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

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

ID: W7I9
Facility ID: 00167

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245578**
2. STATE VENDOR OR MEDICAID NO. (L2) **422670600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY RESIDE CE AND RE ABILITATIO CE TER**
(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

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) **03/01/2015**
6. DATE OF SURVEY **01/11/2016** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **66** (L18)
13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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	IID
	56	10		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 01/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **09/01/1991** (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. **06201** (L31)

30. REMARKS
Posted 01/14/2016 Co.

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

DETERMINATION APPROVAL

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245578

April 20, 2016

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

Dear Mr. Kallstrom:

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 January 3, 2016 the above facility is certified for:

56	Skilled Nursing Facility/Nursing Facility Beds
10	Nursing Facility II Beds

Your facility's Medicare approved area consists of all 56 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

An equal opportunity employer

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
January 12, 2016

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578026

Dear Mr. Kallstrom:

On December 10, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 25, 2015. 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 January 11, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 4, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 3, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 25, 2015, effective January 3, 2016 and therefore remedies outlined in our letter to you dated December 10, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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
245578	A. Building B. Wing	1/11/2016

Name of Facility	Street Address, City, State, Zip Code
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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 F0167 Reg. # 483.10(g)(1) LSC	12/15/2015	ID Prefix F0242 Reg. # 483.15(b) LSC	01/03/2016	ID Prefix F0278 Reg. # 483.20(g) - (j) LSC	12/15/2015
ID Prefix F0323 Reg. # 483.25(h) LSC	01/03/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	01/03/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	01/03/2016
ID Prefix F0441 Reg. # 483.65 LSC	01/03/2016	ID Prefix F0456 Reg. # 483.70(c)(2) LSC	01/03/2016	ID Prefix F0465 Reg. # 483.70(h) LSC	01/03/2016
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/kfd	01/12/2016	18623	01/11/2016
CMS RO				

Followup to Survey Completed on: 11/25/2015

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

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245578	01 - BETHANY COVENANT HOME	1/4/2016

Name of Facility	Street Address, City, State, Zip Code
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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 K0050	01/03/2016	ID Prefix Reg. # NFPA 101 LSC K0062	01/03/2016	ID Prefix Reg. # NFPA 101 LSC K0069	12/28/2015
ID Prefix Reg. # NFPA 101 LSC K0144	01/03/2016	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/kfd	01/12/2016	19251	01/04/2016
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/24/2015

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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: W7I9
Facility ID: 00167

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245578**
2.STATE VENDOR OR MEDICAID NO.
(L2) **422670600**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY RESIDE CE A D RE ABILITATIO CE TER**
(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2015**
6. DATE OF SURVEY **11/25/2015** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :
12.Total Facility Beds **66** (L18)
13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56	10		
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 12/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/12/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

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

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS
.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 10, 2015

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578026

Dear Mr. Kallstrom:

On November 25, 2015, 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:

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 4, 2016, 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 January 4, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 25, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 25, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112   Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING ______ B. WING ______	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the most recent surveys results, were posted for residents and the public as required. This had the potential to affect families, staff, visitors and all 54 residents residing at the facility.	F 167	It the protocol of Bethany Residence & Rehabilitation Center to make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. The most recent survey has been added	12/15/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/21/2015

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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	245578	A. BUILDING ______ B. WING ______	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

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F 167	Continued From page 1 Findings include: During the initial entrance to the facility on 11/22/15, at 11:30 a.m. the last posted survey results were dated 6/5/14, and posted in a three ring binder near the elevator on the main floor. Since the 6/5/14, survey there were surveys which would have required a new posting of surveys results. The dates were 5/28/15 and 9/14/15. The assistant director of nursing, (ADON) was interviewed on 11/22/15, at approximately 2:15 p.m. and confirmed the most current survey results were posted were dated 6/5/14, and were in a three ring binder on the wall next to the elevators. In addition, the ADON confirmed the facility had another survey since 6/5/14, during the summer of 2015 but could not remember the date. On 11/24/15, at 6:45 a.m. to 10:45 a.m. the survey results stored inside the navy blue three ring binder located outside the elevator to the left were for 6/5/14. On 11/24/15, at 11:58 a.m. during the environmental tour the administrator verified the survey results in navy blue three ring binder were not from the most recent survey as the facility had a survey in 5/28/15, and a substantiated complaint three weeks ago. The administrator reviewed binder and verified the posted results were from 6/4/14. When asked his expectation he stated "they should be current." Even though the ADON on 11/22/15, at 2:15 p.m. acknowledged the survey results posting was outdated, the facility still did not update the survey results as of the facility environmental tour which was completed two days later.	F 167	to the survey book for residents to view along with a posted sign. Staff have been educated on protocol and regulation of posting of Minnesota Department of Health Survey findings. Facility Administrator/designee will audit for the availability of the most recent surveys and will report to facility QAPI meetings. Administrator is responsible for overall compliance.	

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F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident preferences was accommodated for bathing for 2 of 4 residents (R4, R16) reviewed for choices in daily routine. This had the potential to affect 18 residents who resided on the first floor of the facility. Findings include: R4's diagnoses included paraplegia, anxiety state, epilepsy, major depression, hemiplegia and hemiparesis obtained from Admission Record dated 11/25/15. On 11/22/15, at 5:15 p.m. during interview when asked if resident was able to choose whether to take a shower, tub or bed bath resident stated "No the facility has no tub always a shower. I wish we would have a bath and be able to make a choice." On 11/23/15, at 1:50 p.m. in front of the tub room door a housekeeping cart was observed stored and a transfer machine both blocked the door. Surveyor moved the stuff and went into the tub	F 242	It is the policy of Bethany Residence & Rehabilitation Center Fall the residents are able to make choices about aspects of his or her life in the facility that are significant to the resident. Resident #4 and resident #16 care plan has been reviewed and revised based on resident choice for use of tub bath. Tub bath has been repaired and staff have been in-serviced on use of tub. Residents have been interviewed on their choice of tub or shower and nurse aide assignment sheets and care plans have been updated accordingly. Residents will be asked at a minimum quarterly if their preferences are being met. The care conference form has been updated to include this asking residents if their preferences are being met. Random audits for resident choice will be performed and will be reported on at the facility QAPI meeting.	1/3/16

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room observed a tub bath with a sliding chair inside it.

On 11/24/15, at 7:18 a.m. a transfer lift machine and vacuum were stored in front of the tub room door.

On 11/23/15, at 3:15 p.m. when approached and asked if the unit had a tub bath anonymous staff stated "I don't think it works. I want the best for the residents here but this facility has been run down so much and it surprises me at some of the things here. I hope this new management will take up on something's and do the best." When asked if the staff actually gave residents a choice on their shower day staff stated "I don't think so."
-At 3:17 p.m. when approached and asked if the tub worked housekeeping (HK)-A stated "I don't think the tub down here has been used for a long time. The staff has stated they are not able it close it properly as it leaks. They just don't know how to work it. I and [HK-B] once closed it and filled it with water and it was just fine. The residents can go upstairs to get a tub bath there."

On 11/24/15, at 9:03 a.m. when asked about the shower day R4 stated she received a shower on Saturday and indicated "I have never been offered a choice for tub bath here if I was given a choice I would take the tub bath over the shower. I have always assumed they do not have a tub bath here as they say it's your shower day and I go."

On 11/24/15, at 9:11 a.m. when asked about residents bathing schedules (NA)-C stated, "Most of the residents don't like baths. The tub is upstairs a whirlpool bath. The tub down here does not work. I think they are in the process of

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F 242	Continued From page 4	F 242		

fixing it. I think it has been leaking. The one upstairs is much nicer. Sometimes the aides don't have time to take them upstairs because a shower is faster."

On 11/24/15, at 10:20 a.m. the consultant registered nurse (RN) stated she would want resident's preferences to be asked in reference to bathing and staff needed to know a resident preference.

R4's care plan dated 8/28/14, indicated R4 had an activities of daily living (ADL) self-care performance deficit related to left sided weakness, required extensive assist with dressing, toileting and bathing and limited assist with hygiene. The care plan directed staff to encourage R4 to participate to the fullest extent possible with each interaction.

R4's annual Minimum Data Set (MDS) dated 8/19/15, indicated R4 had indicated when asked how important is was to choose between a tub bath, shower, bed bath, or sponge bath "Very Important." In addition the MDS indicated R4 had intact cognition.

R4's ADL Care Area Assessment (CAA) dated 8/31/15, R4 required extensive assistance with dressing, toileting, and bathing; limited assistance with transfers and personal hygiene.
In addition the cognitive Loss/dementia CAA dated 8/31/15, indicated R4's cognition was intact.

