touch unclean areas such as	F 371		

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F 371	Continued From page 23 the counter, her uniform, the side of the butter container and the refrigerator with her gloved hands and then directly touched the bread. At 12:50 p.m. DA-B verified she had touched areas in the kitchen with her gloved hands and then had directly touched the bread for residents. DA-B stated the facility had a staff member in the past who buttered the bread in the kitchen before the meals, but due to budget cuts, the bread now had to be buttered during the meal service. She stated it was difficult to not touch the bread while applying butter. At 3:00 p.m. on 2/29/12, the Dietary Lead (DL) verified the staff members were not to be touching the residents' bread with dirty gloves. Review of the facility's General Food Preparation and Handling policy dated 2005, read: "7. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact of prepared foods." Main Dining Room Kitchenette- At 1:00 p.m. on 2/29/12, the sanitation tour of the main dining room kitchenette was conducted. The coffee machine was observed to use concentrated liquid coffee. When the door to the coffee dispenser was opened and the bottles of concentrated coffee were removed, a film of unknown substance was observed to be floating in the lower container of concentrated coffee.	F 371		

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F 371	Continued From page 24 The edges of the lower container were coated with a white frothy matter and the upper bottle of concentrated coffee was observed to have a thick white substance which was in a small curd-like formation. DA-B stated she was not sure what the substance was but added it formed when the machines had not been cleaned. She stated the machines are to be cleaned every weekend, but was not sure if they had been cleaned. Short term acute Rehab Kitchenette- At 1:15 p.m. on 2/29/12, the kitchenette on the first floor of the short term stay was observed with DA-C. The kitchenette was equipped with a standard refrigerator. The upper freezer was observed to have frozen ice-cream and gluten free rolls and waffles, however, the freezer was not observed to have an internal thermometer. DA-C verified the items in the freezer were frozen but there was not a thermometer in the freezer. A three tiered cart was observed to have four dome plate covers stacked on it. All four of the dome covers were observed to have water sitting in them. DA-C verified all of the covers contained moisture. The kitchenette also contained a concentrated liquid coffee dispenser. When the dispenser was opened, white matter was observed in the reservoir. DA-C stated it was to be cleaned every weekend but added it had not been cleaned. Main Kitchen- At 1:20 p.m. on 2/29/12, the sanitation tour was conducted with the DL. The kitchen was equipped with a large tilting kettle with a lid. The DL stated that the tilting kettle (Braser) was used	F 371		

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F 371	Continued From page 25	F 371		

for making soups, stews and for grilling cheese sandwiches. When the cover of the kettle was opened, moisture was observed along the bottom and the edges of the pan. The DL stated the kettle was last used on 2/23/12. She verified the kettle was damp.

The main kitchen was observed to have a small chest freezer across from the stove area. The small freezer was observed to have four boxes of ice-cream bars and two boxes of individual serving cups of ice-cream. The treats were frozen, however, the freezer was not observed to have an thermometer. The DL verified the freezer was lacking a thermometer.

The DL stated that the coffee machines were to be cleaned on the weekends and they were not to have matter floating in them. She stated the staff members were sign off the laminated documents in each of the kitchens when they had competed a cleaning task. However, the laminated documents were cleaned off weekly, therefore, they did not have a record of when the last time the coffee machines had been cleaned.

Dishwasher-

On 2/29/12 at 1:30 p.m. the sanitation tour of the main kitchen was completed with the dietary lead (DL). The hot water sanitization dish washer was observed to be running as dietary aide (DA)-C cleansed the noon meal dishes. The external thermometer on the dishwasher revealed the final rinse temperature of the machine was 155 degrees Fahrenheit. The dishwasher was observed to have several loads of dishes ran through dishwasher, however, the final rinse

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F 371	Continued From page 26 temperature was not observed to over 155 degrees. At 2:00 p.m. after the dishes had been completed and the dishwasher had been off for a few minutes, a thermometer was ran through the dishwasher and the final rinse temperature was observed to be 181 degrees. Review of the facility Dish Machine Temperature Log Sample Forms for February and January 2012, revealed the facility was monitoring the final rinse temperature of the dishwasher three times a day. However, the final rinse temperature ranged from 160-182 degrees. At 2:00 p.m. on 2/29/12, the DL stated she was not aware the dishwasher final rinse temperature was not being maintained over 180 degrees. Review of the undated facility policy entitled Sanitation of Dishes, directed the staff to maintain mechanical dish machines using hot water to sanitize to maintain the final rise cycle at 180 degree or above. At 9:30 a.m. on 3/1/12, DA-D started washing the breakfast dishes. The first load of dishes was observed to be 181 degrees during the final rinse. The second load final rinse was noted to be 165 degrees. The third load final rinse temperature was 155 degrees. At this time, the DL stated she was not aware the dishwasher started out at the correct final rinse temperature, but was not maintaining the final rinse temperature. At 9:45 a.m. on 3/1/12, the maintenance director stated he was not aware the dishwasher was having difficulty maintaining the final rinse temperature. He stated he would look into the problem.	F 371		

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F 371	Continued From page 27 At 2:00 p.m. on 3/1/12, the DL stated the maintenance director was unable to determine the problem with maintaining the final rinse cycle and the facility had contacted the manufacturer to add chemical sanitization to the dishwasher.	F 371		

