

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 1134

May 19, 2017

Mr. Matthew Fischer, Administrator Bethany Home 1020 Lark Street Alexandria, MN 56308

Re: Bethany Home - Independent Informal Dispute Resolution (IIDR)

CMS Certification Number (CCN): 245434

Project Number: S5434025

Dear Mr. Fischer:

In a letter dated August 11, 2016, Bethany Home requested removal of a deficiency cited at F323 as a result of a recertification survey completed on July 22, 2016 by the Licensing and Certification Program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated March 24, 2017. The revised CMS 2567 is enclosed. The revisions reflect the deletion of several fall incidents for the affected resident, R87, which were noted to be duplicative as discussed at the IIDR review meeting.

In addition, the corresponding State licensing order issued under Minnesota Rule 4658.0520, Subp. 1 (St. - 2 - 0830), has been reviewed and revised. The revised Minnesota Department of Health State form is enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Holly Kranz, HFE NEII

Licensing and Certification Program

Health Regulation Division

Email: Holly.Kranz@state.mn.us Minnesota Department of Health

Phone: (507) 334-2742 Fax: (507) 344-2723

Hally Kranz

Bethany Home May 18, 2017 Page 2

cc: Office of Ombudsman for Long-Term Care Mary Absolon, Program Manager Pam Kerssen, Assistant Program Manager Licensing and Certification File

IIDR Response Letter

PRINTED: 05/19/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING		07/2	22/2016
	PROVIDER OR SUPPLIER IY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT A survey was cond Department of Hea July 22, 2016. The Immediate Jeopard facility's failure to co effectively impleme walker which result harm or death. The and was removed of As a result of identi extended survey way Minnesota Department 22, 2016. The facility's plan or as your allegation of Department's accepenrolled in ePOC, y at the bottom of the form. Your electror be used as verificate Upon receipt of an on-site revisit of you validate that substate regulations has been your verification. 483.13(c)(1)(ii)-(iii),	ucted by the Minnesota alth on July 18,2016 through survey resulted in an y (IJ) at F323 related to the emprehensively assess and nt fall interventions for a Merry ed in the high potential for IJ began October 24, 2015 on July 20, 2016 at 3:30 p.m. fication of the IJ at F323, an as conducted by the nent of Health on July 21 and for compliance upon the otance. Because you are our signature is not required a first page of the CMS-2567 nic submission of the POC will cion of compliance. acceptable electronic POC, an aur facility may be conducted to ntial compliance with the en attained in accordance with PORT	F 000	DEFICIENCY)		8/9/16
ABORATOP	been found guilty of mistreating resident had a finding entered registry concerning	ot employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment	JATURE	TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

08/12/2016

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

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		245434	B. WING		07/22/20	16
NAME OF P	PROVIDER OR SUPPLIER Y HOME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308	,	
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F 225	and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must entinvolving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and control of the facility must have a state survey and control of the administrator representative and with State law (includertification agency incident, and if the appropriate correct.) This REQUIREMENT by: Based on interview facility failed to ensign authorized to the administrator representative and with State law (includertification agency incident, and if the appropriate correct.)	appropriation of their property; wledge it has of actions by a tan employee, which would or service as a nurse aide or the State nurse aide registry ties. Issure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). Inve evidence that all alleged ughly investigated, and must ential abuse while the rogress. Investigations must be reported for his designated to other officials in accordance uding to the State survey and to other officials in accordance uding to the State survey and to within 5 working days of the alleged violation is verified inve action must be taken. In the state agency (SA) for 1 of 3	F 225	This plan of correction is submitted to comply with all applicable state a Federal regulatory requirements. Twritten responses do not constitute Admission of non-compliance with requirements nor an agreement with	and hese an any	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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				1020 LARK STREET			
BETHAN	Y HOME			ALEXANDRIA, MN 56308			
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F 225	5/11/16, identified problems with no runderstood and reall areas of daily livitiled Order Summ physician dated 6/3 diagnoses to include Parkinson's diseased. R87's care plan reresident is dependemotional, intellect r/t [related to] Lewy The care plan furth physically abusive Lewy Bodies, unspective and unable to move. Refloor. residents mode a tooth. no one seeknow what resident Action: resident wassist of 3 and EZ-10/26/15," IDT (infall from 10/24/15, walker and landed abrasion under [R8 result of the fall." Sof R87's brain date following Clinical in a fall, initial encour with more confusion.	num Data Set (MDS) dated ong and short term memory ecall ability, was rarely to never quired extensive assistance for ring (ADL). The facility form ary Report signed by the 27/16, identified R87's medical de dementia with Lewy Bodies, e, and anxiety disorders. Viewed 7/13/16, indicated, "The rent upon staff etc. for ual, physical and social needs a Bodies, Physical Limitations" rer indicated "The resident has behaviors r/t dementia with recified psychosis". Thursing progress notes are was found face down on floor, resident tipped merry walker was found face down on floor, resident hit head/mouth on uth was bleeding from loosing en [sik] the incident so we don't the was trying to do at the time. Its lifted up from the floor w/	F 22	Findings. It is the policy of Ecumen Bett that each resident receives are provides the necessary care at to attain or maintain the higher practicable physical mental are psychosocial wellbeing in accept the comprehensive assessment of care. To assure continued the following plan has been in Pagarding cited residents: F225 Investigate Report allegations/individuals Per Abuse Prevention policy: considered an injury of unknown and must be reported when the injury was not observed be or the source of the injury conexplained by the resident. A. For R87 any further falls the a serious injury of unknown sunwitnessed and the resident to explain, shall be reported to explain, shall be reported to immediately. For all incidents a serious injury that are unwith the resident is not able to expreported to OHFC immediated abuse policy. C. Education to all licensed sindividuals responsible for reported on 8-9-16 via email. education includes the Abuse	and the facility and services est and sordance with ent and plan compliance applemented. An injury is own source the source of y any personuld not be that result in ource that is is not able to OHFC olicy. In the conting that result in the seed and olain shall be ly per the staff and porting the conting the continuous the continuo		

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F 225	the nose. Review of the facilit Adult Incident Log, reports to the SA, is submitted related to unwitnessed fall on On 7/22/16, at 11:2 (DON) verified a rethe SA when R87 h 10/24/15. The DON considered it a maj was unknown that I day or two after the verified she had no state agency when had a fractured jaw typically report an is fall when the reside When interviewed social services dire responsibility of over and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for allengier, exploitation the facility vulnerab given the scenario cognitively impaired fracture, SSD state	Ila (upper jaw) at the base of ty form titled 2015 Vulnerable which logged the facility ndicated a report had not been to R87's fractured jaw from an	F 225	Prevention policy specifically in rereporting serious injuries of unknoring origin due to unwitnessed falls and resident not able to explain what happened. Nursing incident check now includes reporting serious injunknown origin to OHFC, and eduenthe on the use of the Federal Long Teleport ability Under F225 injuries unknown source. Face to face melewere also held the week of 8-8-16 provide education on reporting injunknown origin. The policy, check algorithm will be review at an all simeeting on 8-23-16 as an additioneducation opportunity. D. Audits will be completed on a beginning 8-9-16 to assure any seinjury of unknown origin is reported OHFC per policy. Audits will be confere each reported fall for 4 week assure compliance with the Abuse Prevention policy. E. Completion date 8-9-20-16. A results will be reviewed at the Sep 21, 2016 QAPI meeting where the will determine what, in any additione ducation is required, and determine the frequency of audits. Director Nursing or designee will be responsible.	own d the c list that uries of ucation orm Care of eetings o to uries of dist and taff nal ll falls erious d to ompleted s to eteam nal ine the or of	

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F 225	resulting injury; SSI so" regarding R87's unwitnessed fall. St had discussed the be a reportable inciprocedure for reportable inciprocedure for reportable inciprocedure for reportations are presinjury is considered and must be report conditions are presinjury was not obsessource of the injury resident; and (2) The form of the extent of the injury. SSD request electronic record be questions. On 7/22/16, at 1:56 had been reviewed (IDT) and stated, "winjury." SSD further did not result in a hinguity of life; there when interviewed administrator indications and injury to the quality of life; there when interviewed review procedures. The facility policy tipe of the facilities updated 7 considered an injurbe reported when be are present.	ncident included no nt unable to explain and the D responded, "I would think is fractured jaw due to an SD indicated the facility staff incident and had not found it to dent. SSD verified the usual ting an injury of unknown oud the facility policy: An an injury of unknown source ed when both of the following ent: (1) The source of the rved by any person or the could not be explained by the ne injury is suspicious because injury or the location of the more time to review the effore answering any more p.m. SSD identified R87's fall with the interdisciplinary team re didn't think it was a serious explained the fractured jaw ospitalization or affect R87's fore it was not a serious injury. on 7/22/16, at 1:56 p.m. the ated the report would be ity Assurance meeting to	F 225			

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F 225 F 226 SS=D	be explained by the (2) The injury is sus of the injury or the I injury is located in a vulnerable to traum observed at one paincidence of injuries 483.13(c) DEVELO ABUSE/NEGLECT The facility must depolicies and proced mistreatment, negle and misappropriation	source of the injury could not resident; and spicious because of the extent ocation of the injury (e.g., the an area not generally a) or the number of injuries rticular point in time or the sover time." P/IMPLMENT, ETC POLICIES	F 22		8/9/16
	by: Based on interview facility failed to imp procedures to inclu reporting of injuries Agency (SA) for 1 of Findings include: The facility policy tit Prevention Plan For Facilities updated 7 considered an injurible reported when be are present: (1) The observed by any perinjury could not be (2) The injury is sustained.	and document review the lement abuse policies and de consistent, immediate of unknown origin to the State of 3 residents (R87) reviewed. The led Ecumen's Abuse of Minnesota Skilled Nursing (2015, identified "An injury is yof unknown source and must oth of the following conditions e source of the injury was not erson or the source of the explained by the resident; and spicious because of the extent ocation of the injury (e.g., the		F226 Develop/Implement abuse/neglect etc. policies The facility does have a policy for reporting injury of unknown origin. Per Abuse Prevention policy: An injury is considered an injury of unknown source and must be reported when the source of the injury was not observed by any persofor the source of the injury could not be explained by the resident. A. For R87 any further injury of unknow origin per policy will be reported and reviewed by the IDT. All major injuries that are unwitnessed and the resident is not able to explain shall be reported to OHFC immediately per the abuse prevention	f n n at

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F 226	vulnerable to traum observed at one paincidence of injurie R87's annual Minin 5/11/16, identified I problems with no runderstood and recall areas of daily livitiled Order Summa physician dated 6/2 diagnoses to include Parkinson's diseas R87's care plan reversident is dependentional, intellect r/t [related to] Lewy The care plan furth physically abusive Lewy Bodies, unspained and the follow -10/24/15-"Data: recover sideways and unable to move. Refloor. residents mo a tooth. no one seeknow what resident wassist of 3 and EZ -10/26/15," IDT (intelligible form 10/24/15, walker and landed abrasion under [R8 result of the fall." See annual minimum observed and landed abrasion under [R8 result of the fall."	an area not generally ha) or the number of injuries articular point in time or the s over time." num Data Set (MDS) dated ong and short term memory ecall ability, was rarely to never quired extensive assistance for ring (ADL). The facility form ary Report signed by the 27/16, identified R87's medical de dementia with Lewy Bodies, e, and anxiety disorders. viewed 7/13/16, indicated, "The ent upon staff etc. for ual, physical and social needs or Bodies, Physical Limitations" her indicated "The resident has behaviors r/t dementia with ecified psychosis". hursing progress notes ving: esident tipped merry walker was found face down on floor, esident hit head/mouth on uth was bleeding from loosing en [sik] the incident so we don't t was trying to do at the time. es lifted up from the floor w/	F 2	policy. B. All residents that are for falls could be affected immediately. For all falls serious injury, that are unthe resident is not able to reported to OHFC immediates policy. C. Education to all licentindividuals responsible for provided on 8-9-16 via electronic individuals responsible for provided on 8-9-16 via electronic injuries of unknown unwitnessed falls and the able to explain what happincident check list that not reporting serious injuries origin to OHFC, and edutof the Federal Long Termability Under F225 injuries source. Face to face methed the week of 8-8-16 reducation on reporting in unknown origin. The policy, checklist and review at an all staff medias an additional education. Audits will be complete beginning 8-9-16 to assurinjury of unknown origin OHFC per policy. Audits after each reported fall for assure compliance with the Prevention policy. E. Completion date 8-9 results will be reviewed a 21, 2016 QAPI meeting will determine what, in an armore in the policy in the policy.	d by not reporting that result in a nwitnessed and pexplain shall be diately per the sed staff and per reporting mail. The buse and cally in regards to sown origin due to peresident not pened. Nursing the includes of unknown cation on the use of Care Report the sof unknown etings were also to provide significant of algorithm will be eting on 8-23-16 on opportunity. The peter on all falls are any serious is reported to will be completed or 4 weeks to the Abuse contact of the set o		

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F 226	following Clinical in a fall, initial encoun with more confusion Nondisplaced fractisuperior most maxithe nose. Review of the facility Adult Incident Log, reports to the SA, in submitted related to unwitnessed fall on On 7/22/16, at 11:2 (DON) verified a rethe SA when R87 h 10/24/15. The DON considered it a maj was unknown that I day or two after the verified she had no state agency when had a fractured jaw typically report an infall when the reside When interviewed social services dire responsibility of over and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for allenglect, exploitation	formation: [R87] presents with ter. Nurse states -facial pain in than usual. Conclusion: ure thorough the anterior lla (upper jaw) at the base of ty form titled 2015 Vulnerable which logged the facility indicated a report had not been to R87's fractured jaw from an	F 2	226	education is required, and determing future frequency of audits. Director Nursing or designee will be responsible.	of	

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F 226	given the scenario of cognitively impaired fracture, SSD state guidelines." When is computer and the in observation, reside resulting injury; SSI so" regarding R87's unwitnessed fall. So had discussed the if the a reportable inciprocedure for reportable injury is considered and must be reportated injury was not obsessource of the injury resident; and (2) The final form of the injury. SSD request electronic record be questions. On 7/22/16, at 1:56 had been reviewed (IDT) and stated,"winjury." SSD further did not result in a hequality of life; therefore the interviewed administrator indicate indicate in the interviewed administrator indicate in the interviewed in the interviewed interviewed in the interviewed in the interviewed interview	of an unwitnessed fall of a diresident resulting in a diresident resulting in a direction of the reviewed on SSD's lap top incident included no introduced included no introduced. The would think a fractured jaw due to an SD indicated the facility staff incident and had not found it to dent. SSD verified the usual ting an injury of unknown but the facility policy: An an injury of unknown source ed when both of the following ent: (1) The source of the rived by any person or the could not be explained by the ne injury is suspicious because injury or the location of the more time to review the effore answering any more. p.m. SSD identified R87's fall with the interdisciplinary team the edidn't think it was a serious explained the fractured jaw ospitalization or affect R87's fore it was not a serious injury. The report would be ity Assurance meeting to	F 2	226		

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F 226	Continued From pa	ge 9	F 220	5		
F 282 SS=D	PERSONS/PÉR CA The services provide must be provided b	RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of	F 282	2	8/9/16	
	by: Based on observat review the facility fa care for 2 of 3 resid were dependent up cares and for 1 of 1 bilateral hand contr motion (ROM). Findings include: R78's admission M 7/1/16, identified R3 impaired, required a areas of daily living assistance to walk i which included Park arthritis and vision i	ion, interview and document illed to implement the plan of ents (R78, R28) reviewed who on staff for shaving and oral resident (R65) reviewed with actures and required range of linimum Data Set (MDS) dated 8 was moderately cognitively extensive assistance for all (ADL)with exception of limited n corridor and diagnoses kinson's disease, dementia, mpairment.		F282 Services by Qualified Persons care plan Policy: Nursing care standards: to end that every resident receives care to a their highest practicable level of functioning. This includes: Assistance or supervision of shaving residents an necessary to keep them clean and we groomed. Assistance as needed with hygiene to keep the mouth, teeth or dentures clean. Assistance with ROI placement of a device. Residents do the right to refuse care/assistance a refusals will be charted in the reside record. A. For R78 shaving will be offered provided by staff daily. Care plan for	nsure reach se with as well n oral M or have ll nt's	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 282	Continued From pa	age 10	F 282			ı	
F 282	care deficit related hypertension, diabe evidenced by requiresident requires expersonal hygiene. The undated resider required assist of orgrooming. On 7/19/16, at 9:28 shave because of rethey are a little laxes stubble on chin and (NA)-H. R78 had falip and chin area. On 7/20/16, at 1:00 room in a stationary	to Parkinson's Disease, etes, and dementia as ring assist with ADL's -The extensive assist of 1 staff with ent care sheet, indicated R78 one staff with dressing and a.m. R78 stated, "I can't my Parkinson, that is one thing on." At this time R78 has d upper lip. Y a.m. R78 was propelled from ing room by nursing assistant acial hair stubble on the upper p.m. R78 was seated in his y chair in front of the television.	F 282	has been reviewed with staff provicares for R78 in regards to offering providing shaving. For resident R28 oral cares will be and provided by staff at least 2 time day. Care plan R28 has been updainclude resident does not wear dereast providing care for R28 in regaproviding oral cares at least 2 time day. For R65 has had fixed contracture (irreversible) for years per OT eval 11-17-12. The kerlix rolls in hands prevent moisture related issues an prevent contractures. MD orders cand plan of care has been revised staff working with R56 will be provieducation on placement of kerlix in It will be the responsibility of all nurstaff to assure kerlix is in place. The plan has been updated will be revised.	offered es per ated to ntures. with ards to es per s luation are to nd not to larified . All ided n hands. rsing ne care ewed		
	room dressed, has mustache and bear On 7/20/16, at 8:51 to shave independent needs help. NA-H facility and NA-H when interviewed werified if he was all do it every day. R78 face each morning	a.m. R78 was seated in sonot had face shaved, and heavy stubble. a.m. NA-H indicated R78 tries ently and will ask staff when he indicated R78 was new to the as unsure of whether R78 had		with staff providing care for R65 in regards to placement of gauze roll hands. B. All residents requiring assistar cares have to potential to be affect this same practice. C. Written Education was provide staff via email and on Point of Care messaging on 8-9-16 in regards to expectations related to shaving, or cares, placement of devices relate contractures and providing assista all resident per their plan of care. face education was provided to staweek of 8-8-16. Will also provide additional training opportunity at the 16 all staff meeting.	s in nce with ted by ed to all e o care ral d to nce to Face to aff the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING		07/	22/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 1020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 282	verified his facial hitoday and was unashaved him. On 7/20/16, at 1:17 no behaviors and da walk, however, i example if his wife pain in his hip. On 7/21/16, at 9:54 unable to shave inhands. NA-E verifithis a.m. NA-E indishave this a.m. an "every so often." On 7/21/16, at 11:0 a good memory and NA-F indicated he/R78 often, however clean shaven. NA-assisted R78 with sated, "We would they can't themselved on 7/21/16, at 11:0 shaved this morning isn't so hard to get R78 further identifity was easier to keep stating "I drool." On 7/21/16, at 11:1 (LPN)-E verified R not been shaved. On 7/21/2016, at 11:1 (LPN)-E verified R not been shaved.	air had not been shaved off able to recall when staff last 7 p.m. NA-I identified R78 had did occasionally refuse to go for t was usually for a reason, for was here or if he was having 4 a.m. NA-E indicated R78 was dependently due to shaky ed he/she had not shaved R78 cated R78 refused the offer to d had a routine of shaving only 00 a.m. NA-F verified R78 had ad what he says is accurate. She did not provide cares for er, did believe R78 was usually F indicated staff usually oral care and shaving. NA-F normally shave a person if	F 2	D. Audits implemented on 4 residents per week assure shaving, oral ca application of kerlix/dev per policy. Further educ will be provided/conduct is not met. E. Completion date 8-results will be reviewed 21, 2016 QAPI meeting will determine what, in a education is required, a future frequency of aud Nursing or designee will will determine will designee will be reviewed 21, 2016 QAPI meeting will determine what, in a education is required, a future frequency of aud Nursing or designee will be reviewed 21, 2016 QAPI meeting will determine what, in a education is required, a future frequency of aud Nursing or designee will be reviewed 21, 2016 QAPI meeting will be reviewed 21, 2016 QAPI meeting will determine what, in a education is required, a future frequency of aud Nursing or designee will be reviewed 21, 2016 QAPI meeting will determine what, in a education is required, a future frequency of aud Nursing or designee will be reviewed 21, 2016 QAPI meeting will be reviewed 21, 20	x x 4 weeks to res, and rices are provided eation and audits ted if compliance 9-2016. Audit at the September where the team any additional and determine the its. Director of		