R16's diagnoses included abnormality of gait, malignant neoplasm of larynx, tracheostomy,

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F 242	Continued From page 5 muscle weakness, osteoporosis and glaucoma obtained from Admission Record dated 11/25/15. On 11/22/15, at 4:38 p.m. during interview when asked if resident was able to choose whether to take a shower, tub or bed bath resident stated "We don't take a tub bath here, they took them all out we get a shower." On 11/24/15, at 9:33 a.m. when surveyor was in the tub room with both NA-A and NA-B, R16 approached and stated "I have only been given a bath one time since I have been in the facility. One time I was not even able to get it done because the staff was not able to close it and was leaking." When asked if the staff gave her a choice to get a tub bath upstairs resident stated "No the staff are too busy and it's busy upstairs. They just come and tell you it ' s your shower and help you into the shower." -At 9:42 a.m. HK-B approached stated a while ago she had fixed the tub bath. She indicated it was working well. HK-B verified the water running out was rusty color and thought was because the tub had not been used for a while and if the water ran for a little longer would clear up. She indicated the water would be like that if it was not run even in her house. The care plan dated 12/17/13, indicated R16 needed limited to extensive assist at times with personal hygiene and bathing. R16's annual MDS dated 12/10/14, indicated R16 had indicated when asked how important it was to choose between a tub bath, shower, bed bath, or sponge bath "Very Important." R16's ADL CAA dated 12/18/14, indicated	F 242		

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F 242	Continued From page 6 required extensive assist with dressing and bathing. R16's quarterly MDS dated 9/9/15, indicated R16 had intact cognition. On 11/24/15, at 9:27 a.m. the house keeping cart was observed parked outside the tub bathroom and a lift machine. NA-B, NA-A and surveyor went into the tub room after both NA's moved the stuff away. Surveyor requested both NA's to show how the tub worked. NA-A indicated he had only used the tub once for the last one year he had been working at the facility. NA-B stated she had used it only once in the last six months. Both NA's were observed to touch the door using the attached handle then closed it but a gap was noted at the bottom which leaked some water out. The running water was noted to be a rusty color and was not fading away even after running it for three to four minutes. When asked if the residents were given a choice of a tub bath, bed bath or shower. Both NA's stated they were not regular staff in the unit and were regular on the second floor and in that unit the residents were given a choice. Both indicated they would approach residents and told them "it's you shower day" and residents would come. Both acknowledged residents in the unit that were alert were not given the choice but rather were told "it's your shower." On 11/24/15, at 11:58 a.m. to 12:16 p.m. during the environmental tour when asked about resident first floor tub the administrator stated he was not aware that staff had not been using it until that morning when surveyor had brought the concern up. The administrator stated it had been indicated to him the tub had been fixed sometime	F 242		

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F 242	Continued From page 7 when he started working at the facility in June that year. The administrator stated he would have expected staff to offer residents choices. On 11/25/15, at 8:22 a.m. RN-C who also completed all the facility MDS' stated when the MDS was coded "very important" for preferences it meant the resident wanted to be given a choice of what they wanted. RN-B stated it was the facility policy to offer residents choice of a shower, tub bath or bed bath. On 11/25/15, at 9:20 a.m. the director of nursing (DON) stated she would expect staff to give residents choice and encourage them as much as possible to be involved in their care. When told the staff had indicated they did not have time and the shower was faster DON stated "that is a problem."	F 242		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278		12/15/15

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F 278	Continued From page 8 false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to accurately assess a pressure ulcer for 1 of 1 (R26) resident observed with a pressure ulcer. Findings include: On 11/24/15, at 7:42 a.m. licensed practical nurse (LPN)-B was observed to complete a dressing change for R26's right toe. R26's leg was discolored from the knee to the foot. The right great toe was covered with gauze and the tape was dated 11/23/15. LPN-B cut the tape from the dressing and removed the soiled dressing. The top of the right great toe was calloused with an open area that measured less than 0.5 centimeters (cm) at the top of the callous. The callous was yellow with blood specks on it. The dressing contained yellow drainage. LPN-B washed the wound with spray cleanser and wiped the toe with a 4 x 4 gauze using the right hand. LPN-B then applied a dry dressing to the great toe and taped dressing in place.	F 278	It is the policy of Bethany Residence & Rehabilitation Center that resident assessments that are performed are accurate. Resident #26 wound has been reassessed and a correction MDS has been submitted on 12/4/15. All MDS assessments are completed according to the RAI manual. Licensed nurses have been trained on observation and assessment of pressure ulcers. Audits of wounds have been performed for accurate MDS assessment documentation. Results will be reported at facility QAPI meeting. Director of Nursing is responsible for overall compliance.	

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F 278	Continued From page 9 R26's quarterly Minimum Data Set (MDS) dated 10/14/15, indicated R26 was cognitively impaired and had a stage two pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled or serosanguineous filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising) first seen 8/31/15. The quarterly MDS indicated the most severe tissue type present in the pressure ulcer was eschar (tan/black or brown dead tissue covering). R26's care plan revised on 10/21/15, indicated R26 had skin breakdown and noted the area to be a "Stage II pressure ulcer on right great toe." The Wound Assessment Flow Sheet for R26 indicated R26 had an acquired stage 2 wound on the right great toe and identified the following: An Assessment dated 10/7/15, indicated wound was 1 cm x 0.4 cm x 0.1 cm and filled with 90 percent (%) granulation (red tissue with bumpy appearance) tissue and 10% eschar. There was minimum drainage. An Assessment dated 10/14/15, indicated wound was 0.75 cm x 0.4 cm x 0.1 and filled with 90% granulation tissue and 10% eschar. There was no drainage. An Assessment dated 10/21/15, indicated wound was 0.5 cm x 0.4 cm x 0.1 and filled with 90% granulation tissue and 10% eschar. There was minimum drainage. During interview on 11/24/15, at 1:07 p.m. consultant registered nurse (RN) confirmed eschar would not be in a Stage II pressure ulcer.	F 278		

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F 278	Continued From page 10 On 11/25/15, at 9:10 a.m. RN-C MDS coordinator confirmed Stage II pressure ulcers do not have eschar. RN-C acknowledged R26's MDS was coded a Stage II pressure ulcer and eschar. RN-C said, "I must have just been copying from the nurse's note. I would usually verify and follow up with the nurse." The facility's Procedure for Treatment of Pressure Ulcer created 10/15, instructed staff to determine the stage of the ulcer as follows: "Stage II: Partial thickness loss of dermis [skin] presenting as a shallow open ulcer with a red or pink wound bed, without slough." "Stage IV: Full thickness tissue loss with exposed bone, tendon, cartilage or muscle. Slough or eschar may be present on some parts of the wound bed."	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure bedside rails were safely secured to the bed frame to minimize the risk of injury for 1 of 1 resident (R48) reviewed for accidents.	F 323	It is the policy of Bethany Residence & Rehabilitation Center that residents are kept free of accidents. Resident #48 has had a physical device	1/3/16

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F 323	Continued From page 11 Findings include: On 11/24/15, at 7:42 a.m. R28 was observed to be dressed, wearing tennis shoes, was in wheelchair entering theelevator, and proceeding to first floor dining room for breakfast. Care Area Assessment (CAA) dated 9/11/15, indicated R48 was unsteady with transitions and required staff assistance to stabilize at this time. R48 had left sided weakness from previous history of cerebrovascular accident (CVA). R48 required limited assistance with toileting due to unsteadiness. R48's 14 day Minimum Data Set (MDS) dated 9/15/15, indicated R48 was cognitively intact, independent with bed mobility, required limited two person assist with transfers, supervision one person assist walking in room, and limited one person assist with toileting and personal hygiene. The care plan dated 9/17/15, indicated R48 was moderate risk for falls related to cerebrovascular accident (CVA). Interventions included needed a safe environment. R48 had activities of daily living (ADL's) self-care performance deficit related to stroke, required assistance with transfers and toileting and at times needed assist of one with bed mobility. The goal was to improve current level of function with bed mobility and transfers. On 11/24/15, at 9:23 a.m. observed grab bar on right side of bed to be slightly loose. Observed grab bar on left side to be loose, wobbly, had gap between bed and grab bar, was in disrepair, screw was observed sitting on bedside table.	F 323	assessment performed and a new grab bar has been replaced on the bed. Care plan reflects his need for use of the device to facilitate bed mobility. The Physical Device Policy has been reviewed and is current. All staff have been educated on safety and prevention of accidents. Weekly audits for environmental and device safety will be performed by Administrator or designee and will be reported at facility QAPI meeting. Administrator is responsible for overall compliance.	