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. At the time of this survey, Bethany Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	RECEIVED APR -2 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok PB 4-2-12	

DC: 04.10.2012
EXIT: 03.01.2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Knudt — TITLE: Executive Director — (X6) DATE: 3-29-12

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

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K 000	Continued From page 1 Pat.Sheehan@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. The facility was surveyed as 2 building. Bethany Home was constructed at 5 different times. The original building (01 Main building) was constructed in 1964, is 1-story, with a basement and was determined to be of Type II(000) construction. In 1979, a 1-story addition, with a basement was constructed to the west side of the building that was determined to be of Type II(000) construction. In 1995, two 1-story additions were constructed to the south side and the middle of the south wings, between the 1964 and 1979 buildings and was determined to be of Type V(111) construction. In 2003 the Sub Acute building was constructed to the north of the 1964 building, is 3 stories and was determined to be Type II (111) construction. Also in 2003 a chapel addition was constructed to the east of the 1964 building, is 1-story and Type V (111) construction. Both of these additions are separated by 2-hour fire barriers. The 01 Main building is divided into 5 smoke zones on the each floor and the 02 Sub	K 000		

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K 000	Continued From page 2 Acute building is divided into 2 smoke zones on each floor by fire barriers of 30-minutes, 1-hour and 2-hours. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K29: 3-9-12 TP 1. Malfunctioning doors were immediately repaired. 2. ~~March 1, 2012~~ 3. Maintenance staff will tour the facility on a monthly basis and verify that all doors to hazardous locations close fully and latch into frames. This task has been added as a recurring monthly task to our computerized maintenance schedule. It will be monitored by the Maintenance Coordinator and Safety Committee.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	K 029		

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K 029	Continued From page 3 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 10:30 AM and 2:00 PM on 03/01/12, observation revealed, that the doors located in the Storage room labeled "A-18" and the Boiler Room located on the basement level had a doors the led to the corridor are not positively closing and latching within the door frame. This was confirmed by the Maintenance Coordinator (DL).	K 029	K130: 1. All combustibles were immediately removed from near the electrical panels. 2. ~~March 1, 2012~~ 3-2-12 3. Stickers reading "Electrical Panel, keep clear 36 inches" have been purchased and installed on electrical panels in electrical rooms. Yellow and black safety tape has been used to outline 36" in front of panels. Maintenance staff will tour the facility on a monthly basis and verify that all electrical panels are unobstructed. This task has been added as a recurring monthly task to our computerized maintenance schedule. It will be monitored by the Maintenance Director and Safety Committee.	PR
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by:	K 130		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 01 - NURSING HOME B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 130	Continued From page 4 Based on observations, the facility had combustibles to close to the main electrical distribution panel. This deficient practice is in violation of the Minnesota State Fire Code (07) 605.3 Working space and clearance. A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment and could negatively affect all 107 residents, visitors, and staff. Findings include: On facility tour between 10:30 AM and 2:00 PM on 03/01/12, it was observed in the Electrical/Mechanical room in the basement of the Sub-acute building that there were pallets, boxes and other combustible located too close to the main electrical distribution panel. This conditions was also found in the sub-basement in the electrical/mechanical room. This was confirmed by the Maintenance Coordinator (DL).	K 130		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 02 - SUB ACUTE B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS 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. At the time of this survey, Bethany Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: PATRICK SHEEHAN, SUPERVISOR HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	POC ok PS 4-2-12 RECEIVED APR - 2 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carol Kndt — TITLE: Executive Director — (X6) DATE: 3/29/12

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 02 - SUB ACUTE B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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K 000	Continued From page 1 Pat.Sheehan@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. The facility was surveyed as 2 building. In 2003 the Sub Acute building was constructed to the north of the 1964 building, is 3 stories and was determined to be Type II (111) construction. Also in 2003 a chapel addition was constructed to the east of the 1964 building, is 1-story and Type V (111) construction. Both of these additions are separated by 2-hour fire barriers. The 02 Sub Acute building is divided into 2 smoke zones on each floor by fire barriers of 30-minutes, 1-hour and 2-hours. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING 02 - SUB ACUTE B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 72 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff	K 029	K29: 1. Malfunctioning doors were immediately repaired. 2. March 3, 2012 3. Maintenance staff will tour the facility on a monthly basis and verify that all doors to hazardous locations close fully and latch into frames. This task has been added as a recurring monthly task to our computerized maintenance schedule. It will be monitored by the Maintenance Coordinator and Safety Committee.	

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	245434	A. BUILDING 02 - SUB ACUTE B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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K 029	Continued From page 3 and visitors as smoke and fire in this rooms could enter the corridor making it untenable. Findings include: On facility tour between 10:30 AM and 2:00 PM on 03/01/12, observation revealed, that the doors located in the Storage room labeled "A-18" and the Boiler Room located on the basement level had a doors the led to the corridor are not positively closing and latching within the door frame. This was confirmed by the Maintenance Coordinator (DL).	K 029	K130: 1. All combustibles were immediately removed from near the electrical panels. 2. March 1, 2012 3. Stickers reading "Electrical Panel, keep clear 36 inches" have been purchased and installed on electrical panels in electrical rooms. Yellow and black safety tape has been used to outline 36" in front of panels. Maintenance staff will tour the facility on a monthly basis and verify that all electrical panels are unobstructed. This task has been added as a recurring monthly task to our computerized maintenance schedule. It will be monitored by the Maintenance Director and Safety Committee.	
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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8043 8898

March 15, 2012

Ms. Carol Kvidt, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5434021

Dear Ms. Kvidt:

The above facility was surveyed on February 27, 2012 through March 1, 2012 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

and the Time Period For Correction.