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 282	ADL's due to has falthough his abilitie was not able to share electric razor. RN-A expected to shave not expect resident assistance. When interviewed director of nursing that staff follow the require assistance care and not expect with personal hygie plan indicated R28 Staff were to assist offer R28 mouth swand while getting recomplete an oral in needed. The undated resided did not wear the desheet lacked any differ R28. During observation from 8:23 a.m. to 8 assisted R28 with pwashing her face, puring the observation offered the opportucares. R28's oral of dry. -At 8:57 a.m. NA-A	Parkinson's Disease and s change from day to day, R78 are independently with an a identified staff were male residents daily and would s to have to ask for the identified the expectation care plan and residents who with ADL's be provided the sted to ask for assistance. Ited 7/15/16, identified R28 assistance to total assistance and oral cares. The care had upper and lower dentures, with cleaning dentures and to wab and mouth was in the AM eady for bed, and staff were to spection with cares and as Internal care sheet, indicated R28 antures. The resident care irection regarding oral cares of morning cares on 7/20/16, is 4 a.m. NA-A and NA-G personal cares which included perineal cares and dressing. Ition, R28 was not assisted nor nity for completion of oral carvity and lips appeared very assisted R28 with breakfast itioned in bed. R28 was not	F 2	82		

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_	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	wearing any denturbreakfast food item consume the straw -At 9:01 a.m. NA-A shut off the bedroo are good with feed just like today. NA tray to the kitchen, offered the opportucares. During interview or reported R28 no lostated she was goi breakfast to provid swabbing out the nAt 9:07 a.m. NA-A with the breakfast completed morning she did not completed morning she did not completed included swabbing mouthwash. Furth inspect her mouth During interview or confirmed R28 no verified staff are exwith morning cares will at times refuse dry mouth and sleet therefore, oral care offer oral cares to a indicated on the care	res, and R28 refused the is and juice offered. R28 did oberry supplement. It gathered the breakfast tray, im lights and stated some days ing, and some days are not, -A then delivered the breakfast R28 was not assisted nor unity for completion of oral in 7/20/16, at 8:45 a.m. NA-A inger wears dentures, and ing to wait until after R28 ate in e oral cares which included nouth with a toothette. confirmed R28 had finished in the mouth with a toothette or er, NA-A confirmed she had be cares for R28. NA-A verified in the mouth with a toothette or er, NA-A confirmed she did not with cares. 1. 7/21/16, at 10:35 a.m. RN-B longer wore dentures. RN-B longer wore dentures which longer wore which longer wore which longer wore	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE D20 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	2010, directed staff plan for any special assemble the equip Review of R65's qu (MDS) dated 4/27/1 cognitive impairmer included Parkinson disease and cerebrhemiplegia. The M totally dependent or living (ADL's) and h contractures. Reviex Assessment (CAA) had severe cognitive Alzheimer's disease staff for ADL's and Review of R65's cardentified R65 had a upper and lower except dependent on staff range of motion with rolls in both hands and contractures. On 7/18/16, at 5:38 in space wheelchair station prior to the expendent on the expendent on the expendent of the expense of the expe	to review the resident's care needs of the resident. and ment and supplies as needed. arterly Minimum Data Set 6, identified R65 had severent and had diagnoses which is disease, Alzheimer's avascular disease with DS further identified R65 was a staff for activities of daily ad bilateral upper extremity w of R65's annual Care Area dated 8/19/15, identified R65 e impairment due to e, was totally dependent on	F 2	282			

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME				STREET ADDRESS, CITY, STATE, ZIP (1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 282	was lying in bed tiltu against her back, b cover R65 to mid to fisted position, arm fisted hands rested have kerlix in her h. On 7/21/16, at 4:57 in space wheelchair elbows, hands were were clenched fisted clenched hand was left clenched hand was left clenched hand chest, no kerlix was when interviewed or registered nurse midid not have kerlix is care planned and whot in use. RN-A standard were responsible for R65's kerlix were in contractures. RN-A were too contracted out, nor could R65 independently. RN contracted and had a licensed practical. On 7/21/16, at 5:13 open R65's right had contracted, fisted papproximately an in roll into R65's hand was hurting her fing stopped opening R stated there were tineeded to be soaked.	ed to her right side with pillows lankets were observed to brso. R65's hands were in a se were bent at the elbow, against her chest. R65 did not ands. p.m. R65 was seated in a tilt r with both arms bent at the eresting on her chest and d position. R65's right resting over her heart and her was resting on her upper left sobserved in R65's hands. on 7/21/16, at 5:09 p.m. anager (RN)-A confirmed R65 n her contracted hands as was unsure why the kerlix was ated the medication nurses or checking to make sure a both hands for bilateral hand stated she felt R65 hands of for the kerlix to have fallen remove the kerlix stated R65's hands were fully been for years. RN-A directed nurse (LPN)-D to apply kerlix.	F 28	32		

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F 282	R65's to her room a her bathroom, while out of the faucet. N held it under the wa opened R65's hand the kerlix. NA-B the under the water wh washed, dried and NA-B assisted R65 her wheelchair and station. On 7/21/16, at 5:12 supposed to have the at all times. NA-B sthem in after R65's stated she felt about kerlix were not in he place the kerlix into hard time doing so. R65's hands were a could not fall out ar unable to remove the she felt R65's hands at few years. On 7/22/16, at 10:2 required total assis stated on average anot have the cloth in NA-C would then place the contracted hands. On 7/22/16, at 10:3 not had a recent of though had one a file R65 had complete RN-A confirmed R65.	age 16 and NA-B wheeled R65 into a RN-A started to run the water A-B took R65's right hand, arm water while RN-A slowly d, washed, dried and applied an took R65's left hand, held it ile RN-A opened R65's hand, applied another roll of kerlix. back out of the bathroom in wheeled R65 back to nursing a p.m. NA-B stated R65 was he kerlix in both of her hands tated the nurses usually put hands were washed. NA-B at 3-4 times a week R65's hands and often had a NA-B further stated she felt isted very tightly so the kerlix hands he felt R65 would be he kerlix herself. NA-B stated had not worsened over the a a.m. NA-C stated R65 tance with all ADL's, NA-C ha few days a week R65's had not worsened over the a few days a week R65 would holls, (kerlix) in her hands and hace the kerlix in R65's a a.m. RN-A stated R65 had becupational therapy evaluation, hew years ago which identified contractures of both hands. b b's current physician orders aff to ensure R65 had kerlix	F 282			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	_D BE	(X5) COMPLETION DATE	
placed in both contremoved when was the licensed nurses R65 had the kerlix in the kerlix on the (Trexpected the kerlix staff could apply the fully contracted harmon on 07/22/16, at 11: (DON) stated sheet be implemented as not feel that R65's hand contractures to control. The DON ophysician orders in medical record ider was ordered for harmon of care from admission of the control	racted hands and only to be thed twice daily. RN-A stated were responsible to ensure in place and would document AR.) RN-A stated she to be in place as any care exertise. RN-A stated R65 had ads and fingers. 13 a.m. the director of nursing expected resident care plans to directed. DON stated she did cerlix treatment was for her out were more for moisture confirmed R65's current point click care electronic natified R65's kerlix treatment and contractures. Ided Resident MDS 3.0 an of Care revised 03/12, plan was to provide continuity sion to discharge. Plan Policy dated September care plan would be used to all functioning of the resident, inting or reducing decline in I status and/or functional					
DEPENDENT RES A resident who is undaily living receives	IDENTS nable to carry out activities of the necessary services to	F 31	2		8/12/16	
	PROVIDER OR SUPPLIER Y HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa placed in both conti removed when was the licensed nurses R65 had the kerlix i the kerlix on the (T/e expected the kerlix staff could apply the fully contracted han On 07/22/16, at 11: (DON) stated she e be implemented as not feel that R65's k hand contractures k control. The DON c physician orders in medical record ider was ordered for han The facility policy tit Assessment and Pl indicated the care p of care from admiss The facility's Care F 2010, indicated the enhance the optima and/or aid in prever resident's functional levels. A resident who is un daily living receives maintain good nutri	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected resident care plans to be implemented as directed. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional levels. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected resident care plans to be implemented as directed. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional levels. 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated she expected thands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected resident care plans to be implemented as directed. DON stated she red to tell that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional leevels. Assessment and Plan of Care revised 03/12, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional leevels. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good on turition, grooming, and personal	PROVIDER OR SUPPLIER 245434 PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH OBERCIFICATION NUMBER: ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (EACH OBERCIFICATION MUST SE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R56 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix. RN-A stated Shad fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected resident care plans to be implemented as directed. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional levels. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal	

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NAME OF F	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET ALEXANDRIA, MN 56308	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ge 18	F 312			
	by: Based on observat review the facility faremoval of facial h R28) reviewed who for grooming and p Findings include: R78's admission M 7/1/16, identified Ri impaired, required areas of daily living assistance to walk which included Parl arthritis and vision in R78's undated care care deficit related hypertension, diabe evidenced by requires expersonal hygiene. The undated reside required assist of or grooming. On 7/19/16, at 9:28 shave because of r they are a little lax of stubble on chin and On 7/20/16, at 7:57 his room to the dini	dinimum Data Set (MDS) dated 78 was moderately cognitively extensive assistance for all (ADL) with exception of limited in corridor and diagnoses kinson's disease, dementia, impairment. It plan, identified R78 had a self to Parkinson's Disease, etes, and dementia as ring assist with ADL's -The ktensive assist of 1 staff with ent care sheet, indicated R78 ne staff with dressing and B a.m. R78 stated, "I can't my Parkinson, that is one thing on." At this time R78 has		F312 ADL care provided for dependence residents Policy: Nursing care standards: to enthat every resident receives care to their highest practicable level of functioning. This includes: Assistance or supervision of shaving residents necessary to keep them clean and or groomed. Assistance as needed with hygiene to keep the mouth, teeth or dentures clean. Assistance with RO placement of a device. Residents do the right to refuse care/assistance arefusals will be charted in the residence record. A. For R78 shaving has been offer and provided by staff daily. Care planged R78 has been reviewed with staff providing cares for R78 in regards to offering and providing shaving. a. For R28 oral cares will be offered provided by staff at least 2 times per Care planged R28 has been updated to include resident does not wear dentation. The care plan has been reviewed we staff providing cares at least 2 times day. b. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures.	ensure reach ce with as well th oral of have all ent's red and r day. Our continues with distortion per ation are to I not to I not to	

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NAME OF I	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP 1020 LARK STREET ALEXANDRIA, MN 56308	•	
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F 312	room in a stationar R87 remained unsil On 7/21/16, at 9:26 room dressed, has mustache and bear On 7/20/16, at 8:51 to shave independenceds help. NA-H facility and NA-H when interviewed overified if he was aldo it every day. R75 face each morning electric razor but so verified his facial hat today and was una shaved him. On 7/20/16, at 1:17 no behaviors and da walk, however, it example if his wife pain in his hip. On 7/21/16, at 9:54 unable to shave inchands. NA-E verified this a.m. NA-E indicates a.m. NA-E indicates a.m. and "every so often."	p.m. R78 was seated in his y chair in front of the television. naven. a.m. R78 was seated in so not had face shaved, rd heavy stubble. a.m. NA-H indicated R78 tries ently and will ask staff when he indicated R78 was new to the as unsure of whether R78 had	F3	and plan of care has been staff working with R56 hav provided education on place in hands. It will be the responding staff to assure kerl. The care plan has been up reviewed with staff providir in regards to placement of hands. B. All residents requiring care have been reviewed to they have been affected by practice. C. Written education has to all staff via email and on messaging on 8-9-16 in reexpectations related to sha cares, placement of device contractures and providing all resident per their plan of face education was also provided the week of 8-8-16. Will also additional training opporture 16 all staff meeting. D. Audits will be impleme 8-9-16 on 4 residents per verto assure shaving, oral car application of kerlix/device per policy. E. Completion date 8-12-results will be reviewed at 21, 2016 QAPI meeting whe will determine what, in any education is required, and future frequency of audits. Nursing or designee will be	e been cement of kerlix consibility of all ix is in place. It is in place. It is in place of care for R65 kerlix rolls in assistance with o determine if of the same to determine if of the same to determine the place of care. Face to determine the same to determine the place of care of care. Face to determine the same to determine the provided to staff the same that the september the team additional determine the price to of the same to determine the price of the same to determine the price of the same to same the same that the same th	

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F 312	a good memory and NA-F indicated he/s R78 often, however clean shaven. NA-F assisted R78 with c sated, "We would it they can't themselv. On 7/21/16, at 11:0 shaved this morning isn't so hard to get R78 further identified was easier to keep stating "I drool." On 7/21/16, at 11:1 (LPN)-E verified R7 not been shaved. On 7/21/2016, at 1 (RN)-A verified R78 ADL's due to has Falthough his abilitied was not able to shave not expected to shave not expected to shave not expect resident assistance. When interviewed of director of nursing of that staff follow the require assistance care and not expected. The requested facility was not provided.	what he says is accurate. she did not provide cares for r, did believe R78 was usually indicated staff usually oral care and shaving. NA-F normally shave a person if	F 312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	_ ((X3) DATE SURVEY COMPLETED	
		245434	B. WING _		_	07/22/2016
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F 312	6/15/16, identified F cognitively impaired included: Alzheimer arthritis. The MDS extensive assistant hygiene tasks. R28's care plan dat required extensive with personal hygie plan indicated R28 Staff were to assist offer R28 mouth swand while getting recomplete an oral in needed. The undated resided did not wear the desheet lacked any differ R28. The nursing oral as indicated R28 had infragments, and indicated R28 with pureed diet. During observation from 8:23 a.m. to 8 assisted R28 with pureed the opportucares. R28's oral cody. At 8:57 a.m. NA-A	ge 21 R28 was moderately d and diagnoses which r's, psychotic disorder and indicated R28 required re for completion of personal red 7/15/16, identified R28 red assistance to total assistance re and oral cares. The care red and upper and lower dentures. with cleaning dentures and to red and mouth was in the AM redy for bed, and staff were to respection with cares and as ret care sheet, indicated R28 rection regarding oral cares rection regarding oral cares rection regarding oral cares ressment dated 6/13/16, resonal teeth or tooth cated R28 chose not to wear ressment identified R28 had a ressment ide	F3	12		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
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F 312	wearing any denturbreakfast food item consume the strawl-At 9:01 a.m. NA-A shut off the bedroor are good with feedijust like today. NAtray to the kitchen, offered the opportucares. During interview on reported R28 no lor stated she was goir breakfast to provide swabbing out the management of the provided swabbing mouthwash. Further inspect her mouth was a provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse. The provided staff are exwith morning cares will at times refuse and the provided staff are exwith morning cares will at times refuse.	es, and R28 refused the s and juice offered. R28 did perry supplement. gathered the breakfast tray, in lights and stated some daysing, and some days are not, A then delivered the breakfast R28 was not assisted nor nity for completion of oral. 7/20/16, at 8:45 a.m. NA-A ager wears dentures, and ng to wait until after R28 ate e oral cares which included bouth with a toothette. confirmed R28 had finished and cares for R28. NA-A verified the nor offer oral cares which the mouth with a toothette or er, NA-A confirmed she did not with cares. 7/21/16, at 10:35 a.m. RN-B anger wore dentures. RN-B appected to swab R28's mouth, or at least attempting as R28 RN-B confirmed R28 has a ps with the oral cavity open, must be attempted. 7/22/16, at 10:08 a.m. the ff are expected to provide or II resident twice per day as	F3	12		