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F 323	Continued From page 12 During environmental tour on 11/24/15, at 12:29 p.m. administrator stated he was not aware of left grab bar being loose, and (Housekeeper)-B also stated she was not aware. The administrator measured left grab bar distance from bed mattress. He removed the screw sitting on bedside table and tightened the grab bar. Before the screw was in place, he stated grab bar measured three inches outward from bed mattress toward foot direction and two inches outward from bed mattress toward head direction. When the screw was tightened, grab bar measured two inches outward from bed mattress toward foot direction and 1-1/2 inches outward from bed mattress toward head direction. The administrator identified grab bars were not safe and stated they would be replaced. Bethany Residence & Rehabilitation Center Fall Prevention and Management Program dated 11/25/15, indicated "1. The Clinical Administrator is responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment in collaboration with facility equipment experts to aid in fall prevention." "4. Environmental Service and Engineering staff will assure environment is safe."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		1/3/16

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	245578	A. BUILDING ______ B. WING ______	11/25/2015

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F 329	Continued From page 13 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately monitor for adverse side effects and behaviors warranting the use of an antipsychotic medication for 1 of 5 residents (R29) who had been started on an antipsychotic medication reviewed for unnecessary medications. Findings include: At 11/24/15, at 7:15 a.m. R29 was observed sitting on edge of bed, watching the news. R29 requested a pitcher of water. At 7:23 a.m. licensed practical nurse (LPN)-B entered R29's room with a pitcher of water. R29 stated "Where's my purse? What did you do with my purse?" LPN-B responded "Did you put it in your drawer? May I look?" R29 stated "You took it." LPN-B asked, "Is this your purse on the bed?" R29	F 329	It is the policy of Bethany Residence & Rehabilitation Center that each resident's drug regimen must be free from unnecessary drugs. Resident #29 had an AIMS assessment performed. Monthly orthostatic blood pressure has been added to the treatment orders, target behaviors have been reviewed in accordance with the resident plan of care. Licensed staff have been re-educated on policy and procedure for use of psychotropic medications. All residents charts have been audited for Informed Consent for the use of psychotropic medications used for	

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F 329	Continued From page 14 stated "Oh did you put it there, ok." R29's quarterly Minimum Data Set (MDS) dated 11/4/15, indicated R29 was severely cognitively impaired, requiring assistance with all activities of daily living except eating. R29's diagnoses listed on the MDS included congestive heart failure, hypertension, depression and psychotic disorder with delusions (thought disorder with persistent false beliefs). R29 was on hospice. The pharmacist recommendation on 11/6/15, instructed facility staff to: 1) obtain consent 2) complete Aims assessment now and every 6 months 3) add patient specific Target Behaviors and non-pharmacological interventions to the MAR/TAR and care plan 4) add side effect monitoring 5) add orthostatic blood pressure check 1+days a month or per facility protocol Care Plan dated 11/16/15, indicated that R29 used Seroquel for a diagnoses of psychotic disorders with delusions and displays paranoid behaviors. The care plan also indicated R29 believed that staff were stealing from her. Interventions included monitor for side effects and target behaviors. The Order Summary sheet dated 11/25/15, indicated R29 was started on Seroquel 25 milligram every day for psychotic disorder with delusions on 11/5/15. The Target Behavior Sheets dated November 2015, indicated R29's target behaviors was that R29 isolated self in room. During interview on 11/25/15, at 8:13 a.m. registered nurse (RN)-B said, "When a resident is	F 329	behavior. Quarterly review will be done with MDS schedule. New psychotropic medication orders will be reviewed within seven days by the IDT for new residents. The Psychotropic Medication Policy and Procedure has been reviewed and is current. Quarterly audits during MDS for proper use and diagnosis of antipsychotics. Audits have been performed on all residents on antipsychotic medications for AIMS assessment, orthostatic blood pressure readings monthly and for appropriate target behavior monitoring. Results of audits will be reported at the facility QAPI meeting. Director of Nursing is responsible for overall compliance.	

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F 329	Continued From page 15 started on an antipsychotic medication, I put them on acute daily charting but I do not do the AIMs (Abnormal Involuntary movement test, a test for side effects of antipsychotic medication). I cannot answer what the policy is for AIMs or orthostatic blood pressures because I do not know. I check the orthostatic blood pressures monthly when they are on the treatment sheet. The people upstairs add all that to the orders. [RN-C] adds the target behaviors to the sheet and care plan. [R29's] target behavior is 'staying in her room.'" When asked did that match the diagnosis for Seroquel and care plan RN-B replied, "No not really. [R29] is delusional, [R29] thinks we are stealing her belongings. [R29] fixates on things and says things are missing when they are right there. [R29] has become more confused in the last couple of months as she has been more short of breath." On 11/25/15, at 9:56 a.m. the director of nurses (DON) said the staff should be doing the AIMS if pharmacy recommended it or whenever an antipsychotic medication was started. The DON confirmed she would expect orthostatic blood pressures to be done once a month for residents on an antipsychotic. DON verified that there was no AIMS or Orthostatic Blood Pressure on R29's chart for monitoring adverse side effects of the medication. On 11/25/15, at 10:49 a.m. pharmacist stated that an AIMS was expected for all residents on antipsychotic medication and he/she would make the decision if an orthostatic blood pressure were appropriate for R29 based on current medical condition. The pharmacist stated R29's target behaviors did not appear consistent with R29's diagnoses or care plan but that facility staff knew	F 329		

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F 329	Continued From page 16 the resident best. The facility policy for Monitoring Psychoactive Medications policy revised 6/12, instructed staff: "2. AIMS assessment will be done on admission for all resident's prescribed Antipsychotic Medications and on current residents with new orders to start Antipsychotic Medications and then done q 6 months thereafter while receiving medications."	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356		1/3/16

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F 356	Continued From page 17 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure daily nursing hours were posted as required. This had the potential to affect all 54 residents and the public. Findings include: During the initial entrance to the facility on 11/22/15, at 11:30 a.m. the staffing sheet was observed to be posted in a three ring binder. The most current posting of staff in front of the binder was for Friday, 11/20/15. The assistant director of mursing, (ADON) was interviewed on 11/22/15, at 2:15 p.m. and confirmed the front page in the staffing three ring binder was for Friday, 11/20/15, and was in a plastic page protector. Additional nursing posting was found by the ADON behind the Friday the 20th staff posting for Saturday the 21st, Sunday the 22nd and Monday the 23rd. The ADON confirmed the nursing posting was not current and the weekend staff had not brought forward the nursing posting each day. On 11/24/15, at 11:58 a.m. during the environmental tour the administrator stated the daily staff posting was supposed to be posted for the current day and on the weekend the charge nurse was responsible for making sure the staff posting was accurate.	F 356	It is the policy of Bethany Residence & Rehabilitation to post the nurse staffing data on a daily basis at the beginning of each shift. Format for posting of nurse staffing data has been reviewed and revised. Daily audits with be performed for 3 weeks, then weekly for one month to insure correct posting of staffing data. Results will be communicated to facility QAPI meeting. Director of Nursing is responsible for overall compliance.	

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F 441	Continued From page 18	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		1/3/16

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure appropriate hand washing and glove usage was done during a dressing change for 1 of 1 resident (R26) observed for pressure ulcers.

Findings include:

On 11/24/15, at 7:42 a.m. licensed practical nurse (LPN)-B was observed to complete a dressing change for R26's right toe. R26's leg was discolored from the knee to the foot. The right great toe was covered with gauze and the toe tape was dated 11/23/15. LPN-B cut the tape from the dressing, removed the soiled dressing and laid soiled scissors on floor. The top of the right great toe was calloused with an open area that measured less than 0.5 centimeter 9 cm) at the top of the callous. The callous was yellow with blood specks on it. The dressing contained yellow drainage. LPN-B washed the wound with spray cleanser and wiped with area with a gauze 4x4 using the right hand. LPN-B then dipped the right gloved hand into Eucerin cream (moisturizing cream) and applied the cream on R26 leg without changing the soiled gloves. LPN-B then removed right glove and applied a new glove without washing the hands. LPN-B applied a dry dressing to the great toe and taped a dressing on right great toe.

Interview on 11/24/15, at 8:00 a.m. LPN-B stated, "I did not wash between glove change because I did not change both gloves. I did not feel it was wrong to put the gloved hand I had used to clean

It is the policy of Bethany Residence & Rehabilitation to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

All licensed staff were educated on dressing change technique and infection control. Weekly audits will be performed for four weeks then monthly for 3 months to ensure proper infection control techniques with dressing changes.

Results of audit will be reviewed at facility QAPI meeting.

Dressing change policy and procedure was reviewed and current.

Director of Nursing is responsible for overall compliance.

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F 441	Continued From page 20 his toe, in the eucerin cream." On 11/24/15, at 9:43 a.m. registered nurse (RN)-A stated, "I expect staff to change gloves and wash their hands between dirty tasks and clean tasks. I expect them to follow standard precautions for infection control." On 11/25/15, at 9:47 a.m. the director of nurses (DON) expeced staff to wash hands between glove changes especially if there was a visible staining on the gloves or dressings. The DON confirmed staff should not be using the same gloves they used to do a dressing change to remove a cream and spread it on a residents legs. The staff should change gloves first. The facility Procedure for Treatment of Pressure Ulcer created 10/15, instructed staff: Put on exam glove. Loosen tape and remove dressing. Pull glove over dressing and discard into plastic bag. Wash hands. Put on disposable gloves. If irrigation is ordered hold device one to six inches from the ulcer and spray with solution. Dress the pressure ulcer with the prescribed dressing. Use a no-touch technique. Use sterile tongue blades and applicators to remove ointments and cream from their containers.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.	F 456		1/3/16

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F 456	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 3 residents (R11, R14) reviewed for environmental concerns, had their wheelchairs maintained in good repair. Findings include: R11's wheelchair left armrest on 11/22/15, at 12:07 p.m. during meal observation was observed wrapped all around it with gray duct tape. The gray tape was noted to be wrinkled and not creating a seal and exposing the adhesive part not creating a cleanable surface. -At 4:06 p.m. during interview R11's wheelchair remained the same. When asked who assisted her with cares R11 stated the staff helped her with everything daily. On 11/24/15, at 11:58 a.m. to 12:16 p.m. the environmental tour was completed for first floor with the administrator. During the tour the administrator verified and acknowledged R11's armrest was not a cleanable surface. Stated no staff had brought the wheelchair condition to his attention. Administrator stated staff had stopped to report anything to the previous management as things were not being addressed but since he had started at the facility staff had been told to report all concerns to him. R11's annual Minimum Data Set (MDS) dated 8/19/15, indicated R11 had intact cognition, required extensive physical assistance of two staff with transfers from bed to wheelchair, was identified as un-steady and used a wheelchair for mobility.	F 456	It is the policy of Bethany Residence and Rehabilitation Center to maintain the functionality and safety of all wheelchairs. Resident #11 and #16 have had wheelchairs repaired or replaced. All wheelchairs have been reviewed for safety, and functionality and all issues related to wheelchair repairs have been addressed. Staff have been educated on the need to report unsafe equipment or equipment that is need of repair. Audits of wheelchairs will be performed monthly and reported to QAPI. Administrator is responsible for overall compliance.	