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

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

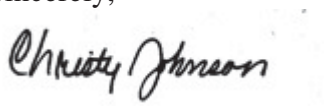
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 705 5th Street Northwest, Suite A, Bemidji, Minnesota 56601-2933. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,



Christy Johnson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 308-2114 Fax: (218) 308-2122

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(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) COMPLETE DATE
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: On 2/27, 2/28, 2/29, and 3/1, 2012, surveyors of this Department's staff, visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Certification Program; 705 5th St. N.W., Suite A, Bemidji, MN 56601-2933	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 2 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to complete a comprehensive assessment that included an assessment of the skin's tolerance to pressure in order to determine an individualized repositioning schedule for 1 of 3 residents (R126) with pressure ulcers. Findings include: R126 had diagnoses including acute renal failure, history of colon cancer, history of gastrostomy tube placement and history of stroke. R126 had been admitted to the facility on 10/27/11, and was	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 3 discharged on 12/24/11. The Resident Admission assessment dated 10/27/11, identified R126 had multiple scabs on his body upon admission including scabs on his left heel. The initial Minimum Data Set dated 11/3/11, identified R126 with cognitive impairments and as requiring extensive assistance with all activities of daily living. In addition, R126 was identified with a Stage one (redness) pressure ulcer on his right hip. The Activities of Daily Living Care Area Assessment (CAA) dated 11/9/11, revealed R126 had a red area on his right hip and was receiving a foam dressing treatment (Allevyn) to the area. The CAA did not identify any other area of redness or open skin. The Braden Score (tool for predicting pressure ulcer risk) dated 10/27/11, identified R126 as being at risk for the development of pressure ulcers. The Skin Assessment dated 11/9/11, identified the area on R126's right hip and directed the staff to reposition the resident every two hours. However, the skin assessment was not comprehensive and did not identify how the repositioning schedule was determined. Information related to the skin's ability to tolerate pressure for R126 was lacking. The policy Skin Assessment and Care dated May 2011, indicated that within 14 days after admission, a comprehensive skin assessment would be completed that included an evaluation of the "skin integrity and tissue tolerance (ability of the skin to tolerate pressure). At 3:00 p.m. on 3/1/12, the director of nursing verified the facility had not completed a comprehensive skin assessment according to the facility policy.	2 540		

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2 540	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure comprehensive skin assessments are completed. The Director of Nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 540		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess bladder function following increased urinary incontinence for 1 of 3 residents (R107) in the sample reviewed for urinary incontinence. Findings include: R107's diagnoses included dementia, depression, hypertension, muscle weakness and lack of coordination.	2 550		

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BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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2 550	Continued From page 5 The admission Minimum Data Set, dated 10/31/11, indicated R107 was occasionally incontinent of urine (less then 7 episodes of incontinence), and required extensive assistance of 1 staff to walk in room and to use the toilet. The Care Area Assessment (CAA) dated 11/1/11, indicated R107's need for assistance with activities of daily living (ADLs) caused an increase in risk for urinary incontinence, and nursing was to assist with toileting as needed. The comprehensive bowel and bladder assessment dated 10/27/11, indicated R107 was able to recognize the appropriate time/place to urinate, had problems with mobility, had no apparent voiding pattern, and had a diagnosis of functional incontinence (incontinence due to cognitive or physical impairment, and/or environmental barriers). The analysis indicated R107 had some urinary dribbling, but generally voided on the toilet and remained dry with only occasional bladder incontinence. The quarterly MDS, dated 1/25/12, indicated R107 was cognitively intact and frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least 1 episode of continent voiding), and required extensive assistance of 1 staff to walk in room and to use the toilet. The bowel and bladder assessment dated 1/25/12, indicated incontinence of bladder was frequent, had increased from the previous assessment, and the increased incontinence was due to a toilet that filled high with water (wetting the back of R107's legs), and increased incontinence at night. The assessment lacked R107's voiding patterns. On 2/29/12, at 3:03 p.m. the registered nurse (RN) clinical manager-B (CM-B) was interviewed	2 550		

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	00108	A. BUILDING _____ B. WING _____	03/01/2012

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2 550	Continued From page 6 and stated urinary incontinence data was entered from the facility care tracker system with data entered by the nursing assistants. CM-B stated if there was a decline in a resident's urinary incontinence, they would do a root cause analysis of why they are more incontinent. CM-B added they then adjust the resident's toileting time and schedule. On 3/1/12, at 9:45 p.m., CM-B stated they did not track R107's voiding patterns when they identified the decline, but added they should have. On 3/1/12, at 8:26 a.m., RN-C was interviewed and verified she had completed the quarterly MDS, and the MDS was accurate. On 3/1/12, at 8:34 a.m., RN-D was interviewed and stated the quarterly assessment for urinary incontinence did not include tracking a resident's voiding patterns. RN-D stated the facility did not document the time of day R107 toileted, or if R107 was continent or incontinent. RN information was documented at the end of the shift on the number of incontinent episodes R107 had that shift. RN-D stated she had not reassessed R107's incontinence. On 3/1/12, at 9:51 a.m., RN-B was interviewed and verified she had completed the MDS in October, and the MDS was accurate. The facility was unable to provide a policy and procedure on urinary incontinence or toileting programs.	2 550		