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F 312	plan for any special assemble the equip The purpose is to k tissues moist, to cle resident's mouth, a mouth.	to review the resident's care needs of the resident. and ment and supplies as needed. eep the resident's lips and oral canse and freshen the nd to prevent infections of the	F 3			
F 318 SS=D	Based on the compresident, the facility with a limited range appropriate treatments	rehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further	F 3	18	8/12/16	
	by: Based on observate review the facility far interventions for idea resident (R65) review (ROM.) Findings include: Review of R65's que (MDS) dated 4/27/1 cognitive impairment included Parkinson disease and cerebra hemiplegia. The Metotally dependent of the review of R65's questioned to the review of R65's que	ion, interview and document alled to implement entified contractures for 1 of 1 ewed for range of motion arterly Minimum Data Set 6, identified R65 had severe at and had diagnoses which is disease, Alzheimer's evascular disease with DS further identified R65 was a staff for activities of daily ad bilateral upper extremity		F318 Increase/Prevent decreat Range of Motion Per Policy: to promote each restability to adapt to attain his or homaximum functional potential. Teach resident's highest practice of physical, mental and psychost functioning. A. R65 admitted to Bethany we contractures. Per OT assessment 12 contractures in hands are in position. Kerlix placed in hands prevent moisture associated day and/or skin breakdown. MD ord been clarified to state such and of care has been updated.	sident's er To promote able level social ith ent 11-17- a fixed s daily is to amage ler has	

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F 318	Review of R65's ar (CAA) dated 8/19/1 cognitive impairme was totally dependent contractures. Review of R65's caidentified R65 had upper and lower exidependent on staff range of motion with rolls in both hands 30 minutes twice districted hand contractures. Review of R65's cur/19/16, revealed at 10/21/2015, directed kerlix roll in bilateral shift, should have kadditional gauze be and gauze when so for contractures. The staff to wash R65's instruction sheet. Review of R65's pr 5/27/16, revealed Froutine visit in whice contractures which and hands. Review of R65's method from the rapy (OT) assess revealed R65 had which were in a fixed evaluation directed.	anual Care Area Assessment 5, identified R65 had severe nt due to Alzheimer's disease, ent on staff for ADL's and had are plan print dated 2/25/16, bilateral contractures of the atremities, was totally for all ADL's, required gentle th daily care, required gauze 23/hrs/day: to be removed for aily for hygiene for bilateral arrent physician orders signed an order with a start date of ad nursing staff to check R65's all hands for placement every serlix in hands at all times and etween thumb, change kerlix billed and as needed every shift ne orders also directed nursing hands twice daily per covider progress note dated R65 had been seen for a h R65 was assessed to have were most notably in her arms cost recent occupational sement dated 11/17/12, bilateral hand contractures and flexed position. The staff to implement ROM and splints for bilateral hand	F 318	B. All resident's with devices for land or contractures has the potent affected by the same practice. C. All resident's that have device. ROM and/or contractures will be reto assure the device is being used appropriate reasons and that the care being placed per MD orders, at the care plan and care sheets are D. Audits for devices to assure M is correct, care plan is correct, device being applied and care sheets are will be done on each resident with device until all residents with a device until all residents with a device until swill be reviewed. E. Completion date 8-12-16. Audit results will be reviewed at the Sep 21, 2016 QAPI meeting where the will determine what, in any addition education is required, and determifuture frequency of audits. Directo Nursing or designee will be response.	s for eviewed for the levices nd that current. ID order rices are current a rice	

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F 318	contractures. - R65's medical recevaluations for han Review of R65's Ju administration recomark for R65's treath hands three times a chart code legend with the treatment was it Review of R65's ca 5/17/16, revealed Frontractures of her note further revealed apply gauze to R65 indicated that was to Review of R65's proposition of R65's proposition of R65's proposition of R65's hand and gauze rolls placeto keep R65's hand and gauze rolls placeto keep R65's hand of R65's had of R65's hand of R65's had of R65's hand of R65's had of R65	ord lacked any further OT d contractures. Ily 2016, treatment rd (TAR) revealed a check tment of kerlix rolls in both a day. The TAR revealed a which a check mark indicated in place on all days. The conference note dated last continued to have hands and extremities. The red staff were to continue to be continue. The progress notes from 1/23/16, to me following: R65 had contractures to required vigilant monitoring to din both hands, extra care	F3	318			

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F 318	and required total a ADL's. -4/23/16, revealed a R65 required total a to contractures and -4/27/16, revealed a which identified R65 contractures and st both hands to help skin integrity. -5/20/16, revealed a identified R65 had a required total assist -5/28/16, revealed a which revealed staf R65's hands due to hands. R65's progregarding inability to -5/29/16, revealed a which revealed staf R65's hands due to hands. R65's progregarding inability to -6/20/16, revealed a identified R65 had a required total assist -6/27/16, revealed a identified R65 had a required total	ssistance from staff for all a ADL note which identified assistance with all ADL's due		18			

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F 318	required total assis On 7/18/16, at 5:38 in space wheelchai station prior to the chands were held in bent and hands res rested near her hea her left upper chest placed in her hands seated in a tilt in sp nurses station follor remained without k On 7/19/16, from 8 was lying in bed tilta against her back, b cover R65 to mid to fisted position, arm fisted hands rested have kerlix in her h On 7/21/16, at 4:57 in space wheelchai elbows, hands were were clenched fiste clenched hand was left clenched hand was left clenched hand chest, no kerlix was When interviewed or egistered nurse m did not have kerlix in care planned and w not in use. RN-A sta were responsible for R65's kerlix were in contractures. RN-A	p.m. R65 was seated in a tilt r across from the nurses evening meal. Both of R65's a fisted position, elbows were ted on her chest, right hand art and her left hand rested on a R65 did not have kerlix. At 6:55 p.m. R65 was ace wheelchair near the wing the evening meal. R65 erlix/gauze in both hands. At 5:45 a.m. to 10:55 a.m. R65 ed to her right side with pillows lankets were observed to brso. R65's hands were in a as were bent at the elbow, against her chest. R65 did not ands. I. p.m. R65 was seated in a tilt r with both arms bent at the eresting on her chest and d position. R65's right resting over her heart and her was resting on her upper left is observed in R65's hands. I. p. m. R65 was seated in a tilt r with both arms bent at the eresting on her chest and d position. R65's right resting over her heart and her was resting on her upper left is observed in R65's hands. I. p. m. R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands. I. p. m. R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands. I. p. m. R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands. I. p. m. R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands.	F 318				

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F 318	contracted and had a licensed practical On 7/21/16, at 5:13 open R65's right had contracted, fisted p approximately an irroll into R65's hand was hurting her fing stopped opening R stated there were tineeded to be soaked the hands up. RN-A R65's to her room a her bathroom, while out of the faucet. N held it under the wad opened R65's hand the kerlix. NA-B the under the water wh washed, dried and NA-B assisted R65 her wheelchair and station. On 7/21/16, at 5:12 supposed to have the tail times. NA-B shem in after R65's stated she felt about kerlix were not in helplace the kerlix into hard time doing so. R65's hands were fould not fall out ar unable to remove the states.	stated R65's hands were fully been for years. RN-A directed nurse (LPN)-D to apply kerlix. 3 p.m. LPN-D attempted to and fingers from the	F 318				

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F 318	required total assist stated on average a not have the cloth r NA-C would then pl contracted hands. On 7/22/16, at 10:3 not had a recent on though had one a fe R65 had complete RN-A confirmed R6 directed nursing staplaced in both contiremoved when was the licensed nurses R65 had the kerlix in the kerlix on the (T/expected the kerlix staff could apply the fully contracted hand On 07/22/16, at 11: (DON) stated she eresident care plans stated she did not fi was for her hand compositure control. The current physician of electronic medical in treatment was order to highest practicable.	3 a.m. NA-C stated R65 tance with all ADL's, NA-C a few days a week R65 would olls, (kerlix) in her hands and ace the kerlix in R65's 7 a.m. RN-A stated R65 had cupational therapy evaluation, ew years ago which identified contractures of both hands. S5's current physician orders aff to ensure R65 had kerlix racted hands and only to be hed twice daily. RN-A stated were responsible to ensure in place and would document AR.) RN-A stated she to be in place as any care exkerlix. RN-A stated R65 had add and fingers. 13 a.m. the director of nursing expected physician orders and to be implemented. DON eel that R65's kerlix treatment ontractures but were more for the DON confirmed R65's reders in point click care record identified R65's kerlix red for hand contractures. policy titled, Restorative eviewed 5/2011, revealed a promote each residents	F 3:			

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F 318 F 323 SS=J	Continued From pa physician orders, tr none were provided 483.25(h) FREE OI HAZARDS/SUPER	eatments and contractures; d. = ACCIDENT	F 318		8/12/16	
	environment remain as is possible; and	isure that the resident ns as free of accident hazards each resident receives on and assistance devices to				
	by: Based on observative review, the facility fassess, ensure addimplement interven further falls for 1 of who sustained multinjury while utilizing combination type dimmediate jeopardy failed to investigate the resident's falls to determine wheth have been implementation.	stion, interview and document ailed to comprehensively equate supervision and tions, to decrease the risk of 3 residents (R87) reviewed iple falls. R87 experienced an a Merry walker (a walker/chair evice), resulting in an (IJ) situation. The facility and comprehensively assess while utilizing the Merry walker er new interventions should ented, and the facility failed to s currently in place were istently implemented to or further falls.		F323 Free of accident hazards/supervision/devices A. On 7-20-2016 the following was implemented immediately for R87. 1. Current Merry Walker was discontinued; 1-1 staff implemented was in place until all assessments w completed and new plan for safety v initiated. 2. We immediately implemented a r written assessment for all falls. The Post-Fall assessment includes root analysis and intervention options to prevent further falls. A new Progress type was created in the electronic ch	new cause	
	when R87 sustaine walking in the Merr	pardy (IJ) began on 10/24/15, d a fall with injury while y walker. The facility's irector of nursing (DON) were		and titled fall which triggers the user review the care plan and make modifications and revise intervention needed.	to	

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F 323	notified of the immon 7/19/16, at 7:05 7/20/16, however, I lower level of G, iso actual harm that is Findings include: R87 was observed gait belt fastened a Merry walker made had been fastened the walker on three was attached to the attached to the fror located between Riwandered about the Merry walker. I a shuffling gait and abrasion near her of doorway to the dinithe Merry walker for stationery in the donursing assistant (I around in the Merry ambulate in the opp to move around the nurses' desk, bump R87 was again obs walking in the Merrhallway with a shufbumping into walls, wheelchairs while walker devictions walker to strafew minutes later, I few	ediate jeopardy (IJ) situation p.m. The IJ was removed on noncompliance remained at a plated scope, with severity of not immediate jeopardy. on 7/18/16, at 5:31 p.m. with a round her waist, standing in a cof PVC pipe. Cloth weights with zip ties to the bottom of esides and a cloth type strap at seat of the walker. The strap at of the walker and was 87's legs. R87 independently a Darling Springs unit utilizing R87 was observed to walk with was noted to have an right eye. When she got to the ng room, R87 couldn't move orward. R87 remained orway to the dining room until NA)-D assisted R87 to turn y walker so R87 could cosite direction. R87 continued a area of the Darling Springs bing into walls and doorways. served on 7/18/16, at 6:48 p.m. y walker in the Darling Springs fled gait. R87 was observed a doorways and residents in walking down the hallway in the end of the R87's navigation. A R87 was observed to right front corner of the Merry	F 323	3. Physician reviewed the current's and provided directives for care. Consulting pharmacy reviewed med regime. Physical Therapy reviewed assessed for recommendations. 4. Interventions for all falls that occur the facility will be reviewed each time appropriateness at IDT meeting. 5. Education was provided to all lice staff on new written assessment and progress note types on 7-20-16, with via email and postings at nurse's stance and postings at nurse's stance and postings at nurse's stance and the email and post fall assessments and intervention have been implemented. Will report QAPI monthly. Will continue to aud needed. B. All resident who are at risk for fall assessment was put in place on 7-2 for all residents in the facility that suffall. Education was provided on 7-2 Face to face education provided the of 8-8-16. Additional educations opportunity will be provide at the 8-3 all staff meeting. Will also have Ecological and assessments 1 x places.	dication and ur in the for the ensed and the erbally, the erbally, the erballs are was to the erballs are was to the erballs are to the erballs are to the erballs are to the erballs are to pic also	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	walker, bounced bathe seat of the Meributtock positioned then stood and conthe hallway while at walker. On 7/19/16, at 10:4 guide R87, who wa her room to the hal independently walk observed to walk w located in the short not within staff view the corner of the sh grasp the door han labeled B-13 and jigturned her body to walker, moved the out from the corner nurses' desk located the dining room. At move about in the I gait. She navigated located near her roside of the nurses' area. At 10:47 a.m (technician) and twiside of the nurses' None of these three of R87 as they walk a.m. licensed pract the nurses' station medication cart which direction from R87, area where R87 co time, R87 was obse within the Merry was	ge 32 ckward and came to rest on ry walker with half of her on the seat of the walker. R87 tinued to wander throughout tempting to navigate the Merry 2 a.m. NA-E was observed to sin the Merry walker, out of way. NA-E then left R87 to in the Merry walker. R87 was ith a shuffled gait. She was hall outside of her room, but with the Merry walker in fort hall, R87 was able to dele to the bathroom door to gele the handle. R87 then the right side of the Merry walker in a sideways direction and moved toward the don the opposite side from 10:46 a.m. R87 continued to werry walker with a shuffled to and from the short hallway on which was located on the station desk without staff in the a lab (laboratory) tech of facility staff walked near the station facing the dining room. The station facing the dining room. The station facing the dining room. The station facing the dining room are and approached the chaced the opposite LPN-C did not move to an all do supervised. During this erved to have turned herself liker to face backwards, and the lifted her right knee onto	F 3.	month x 3 months. D. 8-9-16 we will begin and post fall assessmen are appropriately complemented assessment and a interventions as needed done on all falls x4 weel compliance. E. Completion date for 8 results will be reviewed 21, 2016 QAPI meeting will determine what, in a education is required, a future frequency of audit Nursing or designee will	nt to assure staff eting the dding new d. Audits will be ks to assure 8-12-16. Audit at the September where the team any additional nd determine the its. Director of	

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F 323	the Merry walker see On 7/19/16, at 10:5 observed in the hall water mugs were re Neither NA looked i once again maneuv corner of the hall ar forward. At 10:51 a the Merry walker. T Merry walker were walls in the short havicinity nor in view of At 10:55 a.m. R87 if the corner with the feet, one at a time, bar of the Merry wa right knee onto the a.m. R87 shuffled ti location of the nurs Merry walker bar, s forward with little sh the corner located r observed in the hall to resident rooms b direction. At 11:00 ambulate with smal walker toward the right the movement of th against the nurses' R87 stood up in the caught against the noted on the dining At 11:11 a.m. on 7/7 female resident sea the vicinity of the nu pushed her Merry wan pushed her Merry wan	_	F3	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION		E SURVEY IPLETED
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F 323	propel forward, she walker and shook it while R87 continue the resident located R87's left wrist and R87 made no response the walker. At 11:1 through the area pronto the elevator, work of R87. At 11:19 at in the Merry walker buttock seated on the Merry walker remains resident's wheel charmon from the seat, and walker. The residentyou want me to spawrist. At that time, the two residents. R87's annual Minim 5/11/16, identified From the seat, and walker. The resident you want me to spawrist. At that time, the two residents. R87's annual Minim 5/11/16, identified From the physician 6/27/diagnoses included Parkinson's disease R87's Care Area As 5/11/16, included: "severe impairment CAA r/t [related to] with Lewy bodies, FADL functional /Relassist with ADL's at Disease, Demential	ge 34 grasped the top bar of the back and forth. At 11:17 a.m., d to shake the Merry walker, in the wheel chair grasped stated "go tell your mother". Inse but continued to shake 8 a.m. facility staff walked ushing a housekeeping cart without looking in the direction in. R87 finally seated herself with only the right side of her he Merry walker seat. The ned in contact with the other air. At 11:19 a.m. R87 stood again began shaking the not in the wheelchair stated, "do ank you?" and grasped R87's he surveyor summoned staff. Itered nurse (RN)-A separated from Data Set (MDS) dated R87 had long and short term with no recall ability, was rarely d, and required extensive ctivities of daily living (ADL). A Summary Report signed by 16, indicated R87's medical it dementia with Lewy Bodies, and anxiety disorders. Seessment (CAA) dated Cognitive loss /Dementia: w(with)/cognition triggered dx [diagnosis] of dementia Parkinson's and depression. Inabilitation Potential: Requires and mobilities r/t Parkinson's with Lewy Bodies, HTN eparthritis and Hx [history of	F 323			