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F 456	Continued From page 22 R16's wheelchair was observed to be in ill repair On 11/23/15, at 2:00 p.m. both wheelchair armrest were observed ripped with foam padding exposed and coming out of rip. Both armrest vinyl was observed to be chipped which exposed the mesh underneath, making it an uncleanable surface. During the tour on 11/24/15, the administrator verified the vinyl on both armrests was had peeled off and was exposing the foam acknowledged was not a cleanable surface. Administrator stated staff had not brought the concern to his attention. R16's quarterly MDS dated 10/21/15, indicated R16 had moderately impaired cognition, had functional limitation of both upper and lower extremity on one side, was identified as un-steady and needed assist of one for surface to surface transfers, which included transfers from bed to wheelchair. In addition the MDS indicated R16 used a wheelchair for locomotion.	F 456		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide an	F 465	It is the policy of Bethany Residence and Rehabilitation Center to maintain the	1/3/16

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F 465	Continued From page 23 environment that was clean and in good repair. In addition, the facility failed to ensure the carpet floor was in good repair which had the potential to affect all 54 residents, staff and visitors. Findings include: Closet door On 11/22/15, at 4:16 p.m. upon entering R11's room during room observation, the door to the closet was noted off the hinge and was hanging loosely to the right end/side. The track was completely gone leaving holes with chipped paint and holes where nails had been holding the track. On 11/24/15, at 11:58 a.m. to 12:16 p.m. during the environmental tour the administrator verified the closet door was hanging loosely and stated he had instructed the staff to make sure the loose doors were to the side to make sure it was not a safety issue. When asked if R11's closet door had been identified, administrator stated he would provide some information and was not certain if R11's closet door was one of them which he was aware of. -At 1:52 p.m. the administrator approached and provided an audit completed 11/19/15, and verified R11's door had not been listed with concerns at the time. Shower room flooring On 11/22/15, at 11:48 a.m. during the initial facility tour the grey rubber flooring with transition outside shower room located across from the 1 South nursing station was observed to be frayed and hanging loose. On 11/23/15, at 8:45 a.m. through 10:45 a.m. observed several staff and go past the area including the interim director of nursing no one acknowledged the loose hanging transition rubber. At 2:13 p.m. when surveyor was going	F 465	facility in a clean, safe and function state of repair. A new maintenance policy has been written and all staff have been educated on the proper process for reporting maintenance and safety issues. Per areas identified during the survey process the following areas are being repaired: Resident R11's closet door has been removed and walls repaired. Transition strips from hallway to 1 South shower room. Resident R61 and R6 doorknobs tightened. Resident R38 wheelchair repaired or replaced. The wall by the bathroom sink in resident R65's bathroom. The scale in the 2 North hallway will be replaced or repaired. All carpeting has been evaluated and will be replaced and/or repaired in order to meet all applicable safety and infection control standards. In some cases carpeting will be replaced, in other areas repairs may be made. Repairs will be made to corridor plaster and paint as identified in the following areas: 2nd floor elevator, the hallway between room 226 and shower room, the area	

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past the area got caught and brought it to a staff attention who was at the desk at the time.
On 11/24/15, at 7:18 a.m. to 8:00 a.m. nursing assistants (NA)-A and NA-B were observed going in and out of the shower room but none brought the concern up of the loose frayed rubber.
On 11/24/15, during the tour the administrator verified it and indicated the rubber transition strip was cracked and broken/frayed. Administrator stated he was not aware and no staff had brought it to his attention.
Taped carpet
On 11/23/15, at 2:46 p.m. through 11/24/15, at 9:00 a.m. on the door between 1 North unit and library room where the aquarium was located in was observed with approximately 36 inch long clear tape across the entire length not creating a cleanable surface. On 11/24/15, during the tour the administrator verified if and acknowledged was not cleanable. Administrator stated he would actually put a transition stripe in that area.
On 11/25/15, at 12:25 p.m. during environmental tour with the administrator, the following were observed and verified.
R61 and R6's room doorknob was observed to be loose.
On 11/24/15 at 12:25 p.m. administrator stated they would fix the room doorknob right away.
R61's quarterly Minimum Data Set (MDS) dated 8/26/15, indicated R61 had moderate cognitive impairment and required independent to limited one person assist with most activities of daily living (ADL's).
R6's admission MDS dated 8/25/15, indicated R6 was cognitively intact and was independent to limited one person assist with most ADL's.

R38's wheel chair arms had worn vinyl down to the threads with foam sticking out on both arms.

outside room 222 and near the nurse's station, outside room 213 as well as the door jam stipping for room 228.

Weekly audits of Maintenance Log will be conducted to ensure timeliness of repairs on reported issues. Weekly visual inspections will also be completed by the Administrator and designee. Staff interviews related to building repairs will also be conducted at this time.

Administrator will be responsible for overall compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING ______ B. WING ______	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

(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 465	Continued From page 25 During environmental tour, resident was not in the room. Administrator stated he would ensure wheelchair was on the list to be replaced. R38's quarterly MDS dated 8/19/15, indicated R38 had severe cognitive impairment and required extensive two person assist with most ADL's. R65's room had an area of wall board missing below the sink mirror on the right side measuring approximately four inches by four inches. -During tour, administrator stated he was not aware of the wall gouge where soap dispenser may have been hanging, but indicated it would be repaired. R65's admission MDS dated 10/30/15, indicated R65 was cognitively intact and required limited one to two person assist with most ADL's. During tour the following concerns were observed and verified by the administrator who stated they would be repaired. Carpeting: Carpet in 2S hallway outside closed hazardous chemical storage door had large round yellow spot and several medium yellow spots. Carpet between rooms 234 and 227 was observed to have approximately four foot repair line with several ripples in the carpet. Three small white spots in carpet near 2N nurse's station. Hallway carpet had jagged area where carpet had been pieced together between rooms 227 and 234. Multiple ripples in 2N hallway carpet near room 234. Hallway carpet between rooms 222 and 211 had piece of packing tape covering approximately a four foot split in the carpet.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING ______ B. WING ______	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

(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 465	Continued From page 26 Large area of carpet wear beneath 2N nurse station chair. Round medium size red spot on carpet outside 2N medication room door. Round medium size white spot on hallway carpet outside room 215. Standing scale in 2N hallway near nurse station had multiple rips measuring approximately 4-8 inches in black flooring on elevated side of scale. Black foam handles were ripped on left handle measuring approximately 8-10 inches and chunk of black foam measuring approximately 6-8 inches missing on the right handle. Second floor elevator had moderate size jagged white paint splotches on both lower sides of entryway. Scratches measuring approximately four inches in length on lower hallway wall between room 226 and the shower room. Two scratches measuring approximately three and five inches in length on hallway wall outside room 222. Large gouge on lower hallway plaster wall near 2N nurse's station outside day room door.-Two small white holes on lower hallway wall outside room 213. Loose black weather strip on lower inside part of room 228 door. When asked when there was a maintenance problem how the concern would be addressed, administrator displayed maintenance log book residing at the 2N nurse's station. Problems were tracked by date, description, location, individual who requested it and individual that repaired it. He thought when staff informed nurse of a problem, it was written in the log book.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING ______ B. WING ______	11/25/2015