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2 550	Continued From page 7 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure quarterly urinary incontinence assessments are completed. The Director of Nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 550		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive care plan that addressed gastrostomy site treatments, colostomy cares, the use of antipsychotic medication, and the resident's diet and eating ability for 1 of 1 resident (R126) who required a comprehensive care plan to include these areas. Findings include:	2 560		

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2 560	Continued From page 8 R126 had diagnoses including acute renal failure, history of colon cancer, anxiety, history of gastrostomy tube placement and history of stroke. R126 had been admitted to the facility on 10/27/11, and was discharged on 12/24/11. The initial Minimum Data Set dated 11/3/11, identified R126 with cognitive impairments, as requiring extensive assistance with all activities of daily living, and use of an antipsychotic medication daily. The Behavioral Symptoms Care Area Assessment dated 11/9/11, identified R126 received an antipsychotic medication related to agitation while at dialysis. Review of the Short Term Care Plan check sheet initiated on 10/28/11, identified minimal cares for R126. The clinical record identified several areas which had not been added to the care plan. The following items were identified: -A physician progress note dated 11/10/11 identified R126's gastrostomy site as being red and swollen with a small amount of drainage. The physician had ordered a treatment for the gastrostomy site. The short term care plan indicated R126 had a gastrostomy tube but did not include any sort of treatments for the area. -A nurse's note dated 10/31/11, revealed R126 had a colostomy bag which was to be changed twice a week and as needed if leaking. The short term care plan indicated R126 had a colostomy, but did not include interventions related to the care of the colostomy. -The physicians orders dated 10/27/11, included an order for Zyprexa 2.5 mg (antipsychotic medication) to be given as needed at bedtime for	2 560		

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2 560	Continued From page 9 agitation. The short term care plan did not identify any problems with agitation and did not identify R126 was receiving any antipsychotic medication. In addition, non-pharmacological interventions which could be attempted prior to the use of the medication had not been identified. -The short term plan of care identified R126 as unable to tolerate anything by mouth. The nurses note dated 11/17/11, (21 days from admission) indicated R126 had a swallowing study completed and had been advanced to receive an oral diet. The policy Care Planning IDT (interdisciplinary team) dated May 2011, directed staff to complete a comprehensive care plan within 7 days after a comprehensive assessment, but no later than 21 days after admission. At 1:30 p.m. on 3/1/12, registered nurse (RN)-E stated R126 had resided on the short term acute stay unit in the facility. RN-E added the facility did not complete comprehensive care plans for the residents on the short term unit until they had been at the facility for ninety days. She stated they had never completed comprehensive care plans for residents in the short term stay. She verified R126 had been at the facility for 59 days and the facility had not completed a comprehensive care plan for the resident. She verified the treatments for the gastrostomy and colostomy sites were not on the plan of care. She also verified the short term care plan did not address the diet orders or the use of an antipsychotic medication. At 3:00 p.m. on 3/1/12, the director of nurses verified the facility had not been completing comprehensive care plans for residents who were in the facility greater than 21 days.	2 560		

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2 560	Continued From page 10 SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure a comprehensive care plan is developed within 21 days of the initial assessment. The Director of Nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 560		
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: Based on interview and document review, the	2 830		

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2 830	Continued From page 11 facility did not ensure coordination of hospice services to identify the services to be provided by the hospice aide and the time frame of those services for 1 of 1 resident (R23) in the sample reviewed that received hospice services. Findings include: R23's diagnoses included failure to thrive, hypertension, atrial fibrillation, anemia and late effects of cerebrovascular disease. The significant change Minimum Data Set (MDS) dated 2/2/12, indicated R23 required extensive assist of 1 staff for dressing, personal hygiene, toileting and eating, and was totally dependent on 1 staff for bathing. On 1/23/12, R23 began hospice services for the terminal diagnosis of failure to thrive. On 1/23/12, the hospice registered nurse (RN) met with R23 and family. In a report dated 1/25/12, the hospice RN indicated the need for hospice aide services. The report also identified the hospice aide cares would be coordinated with the facility, and the hospice aide would see R23 once a week for personal cares. The hospice plan of care dated 1/23/12, indicated hospice aide once a week to help with personal cares, but lacked specific cares that would be provided. The facility plan of care dated 1/27/12, indicated hospice aide once a week, but lacked what cares the hospice aide would provide. On 2/29/12, at 9:28 a.m., the registered nurse clinical manager (CM-B) was interviewed and stated the hospice provider was supposed to fax the hospice aide's schedule and what cares would be provided, but they had not done this yet. CM-B was unsure of the date or time of the	2 830		

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2 830	Continued From page 12 hospice aide's next visit, or what personal cares were to be completed with the weekly visit. CM-B stated the hospice aide does not do personal cares for R23, so dressing, personal hygiene, toileting and eating are completed by facility staff. CM-B stated the hospice aide will soak and message R23's feet, and apply lotion to her legs. CM-B verified the hospice aide assignment sheet was not in the facility chart, and the plans of care of the hospice provider and the facility did not identify what cares the hospice aide would provide. On 3/1/12, at 2:18 p.m., the RN hospice coordinator (RN-F) was interviewed by telephone, and stated their protocol was to fax the hospice aide's schedule to the facility, along with the hospice aide assignment sheet. The facility was unable to provide a policy and procedure on hospice services. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure Hospice care is coordinated. The Director of Nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 830		