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CENTER	<u> 15 FOR MEDICARE</u>	& MEDICAID SERVICES			ON	<u>NB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	-		E SURVEY PLETED
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F 323	interventions are in Noted to have 2 fal monitor and implent [as needed]. Reside times will wander in Wander guard is in attempts to wander put across other resident of entering times. Is at risk for [related to] Dement Speech is mumbled right words. Responsense. Is sometimed understands commat this time." Behave to have behaviors of others and wanderi with PRN pain med showing aggression ram into things with PRN pain meds has behaviors." R87's care plan reversident was "at ris Lewy Bodies, and Finterventions include appropriate footwer mobilizing in wheel protocol. Physical to treat as ordered or information on past cause of falls. Reconstituted interventions: (1) Logital to the control of the cause of falls. Reconstituted interventions: (1) Logital to the cause of falls. Reconstituted interventions: (1) Logital to the cause of falls. Reconstituted interventions: (1) Logital to the cause of falls. Reconstituted interventions: (1) Logital to the cause of falls.	ge 35 In plan] for details. Safety place to prevent falls/injuries. Its since previous MDS. Will ment safety interventions PRN ent does wander about unit. At the other resident's rooms. place to alert staff if resident outside. Velcro sashes are sidents' doorways to detour room. Does help detour at impaired communication r/t ia and Parkinson's Disease. If and has difficulty finding the nese does not always make the sunderstood and sometimes unication. No referral needed vioral Symptoms: "Observed of physical abuse towards ing. Staff will provide [R87] is [medications] when is in in her face. [R87] will also in her Merry walker repetitively. It we shown to redirect this riewed 7/13/16, indicated the fix for falls due to dementia with Parkinson's disease." Ided: "Ensure [R87] is wearing ar when ambulating or chair. Follow facility fall therapy eval [evaluation] and as needed. Review falls and attempt to determine ord possible root causes. Imily/caregivers/ IDT am] as to causes. Safety ow bed and safety mats when or gripper slippers to be worn	F3	123			

when in Merry walker. (3) Close dining room and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
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F 323	activity doors in the Merry walker. Bathiresident is not using on base of Merry wilkeep an extra set to walker in case one supervision when ir light to resident at his she moves or gets (8) Staff will monitor minutes and PRN. sitting in recliner." R87's NA care sheer regarding specific of identified safety into (1) to ensure to tak assisting to the reclosed, (3) clip call low bed and safety when not in bed), (close to resident), when ambulating, of dining room, use both wanderguard worn, indicated in the configuration (1) to the NA care sheet of the Merry walker, in given even though monitor R87's when PRN. When interviewed of stated R87 was saff Merry walker and shalf hour".	evening when [R87] is in room door to be closed when g the bathroom. (4) Weights alker to increase stability. (5) in [SIK] slippers in Merry falls off. (6) 1:1 staff assist/ in the dining room. (7) Clip call NOC [night] to alert staff when up (has soft touch call light). It whereabouts every 30 (9) Bring to bathroom before et (a reference NAs used eare for residents) undated, erventions for R87 to include: the R87 to the bathroom before light on R87 at bed time, (4) mat (put mat against wall be solved to mat (a) when the cone assist when in ody pillow to position in bed, and the cone assist when in ody pillow to position in bed, and the cone assist when in object to one assist when in the cone as in the c	F3	23		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 323	usual practice to all in the Merry walker "We try to keep her job of keeping her calthough she had n involving the Merry had stepped on the it to fall over and ca NA-E pointed to the A review of R87's c following 20 docum involved the use of was admitted on Malker; No apparent Care plan and mult being followed at timember (F)-A. Disc the Merry walker, Fwalker continues to a greater risk of inju Merry walker and swill continue with 30 Merry Walker guide plan). (2) 5/17/15- found of walker; head up agbruising on RUE (ripprevious fall; No oth was crying but able Unwitnessed. Will pwhen not in bed to on mat or wheeling also continue Q (eventage of the previous Q (event	ow R87 to walk around while unsupervised. NA-E stated, safe, the nurses do a good close." NA-E verified that ot witnessed R87's falls walker, she'd heard that R87 bottom of the walker causing a cut to R87's face. The temple area. Ilinical record identified the ented fall incidents which the Merry walker since R87 arch 2015:	F3	23			

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F 323	Merry walker aroun back into Merry wal (mechanical device of IDT (interdisciplir (4) 6/20/15- found s Merry walker. Sitting injuries. (4) 6/23/15- found of staff removed Merry resident began scorn No injuries noted. Consider the staff removed Merry resident began scorn injuries noted. Consider the staff removed Merry resident began scorn injuries noted. Consider the staff removed for medical this caused [R87] aleft. Right hip pain a Lump on left side of Pupils sluggish. Guileg. Ice applied to have the emergency down to the emergency down injured (8) 8/4/15- found or resident's room with Was wearing slipped of occurrence. Action Merry walker.	g still around the strap of d 4:00 p.m. Resident assisted lker with 2 staff and EZ of lift. No further documentation hary team) review of fall. Sitting opposite direction in g on floor. No apparent on floor in Merry walker. When y walker to assist off the floor, or or or her butt on the floor. Or being followed. Ty walker, stumbled to the left ed over left leg and resident atton cart to catch herself and and Merry walker to fall to the land right foot rotated inward. If head and above left eye, arded movement to the right lead abrasion and lump. Sent lepartment (ED). In floor in Merry walker in room. In floor in Merry walker in another in no injuries or hitting head. In the left left exist and in Merry walker at time on: Up off floor and back in the loor in front of nurses ker and slipper on. No injuries	F 32	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
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F 323	(10) 9/15/15- found Merry walker in her between legs; shirt in place; R87 agitar checked in on R87 prior to fall. (11) 9/19/15- obser room, was lying un Merry walker was it and into the Merry bumps or bruising to the mouth of the merry was hooked around her back. A small con right buttock. Breturned to bed. (13) 10/24/15- Ressideways and was unable to move. [Resideways and was unable t	d sitting on floor backwards in r room, leg strap still attached off at this time, gripper socks ted at the time. Staff last shortly before, less than hour eved on floor next to bed in der the Merry walker. The ntact, was assisted to the toilet walker at 2:20 p.m. No lumps	F 32	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1020 LARK STREET ALEXANDRIA, MN 56308		
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F 323	the back of the me intervention of add merry walker was is sustained a fall on 10/26/15, at 13:39 face continues to be scabbed. Call place xray to face. RN Uccoordinator] aware after talking to CNF Subsequent nursin had ordered a head tomography X-ray] from 16:53 (4:53 percent of the confusion than usual Conclusion: 1. Not anterior superior method bear of the nose. It is from 10:49 a.m. on resident required a conclusion than usual conclusion than usual conclusion than usual conclusion. The number of t	octor). Also, weights added to rry walker to balance it. (The ed weights to the base of the nitiated after R87 had 6/28/15). A nurses' note dated (1:39 p.m.) included:"Res. see swelled and abrasion is sed to [MD] to inquire about IC [registered nurse unit IMD's] nurse will call back IC [certified nurse practitioner]. If g notes indicated the physician IC That date. Documentation IC (Tocan [computed for that date. Documentation IC (Tocan [computed for that date, indicated the resident Indicated the resident IC (Tocan [computed for that date, indicated the resident IC (Tocan [computed for that date, indicated the resident IC (Tocan [computed for that date, indicated the resident IC (Tocan [computed for that date, indicated the resident IC (Tocan [computed for the foliated the foliated for the foliated for the foliated the noral surgery consult. In of falls and fracture while walker, the facility failed to risk and interventions. In the floor in the bathroom for the floor in the bathroom for the floor in the bathroom for the floor in the floor and into the merry walker for meals. No merry walker for meals.	F3	323		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			E SURVEY PLETED
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F 323	assisted to the bath to the fall, not attem the time of the fall. The bathroom door wanders into her rofurther IDT review of (16) 2/2/16- on floor 7:30 a.m. in Merry of foot wear on at time (17) 4/16/16- found activity room close still in the Merry wa assisted back into the lift and 3 staff assis continue to feel the and continues to be A physician visit for R87 was seen for a "Nursing has no combeen stable." (18) 5/13/16- found was tipped over on next to bed, feet still Was trying to get to Merry walker and flick Aide found resident Staff educated to me floor when [R87] not or remind staff to pick. (19) 6/26/16- found room in Merry Walker.	P was being followed. Was proom less than 2 hours prior apting to go to the bathroom at Action: intervention to keep closed when not using it, [R87] om through out the day. No of the fall documented. In in front of nurses' station at walker. No injuries noted. Had be of occurrence. Continue CP. Issitting on the floor in the to Turtle Beach (resident unit) liker; walker was still upright; he Merry walker with the EZ to Continue with CP; Family Merry walker is safest option	F3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	RIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
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F 323	with family at all carthis is her safest op gives her the freedd independent. Will conterventions. CP for (20) 6/27/16- found Merry walker outsid back and holding he sleeping. No injuried continue with these when interviewed of director of nursing (reviewed resident fall, current interventions and post IDT review is added in the electronic reconstructions and post IDT review is added in the electronic reconstruction. Review of the facilitation in the electronic reconstruction in the facilitation in the electronic reconstruction. Review of the facilitation in the electronic reconstruction in the electronic reconstructi	re conferences and they feel ation to avoid injury and also om to ambulate and be more ontinue with current ollowed. Ilying on floor underneath le of room in hallway, lying on ead up, appeared to be s. CP being followed; Will interventions. On 7/19/16, at 2:55 p.m. the (DON) identified an IDT alls to identify the cause of the ations in place, previous cossible new interventions. This is to the nurse's progress notes for and documented onto a cry form titled Resident for the dates of January 2016 to the following falls involving the string interventions-Continue s. The interventions one, interventions-Continue s. The interventions one, interventions one, interventions one, interventions one, interventions in place. The interventions in place oneses interventions.		23		

-	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG			E SURVEY PLETED
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F 323	documented falls the selected time frame documentation of a re-assessment of Fof any additional intervent re-occurrer R87's electronic an evidence of physica (OT) evaluations and Morse Fall Scale do 8/28/15, 10/26/15, each identified R87 walker, and identified weak gait, stooped with, "steps are shown as the second of these Morse indicated the reside anything above 45 None of the documented as a formal second of the second of the massessment and reconsistently completed falls involved the Massessments and reconsistently completed follows: (1) review (2) interview staff to do, (3) if interview areassess fall risk and interventions are effassessment finding documented as a formal second of the second of the follows: (1) review (2) interview areassess fall risk and interventions are effassessment finding documented as a formal second of the second of the follows: (1) review (2) interview areassess fall risk and that it was difficitly because R87 consistently and that it was difficitly because R87 consistently and the finding documented as a formal second of the follows: (2) interview areassessment finding documented as a formal second of the finding documented as a formal sec	at occurred during the at the log also lacked comprehensive the standard lacked documentation erventions implemented to note of falls. In different with the records lacked any all (PT) or occupational therapy and/or treatment. In addition, occuments completed on an	F3	23			

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		245434	B. WING _		07	7/22/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 323	identify any new on assessments were each fall. A facility Restraint/ Physical dated 2/17/16. RN-current assessmen no other assessmen no other assessmen assessment for R8 been involved with a Merry walker and admitted. RN-A als included all of the confirmed it was an the care plan. RN-A responsible to checand to document su walker currently util obtained from stora facility, and stated swritten copy of the instructions/recommshe may have to coobtain the instruction On 7/19/16, at 4:57 nurse manager was assessment for responsible to checand explained the atthe resident in the Nasses safe. The DON an actual written as of an observation to walker was appropriated. The DO and family were awaremained at risk for	ventions it was difficult to es, and RN-A also stated fall completed quarterly, not after document was provided titled (Quarterly/Annual Evaluation) A verified this was the most to form and verified there were not forms related to a fall risk of the assessment for the use of the had been assessed when so stated the current CP current interventions and a expectation that staff follow a also stated the nurse was each. RN-A explained the Merry ized by R87 had been use in the basement of the she did not believe they had a manufacturer's nendations. RN-A indicated amplete a "Google" search to	F 32	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	()		SURVEY PLETED
		245434	B. WING			07/2	2/2016
BETHAN	PROVIDER OR SUPPLIER IY HOME			STREET ADDRESS, CITY, STATE, ZIP O 1020 LARK STREET ALEXANDRIA, MN 56308	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 323	Merry walker, she was constructed in Merry walker, she was a second problems with the Mexamples such as rit properly. The DOI expectation for care walker included free when walking by. The trying to crawl out on lay the resident in benext to the bed. The expected to follow they had tried nume follow family wishes of the Merry walker manufacturer's recommerced walker is constructed to the printed out recommerced walker is constructed to the resident should be at the he good posture." How currently utilized was which three fabric ty secured to the bottom of the Merry walker height of the pelvis. On 7/20/2016, at 9:	ge 45 nce R87 was not utilizing a yould have to be placed into a ng wheel chair). The DON ementation of interventions completed if staff identified Merry walker, identifying not walking with it, or not using N further indicated the of a resident utilizing a Merry quent observations by all staff he DON said if a resident were if the Merry walker, staff may ed with a safety mat placed a DON reiterated staff were he CP. The DON indicated erous interventions but would a related to the continued use. The DON stated the pommendations for use of the potential of metal and weighted at the none should be individually at the height of the top frame ight of the pelvis to promote wever, the Merry walker R87 as constructed of PVC pipe to the weight of the top frame ight of the walker. In the height of the top frame ight of the walker. In the height of the top frame ight of the walker. In the height of the top frame ight above the pelvis. 33 a.m. physical therapist wed. PT-A confirmed therapy with the pelvis.	F3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED
		245434	B. WING		07	/22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	residents related to and determination individual residents is not something w functional walking videntified resident of Merry walker would balance and streng and ability to prope also verified that M over. PT-A indicate to the facility, a quit therapy services we PT-A indicated that been determined to order for treatment confirmed R87 had services any time is and confirmed R87 for the use of the M. The facility policy tirevised September Recognition identificing will evaluate and do the individual is in the individual is in the individual is in the preceding and where they have events, ect. Treatment to prevent subsequents of serious consequents. The immediate jeon and identified on 7/20/1 be verified by obse	eening and treatment of transfers, balance, walking of the most appropriate lifts for a PT-A stated, "[Merry walker] e recommend, we want it to be with a walker or cane." PT-A considerations for use of a dinclude: look safe, maintain at have a good gait pattern of forward without tripping. PT-A erry walkers were able to tipe at that when R87 was admitted at that time services had not be needed so no physician had been requested. PT-A anot been provided therapy since admission (March 2015) had not been evaluated by PT Merry walker. Itled, Falls- Clinical Protocol 2012, Assessment and ited the following: #5 The staff occument falls that occur while the facility: for example, when open, and observations of the nent/Management: #1- Based ssessment, the staff and ity pertinent interventions to try uent falls and to address risks	F3	23		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		E SURVEY IPLETED
		245434	B. WING		07/:	22/2016
NAME OF F				STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308	•	
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F 323	- 1:1 staffing impler appropriate assess and a new safety ple-the consultant pharmedications - a PT assessment combination wheeld for stability was ord - PT also planned revice upon arrival for R87 - a physician review - a comprehensive developed and staff appropriately; a post required progress relectronic chart to the plan to include modinterventions; all staverbally, via e-mail nurses' stations; NALPNs, activity staff, to confirm impleme Although numerous noncompliance rem severity of a G, isol actual harm that is because the facility assessment and states.	ing: use of the Merry walker for R87 mented for R87 until ments could be completed an initiated armacist reviewed R87's was conducted and a chair/walker with 18" wheels ered e-assessment of the new to determine appropriateness was conducted fall assessment was f were educated to implement at fall assessment, including note, was created in the rigger a review of the care lifications and review of aff were educated either and/or by written postings at as, RNs, case managers, and PT staff were interviewed	F 323			
F 334 SS=E	483.25(n) INFLUEN IMMUNIZATIONS	velop policies and procedures	F 334	1		8/30/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		245434	B. WING			07/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET LEXANDRIA, MN 56308		
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F 334	each resident, or the representative recested benefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or timmunized during the contraindication; and (iv) The resident's representative has immunization; and (iv) That the resident representative was the benefits and point influenza immunization; and (B) That the resident influenza immunization contraindications of the facility must detail the tensure that (i) Before offering the benefits and point immunization; (ii) Each resident is immunization; (iii) Each resident is immunization, unless medically contraindically contraindically contraindically contraindically the resident or the resident	ne influenza immunization, e resident's legal ives education regarding the ial side effects of the offered an influenza per 1 through March 31 e immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical refusal. evelop policies and procedures the pneumococcal resident, or the resident's ereceives education regarding tential side effects of the offered a pneumococcal is the immunization is icated or the resident has nized;	F	3334			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI 1020 LARK STREET ALEXANDRIA, MN 56308	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 334	immunization; and (iv) The resident's documentation that following: (A) That the resident representative was the benefits and population of the pneumococcal impresentation of the pneumococcal impresentation of the pneumococcal contraindication of the pneumococcal impresentation of the pneumococcal impresentation of the pneumococcal impresentation, unless that the pneumococcal impresentation of the pneumococcal impresentation, unless that the pneumococcal impresentation is the pneumococcal impresentation in the pneumococcal impres	medical record includes t indicated, at a minimum, the lent or resident's legal s provided education regarding otential side effects of nunization; and lent either received the nunization or did not receive immunization due to medical refusal. re, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal resident's legal representative	F3	334		
	by: Based on intervier facility failed to ensemble Conjugate Vaccine offered to 4 of 5 reas recommended Control (CDC) who reviewed and failed PCV13 as recommended: R20's Immunization indicated the 91 years.	NT is not met as evidenced w and document review, the sure the Pneumococcal 1-13 (PCV13) vaccines were sidents (R20, R71, R91, R94) by the Centers for Disease use vaccination histories were and to develop guidelines for mended by the CDC. In Audit Report dated 7/22/16, ar old had received 1 on 1/1/07; however, the		F334 Influenza and Pnerimmunization Guidelines for administra PCV13 have been obtain Director's order obtained education on new guideli on 8-4-16. A. R20, R71, R91, R94 PVC13 according to the B. All resident have the affected by this practice. residents will be assesse	tion of the use of ed. Medical , and staff nes completed will be offered CDC guidelines. potential to be Upon admission	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245434	B. WING			07/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET LEXANDRIA, MN 56308		
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F 334	medical record lack offered the PCV-13 by the CDC. R71's Immunization indicated the 95 year Pneumovax dose 1 medical record lack offered the PCV-13 by the CDC. R91's Immunization indicated the 102 year Pneumovax dose 1 medical record lack offered the PCV-13 by the CDC. R94's Immunization indicated the 96 year Pneumovax dose 1 medical record lack offered the PCV-13 by the CDC. When interviewed offered the PCV-13 by the CDC. When interviewed of registered nurse (R the facility's infection the facility was awa recommendation rewas not a standard the vaccination to the physician specifical verified the CDC's reflected in the facility's Pneum December 2012, incompared the control of the physician specifical control of the facility's Pneum December 2012, incompared the control of the facility's Pneum December 2012, incompared the control of the facility's Pneum December 2012, incompared the control of the facility's Pneum December 2012, incompared the control of the facility's Pneum December 2012, incompared the control of the facility's Pneum December 2012, incompared the control of the facility's Pneum December 2012, incompared the control of	ed evidence R20 was also vaccination as recommended a Audit Report dated 7/22/16, ar old had received on 6/22/11; however, the red evidence R71 was also vaccination as recommended an Audit Report dated 7/22/16, ar old had received on 10/1/90; however, the red evidence R 91 was also vaccination as recommended an Audit Report dated 7/22/16, ar old had received on 9/17/09; however, the red evidence R 94 was also vaccination as recommended on 7/22/16, at 1:42 p.m. N)-D who was responsible for n control program confirmed	F3	34	the pneumococcal vaccination (PC as per the CDC guidelines. PCV13 offered first per the CDC guidelines administrated if the resident so des Education will be given at the time offer of the vaccination explaining t VS benefits of the vaccination. Will up with the PPSV23 vaccination peguidelines. All residents currently residing in the building and that have previously he PPSV23 vaccination, will be offered PCV13 according to the guidelines residents who qualify for the PCV 1 vaccination will be offered and vaccination will be offered and vaccination will be administered if the resident desires. C. Audits on all new residents for administration of the PCV13 will be completed on the next 20 admission assure guidelines are being followed. D. Audits on all current LTC resident assure the PVC13 was given/offered they qualify according to the CDC guidelines. E. Completion for the administration the PVC 13 8-30-16. Results will be reported to monthly meeting. DON or designee response.	S will be and sires. of the he risk follower ead the day of the and the day of the eads to ed, ents to ed if	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ATE SURVEY DMPLETED
		245434	B. WING	o	7/22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET ALEXANDRIA, MN 56308	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334 F 371	The policy, howeve	pneumococcal infections. r, did not incorporate the new ensure residents were offered ns.	F 334		8/11/16
SS=F	The facility must - (1) Procure food fro considered satisfac authorities; and	om sources approved or tory by Federal, State or local distribute and serve food			
	by: Based on observative review the facility facteanliness of the wanitation and food This practice had the received food from Findings include: During the initial kit 7/18/16, at 1:14 p.n. the walk-in refrigeration to the refrigeration to the refrigerations and the stainled dark brown substar strong sour odor arinside the unit. Alor there was a signific	cion, interview and document diled to maintain the valk-in cooler to promote safety in the main kitchen. The potential to affect all 80 who the kitchen. The chen tour with cook (C)-A on the it was noted the outside of ator was wet. The frame of the ator had a thick layer of white less steel door frame had a line evident when opened. A line garbage smell was evident and the south wall of the cooler ant number of irregular ack colored substance located		F371 Food Procure, Store/Prepare/Serve-Sanitary The Walk in cooler has been fully cleaned and sanitized by dietary staff in order to store, prepare and distribute foo under sanitary conditions per regulation. Current walk in cooler will be fully replaced with an entirely brand new unit as of 10/1/2016 by Alexandria Refrigeration. A full cleaning schedule to include the entire current walk in cooler has been purinto place to allow for and promote sanitation and food safety. All dietary staff have been educated as of 8/11/2016 on the proper cleaning schedule and process per Ecumen Bethany cleaning policy.	e