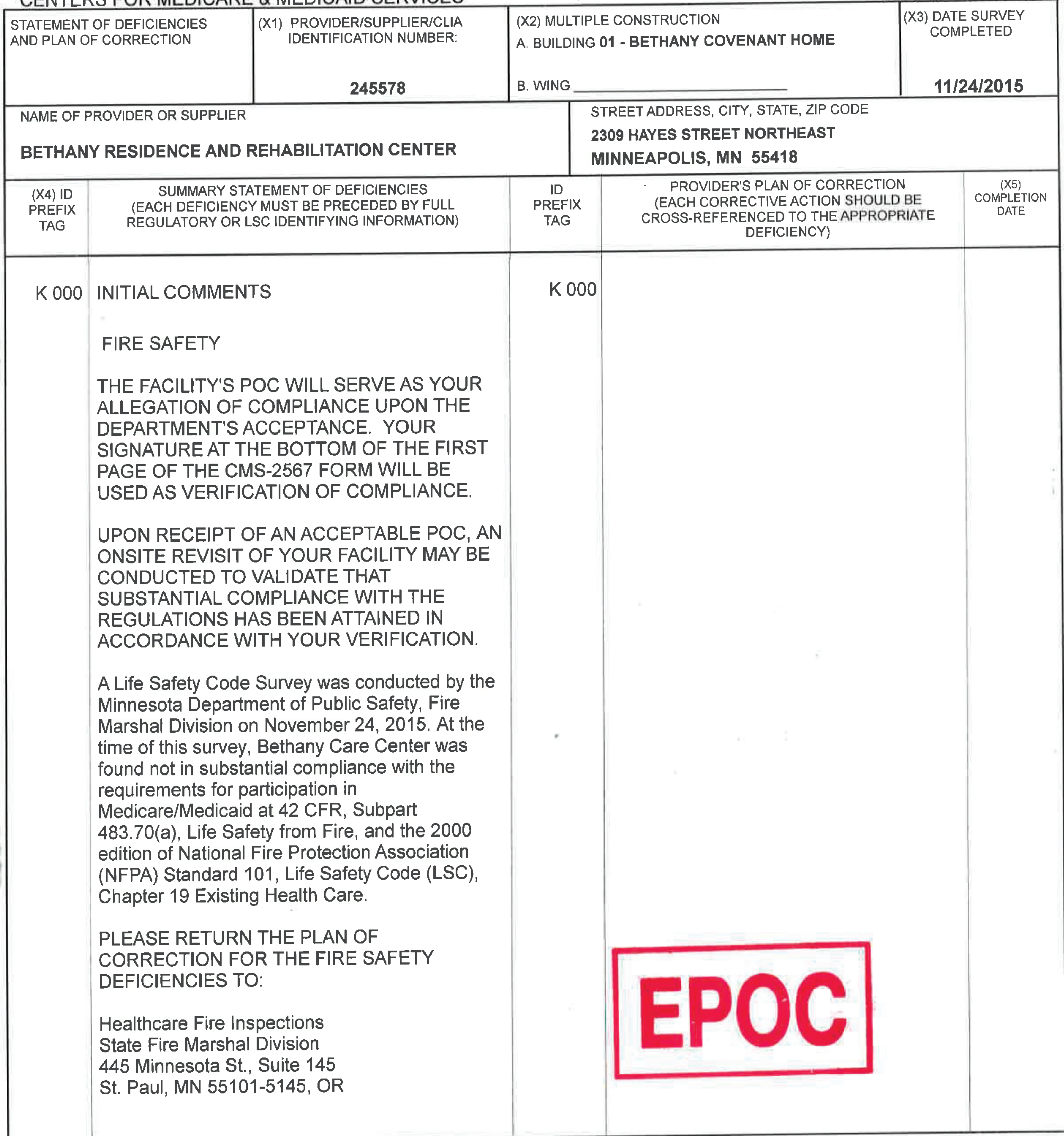
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

(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 465	Continued From page 27 Administrator stated that was a new system which began in June of 2015 and housekeeper-B and housekeeper-A typically checked it daily. In addition, administrator stated there was a log book at the first floor nurse's station. No maintenance policy was provided.	F 465		

F5578025

PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

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
	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING ____________	**11/24/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

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K 000	INITIAL COMMENTS	K 000		

INITIAL COMMENTS

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on November 24, 2015. At the time of this survey, Bethany Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/21/2015

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
	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING ______	11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

(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 1 By email to: Marian.Whitney@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. Bethany Care Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II(222) construction. The building is has a full fire sprinkler system in accordance with NFPA 13, 1999 Ed.. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 66 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is	K 050		1/3/16

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
	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING ______	**11/24/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

(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 050	Continued From page 2 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of records and staff interview, it was determined that the facility failed to conduct the required number of fire drills for each shift in the last 12-month period and vary the times in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 53 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 11/24/2015, a review of the available fire drill reports in 2015 revealed that the facility missed an Night-shift fire drill in the 3rd quarter and conducted Day-Shift fire drills between the hours of 10:00 AM-11:00 AM not varying the times in accordance with Section 19.7.1.2. This deficient practice was confirmed by the Administrator.	K 050	Facility Fire Drill policy was reviewed and revised. A new fire drill schedule has been developed to reflect more variable times during various shifts. Schedule will also insure that all shifts are covered in accordance with policy. administrator is responsible for overall compliance.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		1/3/16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245578	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BETHANY COVENANT HOME B. WING	(X3) DATE SURVEY COMPLETED 11/24/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

(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 062	Continued From page 3 This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect all 53 residents. Findings include: On facility tour between 9:30 AM and 12:30 PM on 11/24/2015, record review revealed that there was no documentation of the 2nd quarter fire sprinkler flow inspection in 2015. This deficient practice was verified by the Administrator at the time of the inspection.	K 062	fire sprinkler system contractor was contacted to discuss inspection frequency for fire sprinkler system. Inspection frequency changed to quarterly. Fire extinguisher flow inspection scheduled for January, April, July and September 2016. Administrator responsible for overall compliance.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide and maintain cooking facilities in accordance with the requirements of NFPA 101-2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96-1998 edition. This deficient practice could affect 53 residents. Findings include: On facility tour between the hours of 9:30 AM and 12:30 PM on 11/24/2015, an inspection of the kitchen range hood fire extinguishing system	K 069	K-type fire extinguisher has been acquired and placed in the kitchen. Administrator is responsible for overall compliance.	12/28/15

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
	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING ______	**11/24/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION CENTER	**2309 HAYES STREET NORTHEAST** **MINNEAPOLIS, MN 55418**

(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 069	Continued From page 4 consisted of a wet chemical system, however there were no K-Type fire extinguisher in the kitchen area as required by NFPA 96- 1998 edition.	K 069		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: During documentation review and staff interview, the facility has failed to properly document weekly and monthly inspections of the emergency generator in accordance with NFPA 110(99). This deficient practice could affect all 53 residents in the event of a loss of power and generator failure. Findings include: During the facility tour between the hours of 9:30 AM and 12:30 PM on 11/24/2015, during documentation review it was revealed that the facility could not provide documentation of the weekly inspections and the monthly generator run test in accordance with NFPA 110 (99). This deficient practice was confirmed by the Administrator.	K 144	Facility Policy for generators inspections has been reviewed and revised. A new log form has been developed and designated staff have been trained on proper procedures for performing weekly inspections and monthly generator tests. Administrator is responsible for overall compliance.	1/3/16

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
December 10, 2015

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5578026

Dear Mr. Kallstrom:

The above facility was surveyed on November 22, 2015 through November 25, 2015 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, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state

statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should 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,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: ____ B. WING ____	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: ______ B. WING ______	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 22, 2015 through 11/25/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

Minnesota Department of Health

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 observation, interview and document review, facility failed to ensure bedside rails were safely secured to the bed frame to minimize the risk of injury for 1 of 1 resident (R48) reviewed for accidents. Findings include: On 11/24/15, at 7:42 a.m. R28 was observed to be dressed, wearing tennis shoes, was in wheelchair entering theelevator, and proceeding to first floor dining room for breakfast.	2 830	Corrected	12/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

(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
2 830	Continued From page 3	2 830		

Care Area Assessment (CAA) dated 9/11/15, indicated R48 was unsteady with transitions and required staff assistance to stabilize at this time. R48 had left sided weakness from previous history of cerebrovascular accident (CVA). R48 required limited assistance with toileting due to unsteadiness.

R48's 14 day Minimum Data Set (MDS) dated 9/15/15, indicated R48 was cognitively intact, independent with bed mobility, required limited two person assist with transfers, supervision one person assist walking in room, and limited one person assist with toileting and personal hygiene.

The care plan dated 9/17/15, indicated R48 was moderate risk for falls related to cerebrovascular accident (CVA). Interventions included needed a safe environment. R48 had activities of daily living (ADL's) self-care performance deficit related to stroke, required assistance with transfers and toileting and at times needed assist of one with bed mobility. The goal was to improve current level of function with bed mobility and transfers.

On 11/24/15, at 9:23 a.m. observed grab bar on right side of bed to be slightly loose. Observed grab bar on left side to be loose, wobbly, had gap between bed and grab bar, was in disrepair, screw was observed sitting on bedside table.