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2 900	Continued From page 13	2 900		
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 document review and interview, the facility failed to ensure necessary treatment interventions were implemented including an appropriate repositioning schedule following the development of a pressure ulcer for 1 of 3 residents (R126) who had pressure ulcers. Findings include: R126 had diagnoses including acute renal failure, history of colon cancer, history of gastrostomy tube placement and history of stroke. R126 had been admitted to the facility on 10/27/11, and was discharged on 12/24/11. The Resident Admission assessment dated 10/27/11, identified R126 had multiple scabs on his body upon admission including scabs on his left heel.	2 900		

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2 900	Continued From page 14 The initial Minimum Data Set dated 11/3/11, identified R126 with cognitive impairments and as requiring extensive assistance with all activities of daily living. In addition, R126 was identified with a Stage one (redness) pressure ulcer on his right hip. The Activities of Daily Living Care Area Assessment (CAA) dated 11/9/11, revealed R126 had a red area on his right hip and was receiving a foam dressing treatment (Allevyn) to the area. The CAA did not identify any other area of redness or open skin. The Braden Score (tool for predicting pressure ulcer risk) dated 10/27/11, identified R126 as being at risk for the development of pressure ulcers. The Skin Assessment dated 11/9/11, identified the area on R126's right hip and directed the staff to reposition the resident every two hours. However, the skin assessment was not comprehensive and did not identify how the repositioning schedule was determined. Information related to the skin's ability to tolerate pressure for R126 was lacking. A nurse's note dated 12/4/11, revealed R126 had developed an open blister (pressure ulcer) on his left heel which was 1.25 cm wide and 2 cm long. Review of further nurse's notes included a nutritional assessment on 12/6/11, which identified the open area on R126's left heel. A Skin Assessment flow sheet dated 12/4/11, identified the open area on the left heel and indicated a treatment of Bacitracin Zinc Ointment and dressing was started for R126. Monitoring notes on 12/6/11, 12/14/11, and 12/20/11, indicated the area decreased in size. However, the record did not contain a comprehensive assessment after the	2 900		

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2 900	Continued From page 15 development of R126's new open area on the left heel which would include possible interventions to assist in wound healing and the prevention of further pressure ulcers. Information related to the skin's ability to tolerate pressure for R126 was lacking. The policy Skin Assessment and Care dated May 2011, indicated that within 14 days after admission, a comprehensive skin assessment would be completed that included an evaluation of the "skin integrity and tissue tolerance (ability of the skin to tolerate pressure). In addition, the policy read, "A registered nurse must complete a skin assessment if a new pressure ulcer develops. The assessment must include a review of the resident's tissue tolerance to pressure." At 1:05 p.m. on 3/1/12, registered nurse (RN)-E reviewed the closed record. She verified the left heel blister had developed while R126 was in the facility and a comprehensive skin assessment had not been completed at the time the area had been identified. At 3:00 p.m. on 3/1/12, the director of nursing verified the facility had not completed a comprehensive skin assessment following the development of an ulcer according to the facility policy. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents who develop pressure ulcers are assessed. The Director of Nursing (DON) or designee could	2 900		

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2 900	Continued From page 16 educate all appropriate staff on the policies and procedures. The Director of Nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the necessary toileting services were provided to minimize urinary incontinence for 1 of 3 residents (R107) in the sample reviewed for urinary incontinence. Findings include:	2 910		

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2 910	Continued From page 17 R107's diagnoses included dementia, depression, hypertension, muscle weakness and lack of coordination. The admission Minimum Data Set, dated 10/31/11, indicated R107 was occasionally incontinent of urine (less then 7 episodes of incontinence), and required extensive assistance of 1 staff to walk in room and to use the toilet. The Care Area Assessment (CAA) dated 11/1/11, indicated R107's need for assistance with activities of daily living (ADLs) caused an increase in risk for urinary incontinence, and nursing was to assist with toileting as needed. The comprehensive bowel and bladder assessment dated 10/27/11, indicated R107 was able to recognize the appropriate time/place to urinate, had problems with mobility, had no apparent voiding pattern, and had a diagnosis of functional incontinence (incontinence due to cognitive or physical impairment, and/or environmental barriers). The analysis indicated R107 had some urinary dribbling, but generally voided on the toilet and remained dry with only occasional bladder incontinence. The quarterly MDS, dated 1/25/12, indicated R107 was cognitively intact and frequently incontinent of urine (7 or more episodes of urinary incontinence, but at least 1 episode of continent voiding), and required extensive assistance of 1 staff to walk in room and to use the toilet. The bowel and bladder assessment dated 1/25/12, indicated incontinence of bladder was frequent, had increased from the previous assessment, and the increased incontinence was due to a toilet that filled high with water (wetting the back of R107's legs), and increased incontinence at night. The assessment lacked R107's voiding patterns.	2 910		