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		245434	B. WING		07/	22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 1020 LARK STREET ALEXANDRIA, MN 56308	·	
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F 371	vegetables (leaf let tomatoes) were sto tomatoes and leaf I without any covering. Throughout the ent and chipped paint winterior walls of the but the walls had be was evident as the interior walls. Local stored vegetables was apples. These fruit of the dark colored. On 7/21/16, at 1:55 stated she had a deaid (DA)-A who cleat Monday which inclus completed, the coorefrigerator. DD states Monday and should she saw DA-A in the equipment required would be entered in confirmed the most had been related to week. It was observed on was placing grocer the walk-in cooler/resence of the most and DD indicated the in the walk-in coole could not keep up woold could not keep up woold.	d and third shelves. Fresh tuce, cabbage, spinach and ored on these shelves. The ettuce were open to air, ag of these food items. ire unit large areas of missing were noted. It appeared the walk-in cooler had been silver een painted a white color. This paint was peeling from the atted adjacent to the shelves of were stored fresh oranges and a items were next to the areas	F 3	Audits of Cleaning so completeness and cleanly cooler will be completed by Dietary Manger or design results will be provided to review.	iness of walk in by Certified nee for 4 weeks,	

CLIVILI	10 1 OIT WEDIONITE	A MEDICAID SERVICES				IVID IVO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
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F 371	working properly. The broken gray seal has thus not working proconditions inside the was responsible for confirmed that mole frame. He stated the make sure the door door was sweating was evident due to humidity level. Whe away from the wall, there was black cold the length of the shength of the shength of the second were several irreguing patches and streak to 1-1/2 inches around black patch of the bher fingers. A dark fingers. Both C-A and odor was evident with they did not have be anymore, but used C-A also confirmed front of the shelf which is a cardboard box, had leaked liquid on C-A indicated both onto the floor. C-A floor in the walk-in cand had rusted. He significant rust local thawing rack which from the rack.	ge 53 g the door seal was not The MM had confirmed the ad separated from the door, operly to maintain the e cooler. The MM stated he cleaning the door seals and d was evident along the door ney just had to be careful to r was shut tight but verified the and consequently, moisture the broken seal and the en C-A removed the shelving both C-A and DD confirmed ored mold extending across elving and down the entire extended from above the shelf down to the floor. There lar shaped black colored mold s on the wall with several, up and or long. DD wiped a large black substance (mold) with residue remained on her and DD confirmed a strong hile in the cooler. C-A stated aking soda in the cooler to use it to control the odor. there was standing liquid in here a pork roast was thawing He confirmed the frozen roast anto the floor during thawing. The pork and fish tend to leak stated they have a galvanized cooler, which was damaged to confirmed the floor had ted in front of the meat extended approximately 6 in.	F	371			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION	` '	TE SURVEY MPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 371	top of a stainless silt was observed that cooler on his kneed bucket containing brag. C-A indicated hinside the cooler, a it had been washed substance was preselevel in the cooler. In oticed the black misurveyor made their black substance of bleach solution, grawall as it was wash. On 7/21/16, at 3:45 scheduled to clean a.m. but confirmed inside the walk-in cher scheduled hour wash the wall and wisince they had been who was assigned indicated only receivant random checks of the had too many other noticed the black signast but was unsurbleach kills it. When interviewed of MM and the admining were unaware of the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system, is schedule for the walk-in cooler and develop a system.	e shelving and placed them on teel cart located in the cooler. It C-A was inside the walk-in and had a small white plastic bleach solution and a cleaning he had never washed the walls and was unsure of the last time if the stated the black sent due to the high humidity C-A indicated he had never hold substance until the maware. As C-A wiped the fithe wall of the cooler with the may colored water ran down the	F3	71		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245434	B. WING		07/	22/2016
NAME OF PROVIDER OR BETHANY HOME	SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308	·	
PREFIX (EACH I	DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
Prior to ref Review of the Food S service sta food service the cleaning Review of 4/08 identify weekly. 483.70(c)(OPERATII The facility mechanical equipment This REQUIPMENT This REQUIPMENT	clean the urning the the unda Service Daff shall note departing sched the dieta fied refrig. 2) ESSENG CON must mal, electrication safe of the cooler land for the practice and the practice the unitial kit to the cooler land the practice are refrigerate refrigerate refrigerate refrigerates.	e unit, including the shelves e stored food items. Ited facility policy, Sanitation of repartment identified the food naintain the sanitation of the ment through compliance with ule. The compliance with the compliance with the sanitation of the ment through compliance with the compli	F 4		n fully ed by epare and nditions e fully new unit aclude the been put	8/11/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
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F 456	inside the unit. Alor there was a signific shaped areas of bla between the second vegetables (leaf let tomatoes) were sto tomatoes and leaf I without any coverint Located adjacent to vegetables were sto apples. These fruit of the dark colored On 7/21/16, at 1:55 stated if any kitcher repairs, a work order entered pallet sent the prevolute sent the prevolute walk-in cooler/rethe surveyor re-entropresence of the modand DD indicated the surveyor resence of the	and garbage smell was evidenting the south wall of the cooler ant number of irregular ack colored substance located d and third shelves. Fresh tuce, cabbage, spinach and red on these shelves. The ettuce were open to air, g of these food items. To the shelves of stored ored fresh oranges and items were next to the areas substance. p.m. dining director (DD) in equipment required any er would be entered into the confirmed the most recent had been related to a storage	F 45	All dietary staff have been as of 8/11/2016 on the proper schedule and process per Ed Bethany Community cleaning. Audits of Cleaning schedule completeness and cleanlines cooler will be completed by ODietary Manger or designee results will be provided to QA review.	er cleaning cumen g policy. dule ess of walk in Certified for 4 weeks,	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY MPLETED
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			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
moisture was evide the humidity level. evident between the the shelving away frareas of dark colore the wall from the arthe floor of the refrigalvanized floor in the damaged and had reformed to on 7/21/16, at 2:10 vegetables from the top of a stainless store the stated the black to the high humidity. On 7/21/16, at 3:45 noticed the black supast. When interviewed the door to the walk evidence of the hum walk-in cooler door door. 483.70(h) SAFE/FUNCTIONAE ENVIRON The facility must presanitary, and comfor residents, staff and	ont due to the broken seal and C-A confirmed the mold was a shelves and when he pulled rom the refrigerator wall, and substance extended down the above the second shelf to gerator. He stated they have a she walk-in cooler, which rusted. p.m. C-A removed the exhelving and placed them on the exhel				8/11/16
	ion, document review and		F465		
	Continued From parmoisture was evide the humidity level. evident between the the shelving away from the wall from the arthe floor of the refrigularized floor in the damaged and had refront of a stainless stop of a stainless st	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 moisture was evident due to the broken seal and the humidity level. C-A confirmed the mold was evident between the shelves and when he pulled the shelving away from the refrigerator wall, areas of dark colored substance extended down the wall from the area above the second shelf to the floor of the refrigerator. He stated they have a galvanized floor in the walk-in cooler, which damaged and had rusted. On 7/21/16, at 2:10 p.m. C-A removed the vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. He stated the black substance was present due to the high humidity level in the cooler. On 7/21/16, at 3:45 p.m. DA-A stated she had noticed the black substance on the racks in the past. When interviewed on 7/21/16, at 5:30 p.m. the MM stated he was unaware of the broken seal on the door to the walk-in cooler and confirmed the evidence of the humidity/moisture problem on the walk-in cooler door and walls inside the cooler door. 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.	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 moisture was evident due to the broken seal and the humidity level. 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When interviewed on 7/21/16, at 5:30 p.m. the MM stated he was unaware of the broken seal on the door to the walk-in cooler and confirmed the evidence of the humidity/moisture problem on the walk-in cooler door and walls inside the cooler door. 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:	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 moisture was evident due to the broken seal and the humidity level. C-A confirmed the mold was evident between the shelves and when he pulled the shelving away from the refrigerator wall, areas of dark colored substance extended down the floor of the refrigerator. He stated they have a galvanized floor in the wall-in cooler, which damaged and had rusted. 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WING 277 STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 57 moisture was evident due to the broken seal and the humidity level. C-A confirmed the mold was evident between the shelves and when he pulled the shelving away from the refrigerator wall, areas of dark colored substance extended down the wall from the area above the second shelf to the floor of the refrigerator. He stated they have a galvanized floor in the walk-in cooler, which damaged and had rusted. On 7/21/16, at 2:10 p.m. C-A removed the vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. He stated the black substance was present due to the high humidity level in the cooler. On 7/21/16, at 3:45 p.m. DA-A stated she had noticed the black substance on the racks in the past. When interviewed on 7/21/16, at 5:30 p.m. the MM stated he was unaware of the broken seal on the door to the walk-in cooler and confirmed the evidence of the humidity/moisture problem on the walk-in cooler door and walls inside the cooler door. 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL E EN/IRON 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245434	B. WING _		07	/22/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1020 LARK STREET ALEXANDRIA, MN 56308	•	122/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 465	interview the facilit condition of the kit and functional mar the main kitchen. To affect all 80 resi the kitchen. Findings include: On 7/18/216, at 1: tour with cook (C)-covering underneasteamer and oven area had an area of which measured a 18 in. The area with a dark brown, stick measured approximate the food particles and the food particles and the food particles and the steamer which stated the brown sut was compacted the steamer which stated the brown sut was compacted the cleanable surface, housekeeping staff	y failed to maintain the chen floor covering in a clean mer to promote sanitation in This practice had the potential dents who received food from 14 p.m. during the initial kitchen A it was noted that the floor ath and surrounding the affixed located in the food preparation of missing maroon floor tile, pproximately 18 inches (in) by as filled with dark and light gray also. In addition, there was haped area directly under the to the missing tile area that was a ky, sludge material which mately 6 in by 4 in. The entire eparation area was soiled with	F 4	Safe/Functional/Sanitary/Contensions Environment Kitchen Floor Tile has be cleaned throughout entire Knowled a safe, functional, should compose the composition of the provide and staff. Damaged Tile in kitcher replaced and repaired as of and the entire kitchen are been put into place All dietary staff have been as of 8/11/52016 on the proschedule and process per Environment the completeness and cleanling floors with be completed by Dietary Manger or designed results will be provided to Content the prov	peen fully (itchen area to canitary and or residents) In has been 8/23/2016 edule to rea floors has been educated oper cleaning Ecumen and policy. dule ess of kitchen Certified er for 4 weeks,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING _	·····	07/	/22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP COI 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 465	(MM) and the admit condition of the dar floor. MM knelt to the across the area and on his hand. MM a surface need to be agreed the damage MM and A confirme was evident on the stated it would be conservice of the undar the Food Service D service staff shall means to the dark the food Service D service staff shall means to the dark the food Service D service staff shall means to the dark the food Service D service staff shall means to the dark the food Service D service staff shall means the dark the dar	the maintenance manager nistrator (A) confirmed the naged floor tile and the dirty he floor, wiped his hand divisible gray dust was evident and A confirmed the floor repaired and/or replaced and die tile surface was unclean. If a dark brown sticky material floor behind steamer and leaned. Ited facility policy, Sanitation of epartment identified the food naintain the sanitation of the ment through compliance with	F 40	55		

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	Y HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correspursuant to a surver found that the deficiency found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				

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

Electronically Signed 08/12/16

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TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	2/2010
RETHAN	NY HOME		K STREET			
	-		PRIA, MN 56		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
2 000	Department of Hearyou electronically, is necessary for State necessary for State enter the word "context. You must then State licensure proceedings of the corrected prior to element of the correction of the correction that you and identify the date. Minnesota Department of the correction that you and identify the date. Minnesota Department of the correction of the column entitled "ID statute/rule out of constatute/rule out of constat	Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Lugh 7/22/2016, surveyors of taff, visited the above provider correction orders are issued. Lour electronic plan of have reviewed these orders, e when they will be completed. Leent of Health is documenting. Correction Orders using an umbers have been lota state statutes/rules for lumber appears in the far left of Prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the list column also includes the n violation of the state statute. "This Rule is not met as wing the surveyors findings method of Correction and crection. LRD THE HEADING OF THE	2 000			

Minnesota Department of Health

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Minnesota Department of Health