During environmental tour on 11/24/15, at 12:29 p.m. administrator stated he was not aware of left grab bar being loose, and (Housekeeper)-B also stated she was not aware. The administrator measured left grab bar distance from bed mattress. He removed the screw sitting on bedside table and tightened the grab bar. Before the screw was in place, he stated grab bar measured three inches outward from bed

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2 830	Continued From page 4 mattress toward foot direction and two inches outward from bed mattress toward head direction. When the screw was tightened, grab bar measured two inches outward from bed mattress toward foot direction and 1-1/2 inches outward from bed mattress toward head direction. The administrator identified grab bars were not safe and stated they would be replaced. Bethany Residence & Rehabilitation Center Fall Prevention and Management Program dated 11/25/15, indicated "1. The Clinical Administrator is responsible for assuring implementation of this policy, for providing a safe environment, and for maintaining appropriate equipment in collaboration with facility equipment experts to aid in fall prevention." "4. Environmental Service and Engineering staff will assure environment is safe." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could train all staff and perform audits to ensure each resident is receiving appropriate care for the use of safety devices. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		1/3/16

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21385	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation interview and document review, the facility failed to ensure appropriate hand washing and glove usage was done during a dressing change for 1 of 1 resident (R26) observed for pressure ulcers. Findings include: On 11/24/15, at 7:42 a.m. licensed practical nurse (LPN)-B was observed to complete a dressing change for R26's right toe. R26's leg was discolored from the knee to the foot. The right great toe was covered with gauze and the toe tape was dated 11/23/15. LPN-B cut the tape from the dressing, removed the soiled dressing and laid soiled scissors on floor. The top of the right great toe was calloused with an open area that measured less than 0.5 centimeter 9 cm) at the top of the callous. The callous was yellow with blood specks on it. The dressing contained yellow drainage. LPN-B washed the wound with spray cleanser and wiped with area with a gauze 4x4 using the right hand. LPN-B then dipped the right gloved hand into Eucerin cream (moisturizing cream) and applied the cream on R26 leg without changing the soiled gloves. LPN-B then removed right glove and applied a new glove without washing the hands. LPN-B applied a dry dressing to the great toe and taped a dressing on right great toe. Interview on 11/24/15, at 8:00 a.m. LPN-B stated, "I did not wash between glove change because I did not change both gloves. I did not feel it was wrong to put the gloved hand I had used to clean his toe, in the eucerin cream."	21385	Corrected	

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21385	Continued From page 6 On 11/24/15, at 9:43 a.m. registered nurse (RN)-A stated, "I expect staff to change gloves and wash their hands between dirty tasks and clean tasks. I expect them to follow standard precautions for infection control." On 11/25/15, at 9:47 a.m. the director of nurses (DON) expeced staff to wash hands between glove changes especially if there was a visible staining on the gloves or dressings. The DON confirmed staff should not be using the same gloves they used to do a dressing change to remove a cream and spread it on a residents legs. The staff should change gloves first. The facility Procedure for Treatment of Pressure Ulcer created 10/15, instructed staff: Put on exam glove. Loosen tape and remove dressing. Pull glove over dressing and discard into plastic bag. Wash hands. Put on disposable gloves. If irrigation is ordered hold device one to six inches from the ulcer and spray with solution. Dress the pressure ulcer with the prescribed dressing. Use a no-touch technique. Use sterile tongue blades and applicators to remove ointments and cream from their containers. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing or designee(s) may review or revise policies and procedures requiring proper infection control methods, provide an in-service in regard to these policies and procedures, and conduct audits to ensure the policies and procedures are being implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		1/3/16
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow State guidelines to ensure Employee Tuberculosis (TB) screening, Tuberculin Skin Test (TST), symptom screening and medical evaluations for 5 of 5 employees (EE-1, EE-2, EE-3, EE-4, EE-5) were completed before providing direct care and 2 of 5 residents (R43, R21) had not completed TB screening. In addition, the facility failed to have a TB risk assessment for the facility. Findings include:		It is the policy of Bethany Residence and Rehabilitation Center to maintain a Tuberculosis Prevention and Control Plan based on the CDC's guidelines. The facility's Tuberculosis Policy was reviewed and updated. EE-1, EE-2, EE-3, EE-4 and EE-5 completed the proper screening questionnaire and were screened using a 2-step Mantoux.	

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21426	Continued From page 8 A review of the employee records was completed on 11/24/15, at approximately 12:00 p.m. with the assistant director of nursing (ADON) and the facility's registered nurse (RN) Consultant. The results of employee records indicated the following: EE-1, a RN was hired on 9/29/1. EE-1's personnel record lacked a screening for signs and symptoms of TB. A chest x-ray was done on 12/13/11 which was negative. EE-2, a nursing assistant (NA) was hired on 10/2/15. EE-2's personnel file lacked evidence of TST, TB symptom screening, and/or chest x-ray. EE-3, a licensed practical nurse (LPN) was hired on 10/2/15. EE-3's personnel record lacked evidence of TST and /or chest x-ray. EE-4, a dietary aide (DA), was hired on 10/16/15. EE-4's personnel record lacked evidence of TST and /or chest x-ray. EE-5, a NA was hired on 10/16/15. EE-5's personnel record lacked evidence of TB symptom screening, TST and or chest x-ray. R43 was admitted to the facility on 6/5/15. R43's medical record and lacked documentation of results on the 2nd step TST which was done on 6/18/15. R21 was admitted to the facility on 2/7/11. R21's medical record lacked symptom screening for TB. R21 had a two step Mantoux on 3/10/11 and 3/18/11. The results of the two step Mantoux had not been documented.	21426	In addition all staff files were audited to insure all staff meet the facility guidelines. Residents R43 and R21 were re-administered tuberculosis screenings. In addition all residents were audited for current compliance with facility tuberculosis screenings. Administrator is responsible for overall compliance.	

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21426	Continued From page 9	21426		

The facility's policy on Tuberculosis Policy and Procedure, revised on 6/15, indicated the facility would screen all employees and residents with 2-step Mantoux and screen questionnaire on admission. Annual Mantoux for staff unless history of positive Mantoux. If the employee had a history of positive Mantoux or allergic reaction the employee must provide proof of the positive Mantoux or allergy if they are unable to they would be required to have a Mantoux and then with positive results would be required to go to clinic for CXR and appointment to be cleared by a physician. That appointment must include a physician to see the employee and evaluate for symptoms. After that the employee would fill out the screening sheet on an annual basis. Employees that have emigrated from another country and received the BCG vaccine are not exempt from the Mantoux per CDC and are required to receive the Mantoux.

The RN consultant completed the facility's risk assessment during the survey on 11/24/15.

The administrator was interviewed on 11/25/15, at 10:30 a.m. and confirmed no additional information had been found for TB testing and screening for the staff and residents reviewed. The administrator provided a document with the letter head of the facility (no date) which indicated, "Administrator will complete TB screening. If Mantoux is indicated, new hire will be sent to nursing to get Mantoux."

SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to the required tuberculosis skin testing process. The quality assessment and assurance committee could perform random audits to

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21426	Continued From page 10 ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor for adverse side effects and behaviors warranting the use of an antipsychotic medication for 1 of 5 residents (R29) who had been started on an	21540	Corrected	1/3/16

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21540	Continued From page 11 antipsychotic medication reviewed for unnecessary medications. Findings include: At 11/24/15, at 7:15 a.m. R29 was observed sitting on edge of bed, watching the news. R29 requested a pitcher of water. At 7:23 a.m. licensed practical nurse (LPN)-B entered R29's room with a pitcher of water. R29 stated "Where's my purse? What did you do with my purse?" LPN-B responded "Did you put it in your drawer? May I look?" R29 stated "You took it." LPN-B asked, "Is this your purse on the bed?" R29 stated "Oh did you put it there, ok." R29's quarterly Minimum Data Set (MDS) dated 11/4/15, indicated R29 was severely cognitively impaired, requiring assistance with all activities of daily living except eating. R29's diagnoses listed on the MDS included congestive heart failure, hypertension, depression and psychotic disorder with delusions (thought disorder with persistent false beliefs). R29 was on hospice. The pharmacist recommendation on 11/6/15, instructed facility staff to: 1) obtain consent 2) complete Aims assessment now and every 6 months 3) add patient specific Target Behaviors and non-pharmacological interventions to the MAR/TAR and care plan 4) add side effect monitoring 5) add orthostatic blood pressure check 1+days a month or per facility protocol Care Plan dated 11/16/15, indicated that R29 used Seroquel for a diagnoses of psychotic disorders with delusions and displays paranoid behaviors. The care plan also indicated R29 believed that staff were stealing from her. Interventions included monitor for side effects	21540		

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21540	Continued From page 12 and target behaviors. The Order Summary sheet dated 11/25/15, indicated R29 was started on Seroquel 25 milligram every day for psychotic disorder with delusions on 11/5/15. The Target Behavior Sheets dated November 2015, indicated R29's target behaviors was that R29 isolated self in room. During interview on 11/25/15, at 8:13 a.m. registered nurse (RN)-B said, "When a resident is started on an antipsychotic medication, I put them on acute daily charting but I do not do the AIMs (Abnormal Involuntary movement test, a test for side effects of antipsychotic medication). I cannot answer what the policy is for AIMs or orthostatic blood pressures because I do not know. I check the orthostatic blood pressures monthly when they are on the treatment sheet. The people upstairs add all that to the orders. [RN-C] adds the target behaviors to the sheet and care plan. [R29's] target behavior is 'staying in her room.'" When asked did that match the diagnosis for Seroquel and care plan RN-B replied, "No not really. [R29] is delusional, [R29] thinks we are stealing her belongings. [R29] fixates on things and says things are missing when they are right there. [R29] has become more confused in the last couple of months as she has been more short of breath." On 11/25/15, at 9:56 a.m. the director of nurses (DON) said the staff should be doing the AIMS if pharmacy recommended it or whenever an antipsychotic medication was started. The DON confirmed she would expect orthostatic blood pressures to be done once a month for residents on an antipsychotic. DON verified that there was	21540		

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21540	Continued From page 13 no AIMS or Orthostatic Blood Pressure on R29's chart for monitoring adverse side effects of the medication. On 11/25/15, at 10:49 a.m. pharmacist stated that an AIMS was expected for all residents on antipsychotic medication and he/she would make the decision if an orthostatic blood pressure were appropriate for R29 based on current medical condition. The pharmacist stated R29's target behaviors did not appear consistent with R29's diagnoses or care plan but that facility staff knew the resident best. The facility policy for Monitoring Psychoactive Medications policy revised 6/12, instructed staff: "2. AIMS assessment will be done on admission for all resident's prescribed Antipsychotic Medications and on current residents with new orders to start Antipsychotic Medications and then done q 6 months thereafter while receiving medications." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean,	21665		1/3/16