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2 910	Continued From page 18 A trial toileting program of waking R107 up every 2 hours at night to toilet was started 1/27/12, and discontinued after 2 nights when R107 refused the toileting program. The plan of care dated 11/3/11, indicated R107 could use the toilet independently at times, but was able to ask staff for assistance if needed. Staff were also to assist with brief changes and pericares. The plan of care lacked R107's voiding patterns and a toileting plan to assist with maintaining continence. On 2/29/12, at 3:03 p.m. the registered nurse (RN) clinical manager-B (CM-B) was interviewed and stated urinary incontinence data was entered from the facility care tracker system with data entered by the nursing assistants. CM-B stated if there was a decline in a resident's urinary incontinence, they would do a root cause analysis of why they are more incontinent. CM-B added they then adjust the resident's toileting time and schedule. On 3/1/12, at 9:45 p.m., CM-B stated they did not track R107's voiding patterns when they identified the decline, but added they should have. CM-B verified R107 did not have a toileting plan in place. On 3/1/12, at 8:26 a.m., RN-C was interviewed and verified she had completed the quarterly MDS, and the MDS was accurate. On 3/1/12, at 8:34 a.m., RN-D was interviewed and stated the quarterly assessment for urinary incontinence did not include tracking a resident's voiding patterns. RN-D stated the facility did not document the time of day R107 toileted, or if	2 910		

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2 910	Continued From page 19 R107 was continent or incontinent. RN information was documented at the end of the shift on the number of incontinent episodes R107 had that shift. RN-D stated she had not reassessed R107's incontinence now that the toilet was fixed, or since R107's refusal to do a night toileting program. RN-D verified R107 did not have a toileting program. On 3/1/12, at 9:51 a.m., RN-B was interviewed and verified she had completed the MDS in October, and the MDS was accurate. The facility was unable to provide a policy and procedure on urinary incontinence or toileting programs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure care and services to prevent decline in bladder function are provided. The Director of Nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	2 910		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary	21015		

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21015	Continued From page 20 procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve breads in a sanitary manner, and failed to maintain a sanitary kitchen related to coffee machines, freezers, plate covers, and the soup kettle. This practice had the potential to affect 68 of 69 residents residing in the facility. Findings include: Main Dining Room On 2/27/12, at 5:28 p.m. during the supper meal in the main dining room, cook-B (C-B) was observed to wash her hands and don clean gloves. C-B began to prepare the food trays, and at 5:34 p.m. took 1 slice of bread out of the package, and buttered it with the same (soiled) gloves. At 5:35 p.m., C-B took 1 slice of bread out of the package and put it in the toaster, taking it out of the toaster and buttering it at 5:35. C-B was observed handling 19 slices of bread with gloves that were soiled from touching the counter, microwave, refrigerator and cupboards. This continued through the meal service, ending at 6:03 p.m. On 2/27/12, at 6:03 p.m. C-B was interviewed, and verified she had used soiled gloves to touch the bread. C-B stated the area around the serving table was considered clean, but she should have washed her hands and put on clean gloves after touching the microwave. When asked if she	21015		

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21015	Continued From page 21 should touch the bread with clean gloves, and not gloves that are soiled, C-B stated, "We probably should be, but we don't," and added a utensil, such as a tongs, could be used. Short Term Rehabilitation Unit On 2/27/12, at 6:03 p.m. dietary aide (DA)-A was observed touching the handles to the coffee and hot water machine. DA-A then opened a cupboard and took a loaf of bread out. DA-A then handled the bread in the bag and touched the meal tickets with gloved hands. At 6:10 p.m. DA-A then reached into the bread bag with the same gloved hands and took out a slice of bread and placed it on a resident plate. At 6:12 p.m. the DA changed gloves without washing her hands. At 6:15 p.m. the DA opened the refrigerator with gloved hands and then changed the gloves without washing her hands. The DA then touched the pizza with the gloved hand while trying to pull it apart from another piece. The DA then reached into the bread bag two more times with gloved hands and took out a slice of bread. The DA was then observed handling the meal tickets with gloved hands. The DA then reached into the bread bag and took out a slice of bread and placed it on a resident plate. DA-A was then observed to change the gloves without washing her hands. Following this, the DA touched the meal tickets, and then changed the gloves again without washing her hands. Following this, the DA again reached into the bread bag and took out a slice of bread and placed it on a resident plate. The DA was then observed handling the meal tickets, and then reached into the bread bag, took out a slice of bread and put it on a resident plate. The DA then opened a cupboard with the gloved	21015		

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21015	Continued From page 22 hands, served some melon with a scoop, removed the gloves and answered the telephone. The DA then washed her hands and applied new gloves. The DA then handled the meal tickets, opened the refrigerator and then changed the gloves without washing her hands. The DA again handled the meal tickets, removed the gloves, used the telephone and put on new gloves without washing her hands. The DA again handled the meal tickets and then reached into the bread bag, took out a slice of bread and placed it on a plate and repeated this two more times. The DA then handled clear plastic wrap. The DA then changed her gloves without washing her hands. The DA then reached into the bread bag, took out a slice of bread and placed it on a resident plate. During interview at 6:49 p.m. DA-A indicated she usually touched the food with gloved hands. The DA indicated there was not any tongs to use. At 12:00 p.m. on 2/29/12, the main kitchen noon meal was observed to be served by DA-B and cook-A. The nursing staff approached the serving window and ordered meals for the residents. The dietary staff were observed to dish up the plates as ordered, however, the dietary staff were observed to directly touch the bread with soiled gloves. At 12:12 p.m. cook-A donned gloves and then picked up a bag of bread and opened it. She then picked up a slice of bread with her gloved hands, placed it on a plate, touched the side of a butter container with her glove and then placed the butter on the bread while holding onto the side of the bread. When she was done buttering	21015		