winneso	ta Department of He	ailli				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ' 00			SURVEY LETED
ANDILAN	OF CONTILOTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	LLILD
		00108	B. WING		07/22/2016	
					1 01/2	.2/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	Y HOME		K STREET RIA, MN 56	308		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			8/9/16
		omprehensive plan of care personnel involved in the				
	by: Based on observati review the facility fa care for 2 of 3 resid were dependent up cares and for 1 of 1	ent is not met as evidenced on, interview and document illed to implement the plan of lents (R78, R28) reviewed who on staff for shaving and oral resident (R65) reviewed with actures and required range of	S	Corrected 8/9/2016 per Director of Nursing	f	
	Findings include:					
	7/1/16, identified R7 impaired, required areas of daily living assistance to walk i	linimum Data Set (MDS) dated 78 was moderately cognitively extensive assistance for all (ADL)with exception of limited n corridor and diagnoses kinson's disease, dementia, mpairment.				
	care deficit related hypertension, diabe	plan, identified R78 had a self to Parkinson's Disease, ites, and dementia as ring assist with ADL's -The				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMEN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/22/2016	
					07/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	YHOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 3	2 565			
	resident requires expersonal hygiene.	tensive assist of 1 staff with				
		ent care sheet, indicated R78 ne staff with dressing and				
	shave because of n	a.m. R78 stated, "I can't ny Parkinson, that is one thing on." At this time R78 has I upper lip.				
	his room to the dini	a.m. R78 was propelled from ng room by nursing assistant acial hair stubble on the upper				
		p.m. R78 was seated in his chair in front of the television. naven.				
		a.m. R78 was seated in not had face shaved, d heavy stubble.				
	to shave independent needs help. NA-H	a.m. NA-H indicated R78 tries ently and will ask staff when he indicated R78 was new to the as unsure of whether R78 had d cares.				
	verified if he was at do it every day. R78 face each morning electric razor but so verified his facial ha	on 7/20/16, at 1:00 p.m. R78 ble to shave himself he would 3 stated staff will shave his when they get him up with an ome times they forget. R78 air had not been shaved off ble to recall when staff last				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURV COMPLETE	
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	Y HOME		K STREET	2000		
(X4) ID		ALEXAND TEMENT OF DEFICIENCIES	RIA, MN 56	PROVIDER'S PLAN OF CORRECTION)N	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	no behaviors and da walk, however, it example if his wife pain in his hip. On 7/21/16, at 9:54 unable to shave indicated hands. NA-E verified this a.m. NA-E indicated heigh a good memory and NA-F indicated heigh R78 often, however clean shaven. NA-F assisted R78 with or shave the shaven. NA-F assisted R78 with or shaven.	p.m. NA-I identified R78 had id occasionally refuse to go for was usually for a reason, for was here or if he was having a.m. NA-E indicated R78 was dependently due to shaky do he/she had not shaved R78 cated R78 refused the offer to lihad a routine of shaving only 0 a.m. NA-F verified R78 had do what he says is accurate. She did not provide cares for re, did believe R78 was usually indicated staff usually indicated staff usually oral care and shaving. NA-F normally shave a person if es."				
	shaved this morning isn't so hard to get of R78 further identified	4 a.m. R78 verified he was not g. R78 stated, " it (facial hair) off" if he is shaved every day. ed with a clean shaven face it clean as things get caught,	•			
		3 a.m. licensed practical nurse '8 had facial stubble and had				
	(RN)-A verified R78 ADL's due to has F although his abilities was not able to sha electric razor. RN-A	1:14 a.m. registered nurse required assistance with Parkinson's Disease and schange from day to day, R78 ve independently with an identified staff were male residents daily and would				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
ANDILAN	OF GOTHLOTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET			
			RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	not expect resident assistance.	s to have to ask for the				
	director of nursing (that staff follow the require assistance of care and not expect the staff follow the required assistance of the staff was an action of the staff were to assist offer R28 mouth swand while getting recomplete an oral in needed. The undated reside did not wear the de	on 7/22/16, at 11:25 a.m. the DON) verified the expectation care plan and residents who with ADL's be provided the ted to ask for assistance. ed 7/15/16, identified R28 assistance to total assistance ne and oral cares. The care had upper and lower dentures. with cleaning dentures and to rab and mouth was in the AM ady for bed, and staff were to spection with cares and as ent care sheet, indicated R28 intures. The resident care rection regarding oral cares				
	from 8:23 a.m. to 8 assisted R28 with p washing her face, p During the observar offered the opportu cares. R28's oral c dry.	of morning cares on 7/20/16, 54 a.m. NA-A and NA-G sersonal cares which included serineal cares and dressing. Ition, R28 was not assisted nor nity for completion of oral avity and lips appeared very				
	while R28 was posi wearing any dentur breakfast food item consume the strawl -At 9:01 a.m. NA-A shut off the bedroor	assisted R28 with breakfast tioned in bed. R28 was not es, and R28 refused the s and juice offered. R28 did perry supplement. gathered the breakfast tray, m lights and stated some days ng, and some days are not,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
RETHAN	IY HOME		K STREET			
DETTIAN	TI TIOWIE	ALEXAND	DRIA, MN 56	6308		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
2 565	just like today. NA-tray to the kitchen, offered the opportucares. During interview on reported R28 no lor stated she was goir breakfast to provide swabbing out the management of the provided swabbing mouthwash. Further inspect her mouth was a provided staff are expected by mouth and sleed therefore, oral care of the provided staff are one of the provided staff and staff of the provided staff are oral cares to a sindicated on the care. The facility's Mouth 2010, directed staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of R65's quarter of the provided staff plan for any special assemble the equipal series of R65's quarter of R65	A then delivered the breakfast R28 was not assisted nor nity for completion of oral 7/20/16, at 8:45 a.m. NA-A niger wears dentures, and nig to wait until after R28 ate e oral cares which included nouth with a toothette. confirmed R28 had finished neal and confirmed she had cares for R28. NA-A verified te nor offer oral cares which the mouth with a toothette or er, NA-A confirmed she did not with cares. 7/21/16, at 10:35 a.m. RN-B niger wore dentures. RN-B pected to swab R28's mouth, or at least attempting as R28 RN-B confirmed R28 has a ps with the oral cavity open, must be attempted. 7/22/16, at 10:08 a.m. the ff are expected to provide or all resident twice per day as re plan. Care Policy dated October to review the resident's care needs of the resident. and oment and supplies as needed. arterly Minimum Data Set				
	(MDS) dated 4/27/1	arterly Minimum Data Set 6, identified R65 had severe nt and had diagnoses which				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00100	B. WING		07/0	0/0046
NAME OF		00108			07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, 8 K STREET	STATE, ZIP CODE		
BETHAN	IY HOME		RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	included Parkinson disease and cerebr hemiplegia. The M totally dependent or living (ADL's) and he contractures. Review Assessment (CAA) had severe cognitive Alzheimer's disease staff for ADL's and Review of R65's calidentified R65 had he upper and lower existed dependent on staff range of motion with rolls in both hands and contractures. On 7/18/16, at 5:38 in space wheelchair station prior to the existed near her heal in bent and hands reserted near her heal her left upper chest placed in her hands seated in a tilt in spenurses station follower mained without keyon 7/19/16, from 8 was lying in bed tiltagainst her back, be cover R65 to mid to fisted position, arm fisted hands rested have kerlix in her hards and contractures.	Is disease, Alzheimer's avascular disease with DS further identified R65 was a staff for activities of daily ad bilateral upper extremity of R65's annual Care Area dated 8/19/15, identified R65 are impairment due to e, was totally dependent on had contractures. The plan print dated 2/25/16, bilateral contractures of the tremities, was totally for all ADL's, required gentle hadily care, required gauze 23/hrs/day: to be removed for aily for hygiene for bilateral p.m. R65 was seated in a tilt reacross from the nurses evening meal. Both of R65's a fisted position, elbows were ted on her chest, right hand art and her left hand rested on a R65 did not have kerlix and her left hand rested on a R65 did not have kerlix acc wheelchair near the wing the evening meal. R65 erlix/gauze in both hands. Beth of R65's hands were in a last were bent at the elbow, against her chest. R65 did not not against her chest. R65 did not not against her chest. R65 did not not severe with the lebow, against her chest. R65 did not not severe with the lebow, against her chest. R65 did not not severe with the lebow, against her chest. R65 did not not severe with the lebow, against her chest. R65 did not least the lebow, against her chest. R65 did not least the lebow.	2 565			

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Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
711101 271	VOI COMMEDITION	BENTH TOXITIEN NOWBETT.	A. BUILDING:		CON	LLILD
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RETHAN	NY HOME	1020 LAR	K STREET			
BEITIAL	41 HOWE	ALEXAND	PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 8	2 565			
2 565	in space wheelchai elbows, hands were were clenched fiste clenched hand was left clenched hand chest, no kerlix was. When interviewed or registered nurse midd not have kerlix is care planned and wont in use. RN-A stawere responsible for R65's kerlix were in contractures. RN-A were too contracted out, nor could R65 independently. RN contracted and had a licensed practical. On 7/21/16, at 5:13 open R65's right had contracted, fisted papproximately an in roll into R65's hand was hurting her fing stopped opening R stated there were tineeded to be soaked the hands up. RN-A R65's to her room a her bathroom, while out of the faucet. Nheld it under the was opened R65's hand the kerlix. NA-B the under the water who washed, dried and	r with both arms bent at the e resting on her chest and d position. R65's right resting over her heart and her was resting on her upper left s observed in R65's hands. on 7/21/16, at 5:09 p.m. anager (RN)-A confirmed R65 in her contracted hands as vas unsure why the kerlix was ated the medication nurses or checking to make sure in both hands for bilateral hand stated she felt R65 hands of for the kerlix to have fallen remove the kerlix to have fallen remove the kerlix stated R65's hands were fully been for years. RN-A directed nurse (LPN)-D to apply kerlix.				

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Minneso	<u>ta Department of He</u>	alth				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/22/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 9	2 565			
	her wheelchair and station.	wheeled R65 back to nursing				
	supposed to have that all times. NA-B statem in after R65's stated she felt about kerlix were not in he place the kerlix into hard time doing so. R65's hands were fould not fall out an unable to remove the she felt R65's hand last few years.	p.m. NA-B stated R65 was he kerlix in both of her hands tated the nurses usually put hands were washed. NA-B at 3-4 times a week R65's er hands and she would then R65's hands and often had a NA-B further stated she felt isted very tightly so the kerlix at she felt R65 would be ne kerlix herself. NA-B stated shad not worsened over the				
	required total assist stated on average a not have the cloth re	3 a.m. NA-C stated R65 cance with all ADL's, NA-C a few days a week R65 would olls, (kerlix) in her hands and ace the kerlix in R65's	O			
	not had a recent oc though had one a fe R65 had complete of RN-A confirmed R6 directed nursing state placed in both conting removed when was the licensed nurses R65 had the kerlix in the kerlix on the (TA) expected the kerlix	7 a.m. RN-A stated R65 had cupational therapy evaluation, ew years ago which identified contractures of both hands. 5's current physician orders aff to ensure R65 had kerlix racted hands and only to be hed twice daily. RN-A stated were responsible to ensure n place and would document AR.) RN-A stated she to be in place as any care exertix. RN-A stated R65 had ds and fingers.				

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On 07/22/16, at 11:13 a.m. the director of nursing

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY LETED
		7. Boileante.				
		00108	B. WING		07/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	be implemented as not feel that R65's k hand contractures to control. The DON ophysician orders in medical record ider was ordered for hand. The facility policy tit Assessment and Plindicated the care pof care from admiss. The facility's Care F2010, indicated the enhance the optimal and/or aid in prever resident's functional levels. SUGGESTED MET The director of nurs review and revise pto ensuring the care resident is followed designee could devand develop a monare providing care a of care. TIME PERIOD FOR	expected resident care plans to directed. DON stated she did serlix treatment was for her out were more for moisture confirmed R65's current point click care electronic ntified R65's kerlix treatment and contractures. Eled Resident MDS 3.0 an of Care revised 03/12, plan was to provide continuity	2 565	DETIGIENCY)		
2 830	(21) days. MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			8/12/16
		general. A resident must e and treatment, personal and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/2	2/2010
BETHAN	Y HOME		K STREET ORIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t resident must rema prefers to remain in	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	review, the facility fassess, ensure addimplement interven further falls for 1 of who sustained multinjury while utilizing combination type dimmediate jeopardy failed to investigate the resident's falls who determine wheth have been implemented ensure intervention adequate and consiminimize the risk for the immediate jeopardy when R87 sustaine walking in the Merry administrator and dinotified of the immediate intervention and the matter	on, interview and document ailed to comprehensively equate supervision and tions, to decrease the risk of 3 residents (R87) reviewed iple falls. R87 experienced an a Merry walker (a walker/chair evice), resulting in an (IJ) situation. The facility and comprehensively assess while utilizing the Merry walker er new interventions should ented, and the facility failed to scurrently in place were istently implemented to r further falls. Dardy (IJ) began on 10/24/15, d a fall with injury while y walker. The facility's irector of nursing (DON) were ediate jeopardy (IJ) situation p.m. The IJ was removed on		Corrected 8/12/2016 per Director Nursing	of	

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
		00108	B. WING		07/2	2/2016
NAME OF E	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY :	STATE, ZIP CODE		
			K STREET	<u>.</u> , <u></u>		
BETHAN	Y HOME		ORIA, MN 56	6308		
(X4) ID	SHMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				22.16.2.001,		
2 830	Continued From pa	ige 12	2 830			
	lower level of G, iso	plated scope, with severity of				
	actual harm that is	not immediate jeopardy.				
	Findings include:					
	i mamige melader					
		on 7/18/16, at 5:31 p.m. with a				
		round her waist, standing in a				
		of PVC pipe. Cloth weights				
		with zip ties to the bottom of sides and a cloth type strap				
		e seat of the walker. The strap				
		nt of the walker and was				
	located between Ra	87's legs. R87 independently				
		e Darling Springs unit utilizing				
		R87 was observed to walk with				
		was noted to have an				
		ight eye. When she got to the ng room, R87 couldn't move				
		rward. R87 remained				
		orway to the dining room until				
		NA)-D assisted R87 to turn				
		walker so R87 could				
		posite direction. R87 continued				
		e area of the Darling Springs				
	nurses desk, bump	oing into walls and doorways.				
	R87 was again obs	erved on 7/18/16, at 6:48 p.m.				
	_	y walker in the Darling Springs				
		fled gait. R87 was observed				
	bumping into walls,	doorways and residents in				
		valking down the hallway in the				
	_	e. The administrator was				
		ne to grasp a corner of the				
		aighten R87's navigation. A R87 was observed to				
	· · · · · · · · · · · · · · · · · · ·	right front corner of the Merry				
		ackward and came to rest on				
	T	ry walker with half of her				
		on the seat of the walker. R87				
	then stood and con	tinued to wander throughout				

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		K STREET DRIA, MN 56	3308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 13	2 830			
	the hallway while at walker.	ttempting to navigate the Merry				
	guide R87, who wa her room to the hall independently walk observed to walk w located in the short not within staff view the corner of the sh grasp the door handlabeled B-13 and jig turned her body to walker, moved the out from the corner nurses' desk located the dining room. At move about in the figait. She navigated located near her roside of the nurses' area. At 10:47 a.m (technician) and twiside of the nurses' sarea. None of these three of R87 as they walk a.m. licensed practithe nurses' station amedication cart whild direction from R87, area where R87 co time, R87 was observed to have the Merry walker seconds.	22 a.m. NA-E was observed to us in the Merry walker, out of a lway. NA-E then left R87 to in the Merry walker. R87 was with a shuffled gait. She was a hall outside of her room, but w. While in the Merry walker in nort hall, R87 was able to dle to the bathroom door ggle the handle. R87 then the right side of the Merry walker in a sideways direction and moved toward the ed on the opposite side from a 10:46 a.m. R87 continued to Merry walker with a shuffled a to and from the short hallway om which was located on the station desk without staff in the at a lab (laboratory) tech of facility staff walked near the station facing the dining room. We staff looked in the direction ked past this area. At 10:47 dical nurse (LPN)-C returned to area and approached the ich faced the opposite. LPN-C did not move to an ould be supervised. During this lerved to have turned herself alker to face backwards, and ave lifted her right knee onto leat.				

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Minnesc	<u>ota Department of He</u>	ealth				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	3308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
2 630	Neither NA looked is once again maneur corner of the hall ar forward. At 10:51 at the Merry walker were walls in the short havicinity nor in view of At 10:55 a.m. R87 the corner with the feet, one at a time, bar of the Merry waright knee onto the a.m. R87 shuffled to location of the nurs Merry walker bar, sforward with little shapped to resident rooms be direction. At 11:00 ambulate with small walker toward the radianst the nurses' R87 stood up in the caught against the noted on the dining. At 11:11 a.m. on 7/female resident seathe vicinity of the nupushed her Merry walker and shook it while R87 continue the resident located R87's left wrist and	n the direction of R87 as she vered the Merry walker into the nd was unable to propel it .m. R87 stood backwards in he front and one side of the located against the corner allway. No staff were in the of R87 to provide supervision. The mained unable to move from Merry walker. R87 raised her placing them onto the bottom lker. She then placed her seat of the walker. At 10:57 he Merry walker towards the es' desk, leaned over the pit on the floor and continued nuffled steps in the direction of near the bathroom. NA-E was to be delivering water mugs ut did not walk in R87's a.m. R87 continued to I steps, navigating the Merry nurses' station. R87 stopped e walker when it butted up station desk. At 11:08 a.m. a Merry walker while it was nurses' station. Staff were room side of the desk. 19/16, R87 and another ated in a wheelchair were in urses' desk. At 11:14 a.m. R87 walker into the other female air. When R87 could not grasped the top bar of the back and forth. At 11:17 a.m., d to shake the Merry walker, in the wheel chair grasped stated "go tell your mother". On the back and forth of the stated of the shake the Merry walker. The walker was but continued to shake the back on the shake the Merry walker.	2 830			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET			
	I		PRIA, MN 56		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
2 830	the walker. At 11:1 through the area pure onto the elevator, wo f R87. At 11:19 a. in the Merry walker buttock seated on the Merry walker remains resident's wheel characteristic walker. The resident walker. The resident you want me to spawrist. At that time, the two residents. R87's annual Minim 5/11/16, identified Formemory problems with the two residents. R87's annual Minim 5/11/16, identified Formemory problems with the physician 6/27/diagnoses included Parkinson's disease R87's Care Area As 5/11/16, included: "severe impairment CAA r/t [related to] with Lewy bodies, FADL functional /Relassist with ADL's and Disease, Dementia [hypertension], ostefalls]. See CP [care interventions are in Noted to have 2 fall monitor and implementation [as needed]. Reside times will wander in the properties of the properties	8 a.m. facility staff walked ishing a housekeeping cart without looking in the direction m. R87 finally seated herself with only the right side of her he Merry walker seat. The ned in contact with the other air. At 11:19 a.m. R87 stood again began shaking the not in the wheelchair stated, "do ank you?" and grasped R87's he surveyor summoned staff. Hered nurse (RN)-A separated for the surveyor summoned staff. Hered nurse (RN)-A sea				