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21665	Continued From page 14 functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: On 11/25/15, at 12:25 p.m. during environmental tour with the administrator, the following were observed and verified. R61 and R6's room doorknob was observed to be loose. On 11/24/15 at 12:25 p.m. administrator stated they would fix the room doorknob right away. R61's quarterly Minimum Data Set (MDS) dated 8/26/15, indicated R61 had moderate cognitive impairment and required independent to limited one person assist with most activities of daily living (ADL's). R6's admission MDS dated 8/25/15, indicated R6 was cognitively intact and was independent to limited one person assist with most ADL's. R38's wheel chair arms had worn vinyl down to the threads with foam sticking out on both arms. During environmental tour, resident was not in the room. Administrator stated he would ensure wheelchair was on the list to be replaced. R38's quarterly MDS dated 8/19/15, indicated R38 had severe cognitive impairment and required extensive two person assist with most ADL's. R65's room had an area of wall board missing below the sink mirror on the right side measuring approximately four inches by four inches. -During tour, administrator stated he was not aware of the wall gouge where soap dispenser may have been hanging, but indicated it would be repaired.	21665	Corrected	

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21665	Continued From page 15 R65's admission MDS dated 10/30/15, indicated R65 was cognitively intact and required limited one to two person assist with most ADL's. During tour the following concerns were observed and verified by the administrator who stated they would be repaired. Carpeting: Carpet in 2S hallway outside closed hazardous chemical storage door had large round yellow spot and several medium yellow spots. Carpet between rooms 234 and 227 was observed to have approximately four foot repair line with several ripples in the carpet. Three small white spots in carpet near 2N nurse's station. Hallway carpet had jagged area where carpet had been pieced together between rooms 227 and 234. Multiple ripples in 2N hallway carpet near room 234. Hallway carpet between rooms 222 and 211 had piece of packing tape covering approximately a four foot split in the carpet. Large area of carpet wear beneath 2N nurse station chair. Round medium size red spot on carpet outside 2N medication room door. Round medium size white spot on hallway carpet outside room 215. Standing scale in 2N hallway near nurse station had multiple rips measuring approximately 4-8 inches in black flooring on elevated side of scale. Black foam handles were ripped on left handle measuring approximately 8-10 inches and chunk of black foam measuring approximately 6-8 inches missing on the right handle. Second floor elevator had moderate size jagged	21665		

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21665	Continued From page 16 white paint splotches on both lower sides of entryway. Scratches measuring approximately four inches in length on lower hallway wall between room 226 and the shower room. Two scratches measuring approximately three and five inches in length on hallway wall outside room 222. Large gouge on lower hallway plaster wall near 2N nurse's station outside day room door.-Two small white holes on lower hallway wall outside room 213. Loose black weather strip on lower inside part of room 228 door. When asked when there was a maintenance problem how the concern would be addressed, administrator displayed maintenance log book residing at the 2N nurse's station. Problems were tracked by date, description, location, individual who requested it and individual that repaired it. He thought when staff informed nurse of a problem, it was written in the log book. Administrator stated that was a new system which began in June of 2015 and housekeeper-B and housekeeper-A typically checked it daily. In addition, administrator stated there was a log book at the first floor nurse's station. No maintenance policy was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings,	21685		1/3/16

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	00167	A. BUILDING: ____ B. WING ____	11/25/2015

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21685	Continued From page 17 systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 3 residents (R11, R14) reviewed for environmental concerns, had their wheelchairs maintained in good repair. Findings include: R11's wheelchair left armrest on 11/22/15, at 12:07 p.m. during meal observation was observed wrapped all around it with gray duct tape. The gray tape was noted to be wrinkled and not creating a seal and exposing the adhesive part not creating a cleanable surface. -At 4:06 p.m. during interview R11's wheelchair remained the same. When asked who assisted her with cares R11 stated the staff helped her with everything daily. On 11/24/15, at 11:58 a.m. to 12:16 p.m. the environmental tour was completed for first floor with the administrator. During the tour the administrator verified and acknowledged R11's armrest was not a cleanable surface. Stated no staff had brought the wheelchair condition to his attention. Administrator stated staff had stopped to report anything to the previous management as things were not being addressed but since he had started at the facility staff had been told to report all concerns to him. R11's annual Minimum Data Set (MDS) dated	21685	Corrected	

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21685	Continued From page 18 8/19/15, indicated R11 had intact cognition, required extensive physical assistance of two staff with transfers from bed to wheelchair, was identified as un-steady and used a wheelchair for mobility. R16's wheelchair was observed to be in ill repair On 11/23/15, at 2:00 p.m. both wheelchair armrest were observed ripped with foam padding exposed and coming out of rip. Both armrest vinyl was observed to be chipped which exposed the mesh underneath, making it an uncleanable surface. During the tour on 11/24/15, the administrator verified the vinyl on both armrests was had peeled off and was exposing the foam acknowledged was not a cleanable surface. Administrator stated staff had not brought the concern to his attention. R16's quarterly MDS dated 10/21/15, indicated R16 had moderately impaired cognition, had functional limitation of both upper and lower extremity on one side, was identified as un-steady and needed assist of one for surface to surface transfers, which included transfers from bed to wheelchair. In addition the MDS indicated R16 used a wheelchair for locomotion. SUGGESTED METHOD OF CORRECTION: The Administrator and/or designee could review the facility's processes for preventative maintenance and inservice responsible staff. They could develop a system to consistently monitor the maintenance/cleanliness of wheelchairs in the facility. TIME PERIOD FOR CORRECTION: Twenty-one	21685		

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21685	Continued From page 19 (21) days.	21685		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the	21830		12/21/15

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21830	Continued From page 20	21830		

esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:
(1) examining the personal effects of the resident;
(2) examining the medical records of the resident in the possession of the facility;
(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and
(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.
(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law

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21830	Continued From page 21 enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident preferences was accommodated for bathing for 2 of 4 residents (R4, R16) reviewed for choices in daily routine. This had the potential to affect 18 residents who resided on the first floor of the facility. Findings include: R4's diagnoses included paraplegia, anxiety state, epilepsy, major depression, hemiplegia and hemiparesis obtained from Admission Record dated 11/25/15. On 11/22/15, at 5:15 p.m. during interview when asked if resident was able to choose whether to take a shower, tub or bed bath resident stated "No the facility has no tub always a shower. I wish we would have a bath and be able to make a choice." On 11/23/15, at 1:50 p.m. in front of the tub room door a housekeeping cart was observed stored and a transfer machine both blocked the door.	21830	Corrected	

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Surveyor moved the stuff and went into the tub room observed a tub bath with a sliding chair inside it.

On 11/24/15, at 7:18 a.m. a transfer lift machine and vacuum were stored in front of the tub room door.

On 11/23/15, at 3:15 p.m. when approached and asked if the unit had a tub bath anonymous staff stated "I don't think it works. I want the best for the residents here but this facility has been run down so much and it surprises me at some of the things here. I hope this new management will take up on something's and do the best." When asked if the staff actually gave residents a choice on their shower day staff stated "I don't think so."
-At 3:17 p.m. when approached and asked if the tub worked housekeeping (HK)-A stated "I don't think the tub down here has been used for a long time. The staff has stated they are not able it close it properly as it leaks. They just don't know how to work it. I and [HK-B] once closed it and filled it with water and it was just fine. The residents can go upstairs to get a tub bath there."

On 11/24/15, at 9:03 a.m. when asked about the shower day R4 stated she received a shower on Saturday and indicated "I have never been offered a choice for tub bath here if I was given a choice I would take the tub bath over the shower. I have always assumed they do not have a tub bath here as they say it's your shower day and I go."

On 11/24/15, at 9:11 a.m. when asked about residents bathing schedules (NA)-C stated, "Most of the residents don't like baths. The tub is upstairs a whirlpool bath. The tub down here does not work. I think they are in the process of

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21830	Continued From page 23 fixing it. I think it has been leaking. The one upstairs is much nicer. Sometimes the aides don't have time to take them upstairs because a shower is faster." On 11/24/15, at 10:20 a.m. the consultant registered nurse (RN) stated she would want resident's preferences to be asked in reference to bathing and staff needed to know a resident preference. R4's care plan dated 8/28/14, indicated R4 had an activities of daily living (ADL) self-care performance deficit related to left sided weakness, required extensive assist with dressing, toileting and bathing and limited assist with hygiene. The care plan directed staff to encourage R4 to participate to the fullest extent possible with each interaction. R4's annual Minimum Data Set (MDS) dated 8/19/15, indicated R4 had indicated when asked how important is was to choose between a tub bath, shower, bed bath, or sponge bath "Very Important." In addition the MDS indicated R4 had intact cognition. R4's ADL Care Area Assessment (CAA) dated 8/31/15, R4 required extensive assistance with dressing, toileting, and bathing; limited assistance with transfers and personal hygiene. In addition the cognitive Loss/dementia CAA dated 8/31/15, indicated R4's cognition was intact. R16's diagnoses included abnormality of gait, malignant neoplasm of larynx, tracheostomy, muscle weakness, osteoporosis and glaucoma	21830		

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obtained from Admission Record dated 11/25/15.