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21015	Continued From page 23 the bread, she handed the plate to a staff member and rested her hands on the counter. A few moments later, cook-A again reached into the bread bag, picked up a slice of bread and buttered it. She was again observed to hold onto the side of the butter dish and onto the bread while she buttered it. She handed the bread plate to the staff member and touched the front of her uniform with the gloved hands. She repeated this process during the meal service between 12:12 p.m. and 12:49 p.m. Dietary aide (DA)-B was also observed to assist with the meal service and butter bread for the residents upon request. She also wore gloves, but was observed to touch unclean areas such as the counter, her uniform, the side of the butter container and the refrigerator with her gloved hands and then directly touched the bread. At 12:50 p.m. DA-B verified she had touched areas in the kitchen with her gloved hands and then had directly touched the bread for residents. DA-B stated the facility had a staff member in the past who buttered the bread in the kitchen before the meals, but due to budget cuts, the bread now had to be buttered during the meal service. She stated it was difficult to not touch the bread while applying butter. At 3:00 p.m. on 2/29/12, the Dietary Lead (DL) verified the staff members were not to be touching the residents' bread with dirty gloves. Review of the facility's General Food Preparation and Handling policy dated 2005, read: "7. Food will be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact of prepared foods."	21015		

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21015	Continued From page 24	21015		

Main Dining Room Kitchenette-

At 1:00 p.m. on 2/29/12, the sanitation tour of the main dining room kitchenette was conducted. The coffee machine was observed to use concentrated liquid coffee. When the door to the coffee dispenser was opened and the bottles of concentrated coffee were removed, a film of unknown substance was observed to be floating in the lower container of concentrated coffee. The edges of the lower container were coated with a white frothy matter and the upper bottle of concentrated coffee was observed to have a thick white substance which was in a small curd-like formation. DA-B stated she was not sure what the substance was but added it formed when the machines had not been cleaned. She stated the machines are to be cleaned every weekend, but was not sure if they had been cleaned.

Short term acute Rehab Kitchenette-

At 1:15 p.m. on 2/29/12, the kitchenette on the first floor of the short term stay was observed with DA-C. The kitchenette was equipped with a standard refrigerator. The upper freezer was observed to have frozen ice-cream and gluten free rolls and waffles, however, the freezer was not observed to have an internal thermometer. DA-C verified the items in the freezer were frozen but there was not a thermometer in the freezer. A three tiered cart was observed to have four dome plate covers stacked on it. All four of the dome covers were observed to have water sitting in them. DA-C verified all of the covers contained moisture. The kitchenette also contained a

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21015	Continued From page 25 concentrated liquid coffee dispenser. When the dispenser was opened, white matter was observed in the reservoir. DA-C stated it was to be cleaned every weekend but added it had not been cleaned. Main Kitchen- At 1:20 p.m. on 2/29/12, the sanitation tour was conducted with the DL. The kitchen was equipped with a large tilting kettle with a lid. The DL stated that the tilting kettle (Braser) was used for making soups, stews and for grilling cheese sandwiches. When the cover of the kettle was opened, moisture was observed along the bottom and the edges of the pan. The DL stated the kettle was last used on 2/23/12. She verified the kettle was damp. The main kitchen was observed to have a small chest freezer across from the stove area. The small freezer was observed to have four boxes of ice-cream bars and two boxes of individual serving cups of ice-cream. The treats were frozen, however, the freezer was not observed to have an thermometer. The DL verified the freezer was lacking a thermometer. The DL stated that the coffee machines were to be cleaned on the weekends and they were not to have matter floating in them. She stated the staff members were sign off the laminated documents in each of the kitchens when they had competed a cleaning task. However, the laminated documents were cleaned off weekly, therefore, they did not have a record of when the last time the coffee machines had been cleaned.	21015		

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21015	Continued From page 26 SUGGESTED METHOD OF CORRECTION: The Dietary Manager (DM) or designee could develop, review, and/or revise policies and procedures to ensure proper food handling and sanitary conditions in the kitchen. . The Dietary Manager (DM) or designee could educate all appropriate staff on the policies and procedures. The Dietary Manager (DM) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21015		
21160	MN Rule 4658.0675 Subp. 6 Mechanical Cleaning and Sanitizing; Hot Water Subp. 6. Hot water sanitization. Machines using hot water for sanitizing may be used provided that wash water and pumped rinse water are kept clean and water is maintained at not less than the temperature specified by NSF International Standard No. 3, incorporated by reference in subpart 2, under which the machine is evaluated. A pressure gauge must be installed with a valve immediately adjacent to the supply side of the control valve in the final rinse line provided that this requirement does not pertain to a dishwashing machine with a pumped final rinse. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain adequate temperatures to ensure appropriate hot water sanitation for the dishwasher. This practice had the potential to affect 68 of 69 residents residing in the facility.	21160		