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STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			SURVEY
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		20120	B. WING			0.100.10
		00108	b. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHAN	NY HOME		K STREET			
		ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
2 630	attempts to wander put across other resersedent of entering times. Is at risk for [related to] Dement Speech is mumbled right words. Responsense. Is sometime understands commat this time." Behave to have behaviors of others and wanderi with PRN pain med showing aggression ram into things with PRN pain meds have behaviors." R87's care plan reversident was "at rist Lewy Bodies, and Finterventions included appropriate footweam obilizing in wheel protocol. Physical threat as ordered or information on past cause of falls. Reconstituted appropriate footweam obilizing in wheel protocol. Physical threat as ordered or information on past cause of falls. Reconstituted appropriate footweam obilizing in wheel protocol. Physical threat as ordered or information on past cause of falls. Reconstituted in the fall of the fall o	outside. Velcro sashes are sidents' doorways to detour room. Does help detour at impaired communication r/t ia and Parkinson's Disease. If and has difficulty finding the nee does not always make as understood and sometimes unication. No referral needed vioral Symptoms: "Observed of physical abuse towards ng. Staff will provide [R87] is [medications] when is in her face. [R87] will also her Merry walker repetitively. We shown to redirect this riewed 7/13/16, indicated the key for falls due to dementia with Parkinson's disease." Jed: "Ensure [R87] is wearing ar when ambulating or chair. Follow facility fall nerapy eval [evaluation] and	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF			SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	.=	
BETHAN	IY HOME		K STREET RIA, MN 56	3308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	she moves or gets (8) Staff will monito minutes and PRN. sitting in recliner." R87's NA care sheer regarding specific or identified safety into (1) to ensure to take assisting to the reclosed, (3) clip call low bed and safety when not in bed), (5 (close to resident), when ambulating, or dining room, use both wanderguard worn. indicated in the con [see purple sheet in directed staff to "obthe NA care sheet of the Merry walker, in given even though monitor R87's when PRN. When interviewed of stated R87 was saff Merry walker and similar hour". On 7/19/16, at 1:35 usual practice to all in the Merry walker "We try to keep her job of keeping her of although she had in involving the Merry had stepped on the	up (has soft touch call light). r whereabouts every 30 (9) Bring to bathroom before et (a reference NAs used care for residents) undated, erventions for R87 to include: e R87 to the bathroom before iner, (2) keep bathroom door light on R87 at bed time, (4) mat (put mat against wall 5) keep gait belt on walker (6) Follow with wheel chair one to one assist when in ody pillow to position in bed, The NA care sheet also ment section: "Merry Walker in NA book]." The purple sheet serve frequently." Although directed staff to observe R87 in the care plan indicated staff to reabouts every 30 minutes and on 7/19/16, at 11:22 a.m. RN-A et to be unsupervised in the tated, "we check on her every p.m. NA-E indicated it was ow R87 to walk around while unsupervised. NA-E stated, safe, the nurses do a good close." NA-E verified that ot witnessed R87's falls walker, she'd heard that R87 bottom of the walker causing using a cut to R87's face.	2 830			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	YHOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 18	2 830			
	following 20 docum involved the use of was admitted on Ma (1) 5/10/15- found of walker; No apparent Care plan and mult being followed at timember (F)-A. Disc the Merry walker, F walker continues to a greater risk of injumerry walker and swill continue with 30 documents.	on floor underneath Merry				
	walker; head up agbruising on RUE (riprevious fall; No othwas crying but able Unwitnessed. Will pwhen not in bed to on mat or wheeling also continue Q (ev	on floor, had tipped over Merry ainst the wall on right side; ght upper extremity) from her noted injuries. Resident to voice if she was hurt. blace safety mat against wall orevent resident from tripping over it with Merry walker. Will ery) 30 minute checks.				
	the floor with one le Merry walker aroun back into Merry wal (mechanical device	by a staff member laying on by still around the strap of d 4:00 p.m. Resident assisted ker with 2 staff and EZ) lift. No further documentation hary team) review of fall.				
		sitting opposite direction in g on floor. No apparent				

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Minneso	<u>ita Department of He</u>	alth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TWINE OF T	TIOVIDEIT OTT OUT TEIETT		K STREET	51711 E, 211 GODE		
BETHAN	Y HOME		RIA, MN 56	308		
(V4) ID	QLIMMADV QTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	staff removed Merry	on floor in Merry walker. When y walker to assist off the floor, oting on her butt on the floor. CP being followed.				
	and right leg crosses grabbed for medica this caused [R87] a left. Right hip pain a Lump on left side of Pupils sluggish. Gu leg. Ice applied to he to the emergency d					
		n floor in Merry walker in room. of 2 staff. Resident was	/(
	resident's room with Was wearing slippe	n floor at 11:30 a.m. in another n no injuries or hitting head. ers and in Merry walker at time on: Up off floor and back in	Q			
		n floor in front of nurses' ker and slipper on. No injuries irrent CP.				
	Merry walker in her between legs; shirt in place; R87 agitat	sitting on floor backwards in room, leg strap still attached off at this time, gripper socks ed at the time. Staff last shortly before, less than hour				
	room, was lying und Merry walker was ir	ved on floor next to bed in der the Merry walker. The ntact, was assisted to the toilet walker at 2:20 p.m. No lumps				

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308 (X4) ID PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 20 bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor underneath Merry walker at 7:00 p.m. The strap	2/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 20 bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor	2/2016
BETHANY HOME 1020 LARK STREET ALEXANDRIA, MN 56308 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 20 bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor	2,2010
ALEXANDRIA, MN 56308 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 20 bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 830 Continued From page 20 bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor	
bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor	(X5) COMPLETE DATE
(12) 9/22/15- found in room on the floor	
(12) 9/22/15- found in room on the floor	
was hooked around R87's foot and was lying on her back. A small quarter sized bruise was found on right buttock. Brought to the bathroom and returned to bed.	
(13) 10/24/15- Resident tipped merry walker over sideways and was found face down on floor, unable to move. [R87] hit head/mouth on floor; mouth bleeding from losing a tooth. No one seen [sik] the incident so don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w, assist of 3 and EZ lift. A follow up nursing note dated 10/26/15 at 11:41 a.m. included, IDT reviewed fall from 10/24/15. Resident tipped over merry walker and landed on her face. Received a small abrasion under nose and lost a tooth as a result of the fall. Seroquel (antipsychotic medication) was recently decreased last Wednesday, [R87] more active since then. Per daughter's request, she would like Seroquel increased to the previous dose, she states she has seen her mom have more added behaviors and would like her mom to be more tired than anxious and falling. Referral filled out for MD (medical doctor). Also, weights added to the back of the merry walker to balance it. (The intervention of added weights to the base of the merry walker was initiated after R87 had sustained a fall on 6/28/15). A nurses' note dated 10/26/15, at 13:39 (1:39 p.m.) included:"Res. face continues to be swelled and abrasion is scabbed. Call placed to [MD] to inquire about xray to face. RN UC [registered nurse unit coordinator] aware. [MD's] nurse will call back	

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STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00108	B. WING		07/2	2/2016
NAME OF PROV	IDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHANY HO	OME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
hack tom from scale hack corresponding to the scale hack corre	nography X-ray] in 16:53 (4:53 p.m. nesults from the presented with a presented and a presented are spite the number izing the Merry wassess R87's fall a presented in Merry-walker act. Resident was assisted and a presented in the placed in the pla	I CT scan [computed for that date. Documentation m.) 10/26/15 indicated CT nat date, indicated the resident facial pain and more al. The report further included: displaced fracture through the ost maxilla (upper jaw) at the Additionally, a nurse's note 10/27/15 indicated the noral surgery consult. The of falls and fracture while valker, the facility failed to risk and interventions. The floor in the bathroom, under the bar with leg strap is found leaning against the nother injuries present. The distribution of the floor and into merry walker for meals.	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.			
	00108	B. WING		07/2	2/2016
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BETHANY HOME		RK STREET DRIA, MN 56	3208		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
still in the Merry vassisted back into lift and 3 staff assocontinue to feel the and continues to A physician visit of R87 was seen for "Nursing has no been stable." (18) 5/13/16- four was tipped over onext to bed, feet was trying to get Merry walker and Aide found reside Staff educated to floor when [R87] to remind staff to bed. (19) 6/26/16- four room in Merry Waseat. No injuries with family at all of this is her safest gives her the free independent. Will interventions. CF (20) 6/27/16- four Merry walker outs back and holding sleeping. No injuricontinue with the When interviewed.	e to Turtle Beach (resident unit) valker; walker was still upright; of the Merry walker with the EZ ist. Continue with CP; Family is Merry walker is safest option on appropriate. Orm dated 4/18/16, identified a "regularly scheduled visit." concerns with [R87], she has and on right side, Merry walker in the floor, laying on gray mat still inside tipped Merry walker. To Herbergers, climbed on flipped Merry walker onto side. In the floor, No injuries from fall, make sure the mat is not on the not in bed. Sign placed on wall pick up the mat when not in and on floor of other resident's alker on floor with feet on the noted. Merry walker discussed are conferences and they feel option to avoid injury and also dom to ambulate and be more continue with current of followed. In diging on floor underneath side of room in hallway, lying on head up, appeared to be ites. CP being followed; Will	2 830	DEPICIENCY		

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
					07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	reviewed resident fa fall, current interver interventions and properties in the electronic records for	alls to identify the cause of the ations in place, previous ossible new interventions. This is to the nurse's progress notes ford and documented onto a sy form titled Resident or the dates of January 2016 to the following falls involving the street interventions-Continue seno injury. One, interventions-Continue seno, interventions-C	2 830			
	selected time frame documentation of a re-assessment of F of any additional int prevent re-occurrer R87's electronic an evidence of physica (OT) evaluations ar Morse Fall Scale do 8/28/15, 10/26/15, each identified R87 walker, and identified	d not include all the lat occurred during the lat occurred during the late late late late late late late lat				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET			
		ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 24	2 830			
	with, "steps are shot Each of these Mors indicated the reside anything above 45 None of the docum specific assessment on 7/19/16, at 4:19 reviewed the progrefalls involved the M assessments and reconsistently comple RN-A identified the follows: (1) review (2) interview staff to do, (3) if interviewal reassess fall risk an interventions are effassessment finding documented as a for RN-A verified that Fand that it was difficial because R87 coactions. RN-A furthemany planned intervidentify any new on assessments were each fall. A facility Restraint/ Physical dated 2/17/16. RN-current assessmen no other assessmen for R8 been involved with a Merry walker and admitted. RN-A als included all of the confirmed it was an the care plan. RN-A	ort, resident may shuffle." see Fall Scale documents ent had a score of 80 with indicating a high risk for falls. ents identified any other nt information. p.m. registered nurse (RN)-A ess notes and verified R87's erry walker and that ew interventions were not eted and/or implemented. usual process after a fall as the nurse's progress notes, o see what [R87] was trying to ble, ask the resident, (4) and whether planned fective. RN-A indicated these				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
		00108	B. WING		07/2	2/2016
					0172	2/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
I RETHANY HOME			K STREET			
5 21111111		ALEXAND	ORIA, MN 56	6308		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	NEGULATORY OR L	SCIDENTIFTING INFORMATION)	TAG	DEFICIENCY)	FNIATE	DATE
2 830	Continued From pa	ige 25	2 830			
	and to document si	uch. RN-A explained the Merry				
		lized by R87 had been				
		age in the basement of the				
		she did not believe they had a				
	written copy of the					
	instructions/recomr	mendations. RN-A indicated				
	she may have to co	omplete a "Google" search to				
	obtain the instruction					
		· / /				
	On 7/19/16, at 4:57	p.m. the DON identified the				
		s responsible to complete an				
		ident use of a Merry walker				
		assessment involved standing				
		Merry walker to see whether it				
		I further explained this was not				
		ssessment, but included more				
		see whether the Merry				
		riate. The DON verified this				
		walker assessment				
		ON further explained the staff				
		rare that R87 was not safe and				
		r falls while in the Merry				
		onfirmed they were honoring				
		ince R87 was not utilizing a				
		would have to be placed into a				
		ing wheel chair). The DON				
		ementation of interventions				
		e completed if staff identified				
		Merry walker, identifying				
		not walking with it, or not using				
		N further indicated the				
		e of a resident utilizing a Merry				
		quent observations by all staff				
		he DON said if a resident were				
		of the Merry walker, staff may				
		ped with a safety mat placed				
		e DON reiterated staff were				
		the CP. The DON indicated				
		erous interventions but would				
	lollow family wishes	s related to the continued use				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00108	B. WING	B. WING		2/2016
					01/2	2/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IV HOME		K STREET			
DETTIAN	TI TIOME	ALEXAND	PRIA, MN 56	308		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
TAG	NEGOLATORT OR E	30 IDENTIF TING INFONMATION)	TAG	DEFICIENCY)	MAIL	BALL
2 830	Continued From pa	ge 26	2 830			
	of the Merry walker	. The DON stated the				
		ommendations for use of the				
		ocated in the storage area.				
		G				
		p.m. RN-A provided				
		ommendations for use of a				
		out from the Internet. These				
		endations included: "The				
		ed of metal and weighted at				
		h one should be individually				
		t. The height of the top frame				
		ight of the pelvis to promote wever, the Merry walker R87				
		as constructed of PVC pipe to				
		ype weights with zip ties were				
		om bar of the walker. In				
		ed the height of the top frame				
		R87 utilized was not at the				
		but above the pelvis.				
		•				
		33 a.m. physical therapist				
		wed. PT-A confirmed therapy				
		eening and treatment of				
		transfers, balance, walking				
		of the most appropriate lifts for				
		. PT-A stated, "[Merry walker]				
		e recommend, we want it to be				
		vith a walker or cane." PT-A considerations for use of a				
		include: look safe, maintain				
	,	th, have a good gait pattern				
		I forward without tripping. PT-A				
		erry walkers were able to tip				
		d that when R87 was admitted				
		ck screen to evaluate if				
		ere required was conducted.				
		at that time services had not				
		be needed so no physician				
		had been requested. PT-A				
	confirmed R87 had	not been provided therapy				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00108	B. WING	B. WING		2/2016
		00100			01/2	2/2010
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IV HOME	1020 LAR	K STREET			
DETHAN	IT HOWE	ALEXAND	RIA, MN 56	308		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				BEHOLEHOT		
2 830	Continued From pa	ge 27	2 830			
	carvicas any tima s	ince admission (March 2015)				
		had not been evaluated by PT				
	for the use of the M					
	ioi the use of the iv	ierry warker.				
	The facility policy tit	tled, Falls- Clinical Protocol				
		2012, Assessment and				
		ed the following: #5 The staff				
		ocument falls that occur while				
		he facility: for example, when				
		open, and observations of the				
		ent/Management: #1- Based				
		ssessment, the staff and				
		fy pertinent interventions to try				
		ent falls and to address risks				
	of serious consequ	ences of falling.				
		pardy that began on 10/24/15,				
		19/16, at 7:05 p.m, was				
		6, at 3:30 p.m. when it could				
		rvation, record review and staff				
	interviews, the the interventions includ	facility had implemented				
		use of the Merry walker for R87				
		mented for R87 until				
		ments could be completed				
	and a new safety pl			Y //		
		armacist reviewed R87's				
	medications					
	- a PT assessment	was conducted and a				
		chair/walker with 18" wheels				
	for stability was ord	ered				
		e-assessment of the new				
		to determine appropriateness				
	for R87					
	- a physician review					
		fall assessment was				
		f were educated to implement				
		st fall assessment, including				
		note, was created in the				
	electronic chart to t	rigger a review of the care				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET DRIA, MN 56	6308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	plan to include modinterventions; all staverbally, via e-mail nurses' stations; NALPNs, activity staff, to confirm impleme Although numerous noncompliance remseverity of a G, isol actual harm that is because the facility assessment and stainterventions to ma SUGGESTED MET The director of nursensure that assessing each fall. A plan of reduce the fall incide conducted to ensure assessed for safety The results of the a quality assurance of the same conducted to ensure the fall incide conducted to ensure assessed for safety the results of the analysis and the same conducted to ensure the fall incide conducted to ensure assessed for safety the results of the analysis and the same conducted to ensure the fall incide conducted to ensure assessed for safety the results of the analysis and the same conducted to ensure the fall incide conducted to ensure assessed for safety the same conducted to ensure the fall incide conducted to ensure assessed for safety the same conducted to ensure the fall incide conducted to ensure assessed for safety the same conducted to ensure the fall incide conducted to ensure assessed for safety the same conducted to ensure the same conducted t	diffications and review of aff were educated either and/or by written postings at As, RNs, case managers, and PT staff were interviewed ntation of the plan. Is interventions were initiated, named at the lower scope and ated scope with severity of not immediate jeopardy, had failed to ensure ongoing aff compliance with identified intain resident safety. IHOD OF CORRECTION: IN THOSE COULD BE COUL	2 830			
2 895	MN Rule 4658.0529 Motion	5 Subp. 2.B Rehab - Range of	2 895			8/12/16
	that is directed towa through positioning implemented and m comprehensive res of nursing services	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROID DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 29	2 895			
	provides that:					
	receives appropriat	h a limited range of motion e treatment and services to notion and to prevent further of motion.				
	by: Based on observati review the facility fa interventions for ide	ent is not met as evidenced on, interview and document illed to implement entified contractures for 1 of 1 ewed for range of motion		Corrected 8/12/2016 per Director of Nursing	of	
	(MDS) dated 4/27/1 cognitive impairment included Parkinson disease and cerebri hemiplegia. The M totally dependent of	arterly Minimum Data Set 6, identified R65 had severe nt and had diagnoses which is disease, Alzheimer's ovascular disease with DS further identified R65 was n staff for activities of daily ad bilateral upper extremity	S			
	(CAA) dated 8/19/1 cognitive impairmen	nual Care Area Assessment 5, identified R65 had severe nt due to Alzheimer's disease, ent on staff for ADL's and had				
	identified R65 had a upper and lower ex dependent on staff range of motion wit	re plan print dated 2/25/16, bilateral contractures of the tremities, was totally for all ADL's, required gentle th daily care, required gauze 23/hrs/day: to be removed for				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE (SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		00108	B. WING	·····	07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DETLIAN	VIONE	1020 LAR	K STREET			
BETHAN	IY HOME	ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 30	2 895			
2 895	30 minutes twice da hand contractures. Review of R65's cu 7/19/16, revealed a 10/21/2015, directe kerlix roll in bilatera shift, should have k additional gauze be and gauze when so for contractures. The staff to wash R65's instruction sheet. Review of R65's pro 5/27/16, revealed R routine visit in which contractures which and hands. Review of R65's month that the revealed R65 had be which were in a fixed evaluation directed exercises and in haccontractures. - R65's medical recevaluations for hands.	rrent physician orders signed norder with a start date of d nursing staff to check R65's I hands for placement every erlix in hands at all times and tween thumb, change kerlix illed and as needed every shift ne orders also directed nursing hands twice daily per ovider progress note dated as had been seen for a name and the same as assessed to have were most notably in her arms of the staff to implement ROM and splints for bilateral hand ord lacked any further OT d contractures.	2 895			
	mark for R65's trea hands three times a chart code legend v the treatment was in	rd (TAR) revealed a check tment of kerlix rolls in both a day. The TAR revealed a which a check mark indicated				

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5/17/16, revealed R65 continued to have