On 11/22/15, at 4:38 p.m. during interview when asked if resident was able to choose whether to take a shower, tub or bed bath resident stated "We don't take a tub bath here, they took them all out we get a shower."

On 11/24/15, at 9:33 a.m. when surveyor was in the tub room with both NA-A and NA-B, R16 approached and stated "I have only been given a bath one time since I have been in the facility. One time I was not even able to get it done because the staff was not able to close it and was leaking." When asked if the staff gave her a choice to get a tub bath upstairs resident stated "No the staff are too busy and it's busy upstairs. They just come and tell you it ' s your shower and help you into the shower."
-At 9:42 a.m. HK-B approached stated a while ago she had fixed the tub bath. She indicated it was working well. HK-B verified the water running out was rusty color and thought was because the tub had not been used for a while and if the water ran for a little longer would clear up. She indicated the water would be like that if it was not run even in her house.

The care plan dated 12/17/13, indicated R16 needed limited to extensive assist at times with personal hygiene and bathing.

R16's annual MDS dated 12/10/14, indicated R16 had indicated when asked how important it was to choose between a tub bath, shower, bed bath, or sponge bath "Very Important."

R16's ADL CAA dated 12/18/14, indicated required extensive assist with dressing and bathing.

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21830	Continued From page 25 R16's quarterly MDS dated 9/9/15, indicated R16 had intact cognition. On 11/24/15, at 9:27 a.m. the house keeping cart was observed parked outside the tub bathroom and a lift machine. NA-B, NA-A and surveyor went into the tub room after both NA's moved the stuff away. Surveyor requested both NA's to show how the tub worked. NA-A indicated he had only used the tub once for the last one year he had been working at the facility. NA-B stated she had used it only once in the last six months. Both NA's were observed to touch the door using the attached handle then closed it but a gap was noted at the bottom which leaked some water out. The running water was noted to be a rusty color and was not fading away even after running it for three to four minutes. When asked if the residents were given a choice of a tub bath, bed bath or shower. Both NA's stated they were not regular staff in the unit and were regular on the second floor and in that unit the residents were given a choice. Both indicated they would approach residents and told them "it's you shower day" and residents would come. Both acknowledged residents in the unit that were alert were not given the choice but rather were told "it's your shower." On 11/24/15, at 11:58 a.m. to 12:16 p.m. during the environmental tour when asked about resident first floor tub the administrator stated he was not aware that staff had not been using it until that morning when surveyor had brought the concern up. The administrator stated it had been indicated to him the tub had been fixed sometime when he started working at the facility in June that year. The administrator stated he would have expected staff to offer residents choices.	21830		

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21830	Continued From page 26 On 11/25/15, at 8:22 a.m. RN-C who also completed all the facility MDS' stated when the MDS was coded "very important" for preferences it meant the resident wanted to be given a choice of what they wanted. RN-B stated it was the facility policy to offer residents choice of a shower, tub bath or bed bath. On 11/25/15, at 9:20 a.m. the director of nursing (DON) stated she would expect staff to give residents choice and encourage them as much as possible to be involved in their care. When told the staff had indicated they did not have time and the shower was faster DON stated "that is a problem." SUGGESTED METHOD OF CORRECTION: The director of nursing and social worker could review and revise policies and procedures to ensure residents were offered choices for bathing. The social worker could inservice all staff to offer residents choices. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 10, 2015

Mr. Scott Kallstrom, Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

Re: Enclosed State Boarding Care Home Licensing Orders - Project Number S5578026

Dear Mr. Kallstrom:

The above facility survey was completed on November 25, 2015 for the purpose of assessing compliance with Minnesota Department of Health Boarding Care Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules 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.

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 Boarding Care 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 is 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 acknowledged electronically and submitted to this office at Minnesota Department of Health.

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria Derfus, Unit Supervisor at gloria.derfus@state.mn.us or (651) 201-3792.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

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3 000	INITIAL COMMENTS *****ATTENTION****** BOARDING CARE HOME LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are	3 000		

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3 000	Continued From page 1	3 000		

delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On November 22, 2015 through 11/25/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00167	A. BUILDING: ______ B. WING ______	11/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY RESIDENCE AND REHABILITATION	**2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418**

(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
3 000	Continued From page 2 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.	3 000		
3 601	MN St. Statute 144.56 Subp. 2c Tuberculosis Prevention And Control (a) A boarding care home must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of The guidelines. (b) Written compliance with this subdivision must be maintained by the boarding care home. This MN Requirement is not met as evidenced	3 601		1/3/16

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3 601	Continued From page 3 by: Based on interview and document review, the facility failed to follow State guidelines to ensure Employee Tuberculosis (TB) screening, Tuberculin Skin Test (TST), symptom screening and medical evaluations for 1 of 5 employees (EE-4) was completed before providing dietary services. In addition, the facility failed to have a TB risk assessment for the facility. This had the potential to affect all 10 residents who resided in the facility. Findings include: A review of the employee records was completed on 11/24/15, at approximately 12:00 p.m. with the assistant director of nursing (ADON) and the facility's registered nurse (RN) Consultant. The results of employee records indicated the following: EE-4, a dietary aide (DA), was hired on 10/16/15. EE-4's personnel record lacked evidence of TST and /or chest x-ray. The facility's policy on Tuberculosis Policy and Procedure, revised on 6/15, indicated the facility would screen all employees and residents with 2-step Mantoux and screen questionnaire on admission. Annual Mantoux for staff unless history of positive Mantoux. If the employee had a history of positive Mantoux or allergic reaction the employee must provide proof of the positive Mantoux or allergy if they are unable to they would be required to have a Mantoux and then with positive results would be required to go to clinic for CXR and appointment to be cleared by a physician. That appointment must include a physician to see the employee and evaluate for symptoms. After that the employee would fill out	3 601	It is the policy of Bethany Residence and Rehabilitation Center to maintain a Tuberculosis Prevention and Control Plan based on the CDC's guidelines. The facility's Tuberculosis Policy was reviewed and updated. EE-4 completed the proper screening questionnaire and was screened using a 2-step Mantoux. In addition all staff files were audited to insure all staff meet the facility guidelines. Administrator is responsible for overall compliance.	

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3 601	Continued From page 4 the screening sheet on an annual basis. Employees that have emigrated from another country and received the BCG vaccine are not exempt from the Mantoux per CDC and are required to receive the Mantoux. The RN consultant completed the facility's risk assessment during the survey on 11/24/15. The administrator was interviewed on 11/25/15, at 10:30 a.m. and confirmed no additional information had been found for TB testing and screening for the dietary staff reviewed. The administrator provided a document with the letter head of the facility (no date) which indicated, "Administrator will complete TB screening. If Mantoux is indicated, new hire will be sent to nursing to get Mantoux." TIME PERIOD FOR CORRECTION: Twenty one (21) days.	3 601		
34585	MN Rule 4660.6900 Subp. 3 Floors, Existing and New Subp. 3. Carpeting requirements. Carpeting, including padding or adhesives, shall conform with the required smoke and flamespread ratings in chapters 1300 to 1365, the State Building Code, 1971 edition; each square yard of the product, or the container, shall be marked for identification of its flamespread rating. Carpeting in patient or resident areas shall be of stain-resistant, high-density, low-pile construction which is cleanable and facilitates wheeled traffic. It shall be stretched and securely fastened to avoid looseness and bunching.	34585		1/3/16

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34585	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility the facility failed to ensure the carpet floor was in good repair which had the potential to affect all 10 residents, staff and visitors. Findings include: On 11/25/15, at 12:25 p.m. during environmental tour with the administrator, the following were observed and verified. Carpet in 2S hallway outside closed hazardous chemical storage door had large round yellow spot and several medium yellow spots. Carpet between rooms 234 and 227 was observed to have approximately four foot repair line with several ripples in the carpet. Three small white spots in carpet near 2N nurse's station. Hallway carpet had jagged area where carpet had been pieced together between rooms 227 and 234. Multiple ripples in 2N hallway carpet near room 234. Hallway carpet between rooms 222 and 211 had piece of packing tape covering approximately a four foot split in the carpet. Large area of carpet wear beneath 2N nurse station chair. Round medium size red spot on carpet outside	34585	Corrected	

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34585	Continued From page 6	34585		

2N medication room door.

Round medium size white spot on hallway carpet outside room 215.

When asked when there was a maintenance problem how the concern would be addressed, administrator displayed maintenance log book residing at the 2N nurse's station. Problems were tracked by date, description, location, individual who requested it and individual that repaired it. He thought when staff informed nurse of a problem, it was written in the log book. Administrator stated that was a new system which began in June of 2015 and housekeeper-B and housekeeper-A typically checked it daily. In addition, administrator stated there was a log book at the first floor nurse's station. The carpeting would affect the 10 residents as they do receive the meal service in the dining rooms, use the shared elevator to go outside and attend activities.

No maintenance policy was provided.

TIME PERIOD FOR CORRECTION: Twenty one (21) days.