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21160	Continued From page 27 Findings include: On 2/29/12 at 1:30 p.m. the sanitation tour of the main kitchen was completed with the dietary lead (DL). The hot water sanitization dish washer was observed to be running as dietary aide (DA)-C cleansed the noon meal dishes. The external thermometer on the dishwasher revealed the final rinse temperature of the machine was 155 degrees Fahrenheit. The dishwasher was observed to have several loads of dishes ran through dishwasher, however, the final rinse temperature was not observed to over 155 degrees. At 2:00 p.m. after the dishes had been completed and the dishwasher had been off for a few minutes, a thermometer was ran through the dishwasher and the final rinse temperature was observed to be 181 degrees. Review of the facility Dish Machine Temperature Log Sample Forms for February and January 2012, revealed the facility was monitoring the final rinse temperature of the dishwasher three times a day. However, the final rinse temperature ranged from 160-182 degrees. At 2:00 p.m. on 2/29/12, the DL stated she was not aware the dishwasher final rinse temperature was not being maintained over 180 degrees. Review of the undated facility policy entitled Sanitation of Dishes, directed the staff to maintain mechanical dish machines using hot water to sanitize to maintain the final rise cycle at 180 degree or above. At 9:30 a.m. on 3/1/12, DA-D started washing the breakfast dishes. The first load of dishes was observed to be 181 degrees during the final rinse. The second load final rinse was noted to be 165	21160		

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21160	Continued From page 28 degrees. The third load final rinse temperature was 155 degrees. At this time, the DL stated she was not aware the dishwasher started out at the correct final rinse temperature, but was not maintaining the final rinse temperature. At 9:45 a.m. on 3/1/12, the maintenance director stated he was not aware the dishwasher was having difficulty maintaining the final rinse temperature. He stated he would look into the problem. At 2:00 p.m. on 3/1/12, the DL stated the maintenance director was unable to determine the problem with maintaining the final rinse cycle and the facility had contacted the manufacturer to add chemical sanitization to the dishwasher. SUGGESTED METHOD OF CORRECTION: The Dietary Manager (DM) or designee could develop, review, and/or revise policies and procedures to ensure dishwashing temperatures are within the proper range for sanitation. The Dietary Manager (DM) or designee could educate all appropriate staff on the policies and procedures. The Dietary Manager (DM) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21160		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must	21695		

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21695	Continued From page 29 provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure the resident environment, including the doors and floors, was kept in good repair for 8 of 40 residents (R23, R92, R32, R21, R99, R42, R191 & R56) in the sample. Findings include: An environmental tour was conducted on 3/1/12, at 9:00 a.m. with the coordinator of maintenance (CM), the coordinator of housekeeping (CH) and the director of finance and operations (DFO). The following was observed and verified by all staff present during the tour: On the floor next to R23's bed were four non skid strips measuring approximately two to three feet long and two inches wide. One strip was rolled up approximately three inches and another was rolled up approximately one inch. R92's bathroom door was scuffed at the bottom. The plastic door protector on the bottom of the bathroom door was secured at the bottom inner edge with gray tape and the door jam was scuffed. R32 had five of the non skid strips on the floor in the bathroom with one peeling up approximately an inch. The bathroom door in R21's room was scuffed	21695		

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21695	Continued From page 30 with rough edges on the left corner. The plastic door protector at the bottom of the bathroom door was peeling up and away from the door. The edge was sharp and at ankle level. R99 had four non skid strips on the floor in front of the toilet. The edges of the strips were peeling up. R42's bathroom door on the right corner was heavily scuffed with rough edges on the wood. The plastic door protector was peeling up and away from the door. The edge was sharp and at ankle height. The door frame to R42's bathroom was heavily scuffed and scraped on the left side of the frame. The floor at R42's bedside had black scuff marks in the area of the non skid strips. R191's (admitted 2/21/12) bathroom door was scuffed at the bottom and the plastic door protector was lifting away from the door at the inner lower edge. R56's bathroom floor appeared dirty and dull and had black scuff marks in the center of the floor. The walls next to the sink and the toilet were scuffed and dirty. On 3/1/12, at 9:05 a.m. the CM indicated the facility was in the process of developing a program for doing monthly maintenance rounds. The CM also indicated at currently the rooms were cleaned and repaired after a resident left the facility. For any other areas of concern, the staff was expected to fill out a work order slip. On 3/1/12, at 9:10 a.m. the CH indicated she would expect her staff to report scuffs and areas needing repair. The CH indicated the housekeeping staff had check lists each day. The check lists included each room in their assigned section. If an area was not included in the check list the staff were instructed to write a note on the	21695		

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21695	Continued From page 31 check list. The check lists were then turned into the CH at the end of each day and the CH then puts in a request to maintenance if needed. All rooms were done daily. On 3/1/12, at 10:20 a.m. the director of nursing indicated the work order for maintenance repairs was on the computer at each desk. All staff including nursing assistants and housekeepers had been trained on how to use the request form to notify maintenance of any repairs needed. On 3/1/12, at 10:30 a.m. nursing assistant (NA)-D indicated she had been trained and was aware of how to use the computer system to contact maintenance for repairs. The CH provided a sheet the facility used to direct them in housekeeping and facility maintenance. The sheet consisted of the state and federal guidelines. Policies regarding routine facility maintenance were requested, but none were provided. SUGGESTED METHOD OF CORRECTION: The Administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms are kept clean and in good repair. The Administrator or designee could educate all appropriate staff on the policies and procedures. The Administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty	21695		

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21695	Continued From page 32 One (21) Days	21695		