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winnesc	<u>ita Department of He</u>	alth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00108	B. WING	B. WING		2/2016
NAME OF I	PROVIDER OR SUPPLIER	OTDEET AD		STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	Y HOME		K STREET DRIA, MN 56	200		
	0.18.44.57.4.074		1		211	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 31	2 895			
	note further reveale apply gauze to R65 indicated that was t	hands and extremities. The ed staff were to continue to 's hands daily. The note o continue. Ogress notes from 1/23/16, to				
	7/13/16, revealed th					
	bilateral hands and	required vigilant monitoring ced in both hands, extra care				
	motion (PROM) to I extremities due to d	65 received passive range of both upper and lower contractures, staff continued to both contracted hands daily.				
	identified R65 had b	monthly charting note which bilateral hand contractures ssistance from staff for all	U			
	identified R65 had b	monthly charting note which bilateral hand contractures ssistance from staff for all				
		a ADL note which identified assistance with all ADL's due blindness.				
	which identified R65 contractures and st	a restorative program note 5 had bilateral hand aff was to put gauze rolls in her contractures and maintain				
		a monthly charting note which bilateral hand contractures and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET RIA, MN 56	308		
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 32	2 895			
	required total assist	tance from staff for all ADL's.				
	which revealed staf R65's hands due to hands. R65's progre regarding inability to -5/29/16, revealed a which revealed staf R65's hands due to hands. R65's progregarding inability to -6/20/16, revealed a identified R65 had be required total assistance.	a order administration note f was unable to place kerlix in resident not able to open her ess notes lacked any follow up o place gauze in R65's hands. A order administration note f was unable to place kerlix in resident not able to open her ess notes lacked any follow up o place gauze in R65's hands. A monthly charting note which collateral hand contractures and tance from staff for all ADL's.				
	identified R65 had b	a monthly charting note which bilateral hand contractures and tance from staff for all ADL's.				
	in space wheelchair station prior to the end hands were held in bent and hands restrested near her heather left upper chest placed in her hands seated in a tilt in spanurses station follow remained without known 7/19/16, from 8 was lying in bed tilted	p.m. R65 was seated in a tilt r across from the nurses evening meal. Both of R65's a fisted position, elbows were ted on her chest, right hand art and her left hand rested on a. R65 did not have kerlix s. At 6:55 p.m. R65 was ace wheelchair near the wing the evening meal. R65 erlix/gauze in both hands. 6:45 a.m. to 10:55 a.m. R65 ed to her right side with pillows lankets were observed to				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		DATE SURVEY COMPLETED	
			A. BUILDING:				
		00108	B. WING		07/2	2/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
BETHAN	Y HOME		K STREET				
			RIA, MN 56		~		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
2 895	Continued From pa	ge 33	2 895				
2 895	cover R65 to mid to fisted position, arm fisted hands rested have kerlix in her had not been space wheelchaitelbows, hands were were clenched fisted clenched hand was left clenched hand was her responsible for R65's kerlix were in contractures. RN-A were too contracted out, nor could R65 independently. RN contracted and had a licensed practical On 7/21/16, at 5:13 open R65's right had contracted, fisted papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had so paper opening R65's right had was hurting her fing stopped opening R65's right had was hurt	orso. R65's hands were in a as were bent at the elbow, against her chest. R65 did not ands. p.m. R65 was seated in a tilt with both arms bent at the eresting on her chest and do position. R65's right resting over her heart and her was resting on her upper left sobserved in R65's hands. on 7/21/16, at 5:09 p.m. anager (RN)-A confirmed R65 in her contracted hands as was unsure why the kerlix was ated the medication nurses or checking to make sure in both hands for bilateral hand stated she felt R65 hands of for the kerlix to have fallen remove the kerlix stated R65's hands were fully been for years. RN-A directed nurse (LPN)-D to apply kerlix.	2 895				
	the hands up. RN-A	ed in warm water to help open A and NA-B then wheeled and NA-B wheeled R65 into					
		RN-Δ started to run the water					

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out of the faucet. NA-B took R65's right hand,

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RETHANY HOME			K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	held it under the wa opened R65's hand the kerlix. NA-B the under the water wh washed, dried and NA-B assisted R65 her wheelchair and station. On 7/21/16, at 5:12 supposed to have t at all times. NA-B s them in after R65's stated she felt about kerlix were not in he place the kerlix into hard time doing so. R65's hands were frould not fall out ar unable to remove the she felt R65's hand last few years. On 7/22/16, at 10:2 required total assistated on average anot have the cloth r NA-C would then prontracted hands. On 7/22/16, at 10:3 not had a recent on though had one a felt R65 had complete RN-A confirmed R65 had complete RN-A confirmed R65 directed nursing staplaced in both contremoved when was proposed to the process of the confirmed R65 had complete RN-A confirmed R65 had complete	ge 34 arm water while RN-A slowly I, washed, dried and applied in took R65's left hand, held it ile RN-A opened R65's hand, applied another roll of kerlix. back out of the bathroom in wheeled R65 back to nursing p.m. NA-B stated R65 was he kerlix in both of her hands tated the nurses usually put hands were washed. NA-B at 3-4 times a week R65's er hands and she would then R65's hands and often had a NA-B further stated she felt isted very tightly so the kerlix at she felt R65 would be ne kerlix herself. NA-B stated is had not worsened over the stance with all ADL's, NA-C at few days a week R65 would olls, (kerlix) in her hands and lace the kerlix in R65's 7 a.m. RN-A stated R65 had coupational therapy evaluation, ew years ago which identified contractures of both hands. So's current physician orders aff to ensure R65 had kerlix racted hands and only to be shed twice daily. RN-A stated is were responsible to ensure	2 895			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET DRIA, MN 56	200		
040.15	CUMMA DV CTA	TEMENT OF DEFICIENCIES	1			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 35	2 895			
2 000	the kerlix on the (TA expected the kerlix staff could apply the fully contracted hand On 07/22/16, at 11: (DON) stated she eresident care plans stated she did not fewas for her hand composture control. The current physician or electronic medical retreatment was order the treatment was order to highest practicable. A policy was request physician orders, trenone were provided.	AR.) RN-A stated she to be in place as any care exertia. RN-A stated R65 had ads and fingers. 13 a.m. the director of nursing expected physician orders and to be implemented. DON eel that R65's kerlix treatment ontractures but were more for the DON confirmed R65's reders in point click care record identified R65's kerlix red for hand contractures. policy titled, Restorative eviewed 5/2011, revealed a promote each residents well being.				
	director of nursing (inservice nursing st of the care plan to i motion as directed, compliance. The re	DON) or designee could aff regarding implementation nclude completing range of and then audit to ensure sults could be reviewed as uality assurance committee				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 920	MN Rule 4658.0525	5 Subp. 6 B Rehab - ADLs	2 920			8/9/16
	Subp. 6. Activities	of daily living. Based on the				

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00108	B. WING		07/2	22/2016
NAME OF PRO	OVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHANY	HOME		K STREET RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
ch as a TbErricher F F 7 ir a a wa F cherrip Trig	ome must ensure of B. a resident who activities of daily living ervices to maintain and personal and or this MN Requirements. Based on observation eview the facility faremoval of facial has a reviewed who or grooming and personal include: 1878's admission Maintained, required extremated, required extremated, required extremated included Park and the included Park arthritis and vision in the included personal hygiene. 1878's undated care are deficit related to the included personal hygiene. 1878's undated care are deficit related to the included personal hygiene. 1878's undated care are deficit related to the included personal hygiene. 1878's undated care are deficit related to the included personal hygiene. 1878's undated residence of the undated residence assist of or the included assist of	dent assessment, a nursing that: is unable to carry out ng receives the necessary ngood nutrition, grooming, ral hygiene. ent is not met as evidenced on, interview and document iled to provide oral care and air for 2 of 3 residents (R78, were dependent upon staff ersonal cares. sinimum Data Set (MDS) dated 78 was moderately cognitively extensive assistance for all (ADL) with exception of limited in corridor and diagnoses kinson's disease, dementia,	2 920	Corrected 8/9/2016 per Director of Nursing	f	

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AND PLAN OF CORRECTION IDENTIFICATION N		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
00108	B. WING		07/22/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 563	08	
(X4) ID SUMMARY STATEMENT OF DEFICIENCI PREFIX (EACH DEFICIENCY MUST BE PRECEDED B TAG REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	LD BE COMPLETE
stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was prophis room to the dining room by nursing (NA)-H. R78 had facial hair stubble on lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seat room in a stationary chair in front of the R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seat room dressed, has not had face shave mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicate to shave independently and will ask staneeds help. NA-H indicated R78 was a facility and NA-H was unsure of whether behaviors or refused cares. When interviewed on 7/20/16, at 1:00 proverified if he was able to shave himself do it every day. R78 stated staff will shave each morning when they get him electric razor but some times they forgoverified his facial hair had not been shated and was unable to recall when standay and was unable to shav	assistant in the upper ited in his is television. Ited in ited, and R78 tries aff when he new to the er R78 had io.m. R78 if he would ave his up with an et. R78 aved off taff last d R78 had se to go for eason, for eas having and R78 was shaky haved R78		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHANY	/ HOME		K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	"every so often." On 7/21/16, at 11:00 a good memory and NA-F indicated he/s R78 often, however clean shaven. NA-F assisted R78 with o sated, "We would reflect the weak this morning isn't so hard to get of R78 further identified was easier to keep stating "I drool." On 7/21/16, at 11:13 (LPN)-E verified R7 not been shaved. On 7/21/2016, at 11:13 (LPN)-A verified R78 ADL's due to has Falthough his abilities was not able to shat electric razor. RN-A expected to shave reflect t	had a routine of shaving only a.m. NA-F verified R78 had d what he says is accurate. she did not provide cares for did believe R78 was usually indicated staff usually ral care and shaving. NA-F normally shave a person if				

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NAME OF PROVIDER OR SUPPLIER 1020 LARK STREET ALEXANDRIA, NN 56308 PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PROCEEDED BY PELLY TAG 2920 Continued From page 39 was not provided. R28's quarterly Minimum Data Set (MDS) dated 6/15/16, identified R28 was moderately cognitively impaired and diagnoses which included: Alzheimer's, psycholic disorder and arthritis. The MDS indicated R28 required extensive assistance for total assistance with personal hygiene and oral cares, The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 must wash and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. The nursing oral assessment dated 6/13/16, indicated R28 had no natural teeth or tooth fragments, and indicated R28 chose no to wear dentures. The assessment distributed R28 had a chewing and swallowing problem and received a pureed diet. During observation of morning cares on 7/20/16, from 8/23 am. to 8/54 am. NA-A and NA-G assisted R28 with personal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral carty and lips appeared very	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
SUMMARY STATEMENT OF DEFICIENCIES ID PREVIDENCE SUMMARY STATEMENT OF DEFICIENCIES ID PREVIDENCE SUMMARY STATEMENT OF DEFICIENCIES ID PREVIDENCE SUMMARY STATEMENT OF DEFICIENCIES ID PREVIDENCE ACTION SHOULD BE CHOSEN FREE GENOLATORY OR LSC IDENTIFYING INFORMATION) 2920			00108	B. WING		07/2	2/2016
EXAMBRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY PREFTX PROVIDERS PLAN OF CORRECTION CONCLUDE CROSS-HEFE BLESS OF CROSS-HEFE BLESS O	NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉGULATORY OR LSC IDENTIFYING INFORMATION) PRÉGULATORY OR LSC IDENTIFYING INFORMATION) PRÉGULATORY OR LSC IDENTIFYING INFORMATION) 2 920 Continued From page 39 was not provided. R28's quarterly Minimum Data Set (MDS) dated 6/15/16, identified R28 was moderately cognitively impaired and diagnoses which included: Alzheimer's, psychotic disorder and arthritis. The MDS indicated R28 required extensive assistance for completion of personal hygiene tasks. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. The nursing oral assessment dated 6/13/16, indicated R28 had no natural teeth or tooth fragments, and indicated R28 chose not to wear dentures. The assessment identified R28 had a chewing and swallowing problem and received a pureed diet. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very	BETHAN	Y HOME			308		
was not provided. R28's quarterly Minimum Data Set (MDS) dated 6/15/16, identified R28 was moderately cognitively impaired and diagnoses which included: Alzheimer's, psychotic disorder and arthritis. The MDS indicated R28 required extensive assistance for completion of personal hygiene tasks. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. The nursing oral assessment dated 6/13/16, indicated R28 had no natural teeth or tooth fragments, and indicated R28 chose not to wear dentures. The assessment identified R28 had a chewing and swallowing problem and received a pureed diet. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing, During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
Am.	2 920	was not provided. R28's quarterly Min 6/15/16, identified F cognitively impaired included: Alzheimer arthritis. The MDS extensive assistant hygiene tasks. R28's care plan dat required extensive with personal hygie plan indicated R28 Staff were to assist offer R28 mouth swand while getting recomplete an oral inneeded. The undated resided did not wear the desheet lacked any difor R28. The nursing oral as indicated R28 had reagments, and indicated R28 had reagments, and indicated R28 had reagments, and indicated R28 with pureed diet. During observation from 8:23 a.m. to 8 assisted R28 with pwashing her face, puring the observation offered the opportunity of the same second reagments.	imum Data Set (MDS) dated R28 was moderately and diagnoses which its, psychotic disorder and indicated R28 required be for completion of personal assistance to total assistance in and oral cares. The care had upper and lower dentures with cleaning dentures and to was and mouth was in the AM and for bed, and staff were to spection with cares and as a sent care sheet, indicated R28 intures. The resident care rection regarding oral cares are sessment dated 6/13/16, no natural teeth or tooth cated R28 chose not to wear assistent identified R28 had a swing problem and received a serious cares which included perineal cares and dressing. Ition, R28 was not assisted nor notity for completion of oral	2 920			

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A. BUILDING:	
00108 B. WING 07/22	2/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BETHANY HOME 1020 LARK STREET ALEXANDRIA, MN 56308	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920 At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not wearing any dentures, and R28 refused the breakfast of items and juice offered. R28 did consume the strawberry supplement. At 9:01 a.m. NA-A gathered he breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not, just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares. During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette. At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares. During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted. During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan.	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 920	Continued From particles and assurance comaudits to ensure comaudi	ge 41 Care Policy dated October to review the resident's care needs of the resident. and oment and supplies as needed. eep the resident's lips and oral canse and freshen the nd to prevent infections of the THOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures mentation of the care plan sion of oral hygiene and ir. The DON or designee, ng for all nursing staff related vices. The quality assessment mittee could perform random mpliance. R CORRECTION: Twenty-one O Subp. 7 Dietary Staff nitary conditions. Sanitary nditions must be maintained in a dietary department at all	TAG 2 920 21015	DEFICIENCY)		8/11/16
	review the facility f	on, interview and document alled to maintain the valk-in cooler to promote safety in the main kitchen.		Corrected 8/11/2016 per Certified I Manager	Dietary	

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 42	21015			
	received food from Findings include:	the kitchen.				
	7/18/16, at 1:14 p.n the walk-in refrigera door to the refrigera frost and the stainle dark brown substar strong sour odor an inside the unit. Alor there was a signific shaped areas of blabetween the second vegetables (leaf lett tomatoes) were sto tomatoes and leaf I without any coverin Throughout the ent and chipped paint winterior walls of the but the walls had be was evident as the interior walls. Loca stored vegetables wapples. These fruit of the dark colored On 7/21/16, at 1:55 stated she had a deaid (DA)-A who cleat Monday which included completed, the coorefrigerator. DD stated would be entered in confirmed the most	chen tour with cook (C)-A on it was noted the outside of ator was wet. The frame of the ator had a thick layer of white ess steel door frame had a nice evident when opened. A ad garbage smell was evident in githe south wall of the cooler ant number of irregular ack colored substance located did and third shelves. Fresh acce, cabbage, spinach and ared on these shelves. The ettuce were open to air, gof these food items. It is until large areas of missing were noted. It appeared the walk-in cooler had been silver een painted a white color. This paint was peeling from the ted adjacent to the shelves of were stored fresh oranges and items were next to the areas substance. p.m. dining director (DD) esignated staff person, dietary aned the walk-in cooler on ided the walls but if not its clean the walls of this ted DA-A worked this past I have cleaned the walls as e unit. DD stated if any kitchen any repairs, a work order into the computer. The DD recent work order entered a storage pallet sent last				

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Minneso	ota Department of He	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME	1020 LAR	K STREET DRIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	Continued From particles week. It was observed on was placing groceristhe walk-in cooler/researce of the moderand DD indicated the inthe walk-in coole could not keep up to C-A stated it had be maintenance manaweek ago, indicatin working properly. To broken gray seal has thus not working proditions inside the was responsible for confirmed that mole frame. He stated the make sure the door door was sweating was evident due to humidity level. Whe away from the wall, there was black cold the length of the she length of the she length of the same several irregulations and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches and streak to 1-1/2 inches around the same shade patches around the same shade patches are same same shade patches are same same same same same same	SC IDENTIFYING INFORMATION)	TAG 21015	CROSS-REFERENCED TO THE APPRO		
		s standing liquid in front of the roast was thawing in a				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	cardboard box. He had leaked liquid or C-A indicated both onto the floor. C-A floor in the walk-in and had rusted. He significant rust loca thawing rack which from the rack. On 7/21/16, at 2:10 vegetables from the top of a stainless st It was observed the cooler on his knees bucket containing brag. C-A indicated hinside the cooler, a it had been washed substance was preselvel in the cooler. On ticed the black substance off bleach solution, grawall as it was wash On 7/21/16, at 3:45 scheduled to clean a.m. but confirmed inside the walk-in cher scheduled hour wash the wall and wash the wall and wash the wall and wash condicated only received in the cooler acks. DA-A explair random checks of thad too many other	confirmed the frozen roast into the floor during thawing. The pork and fish tend to leak stated they have a galvanized cooler, which was damaged a confirmed the floor had ted in front of the meat extended approximately 6 in. p.m. C-A removed the walk-in and had a small white plastic bleach solution and a cleaning in the had never washed the walls in the stated the black sent due to the high humidity C-A indicated he had never substance substance until the maware. As C-A wiped the fithe wall of the cooler with the stated water ran down the	21015	DETIGIENCY)		

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00108	B. WING		07/5	22/2016
NAME OF I	PROVIDER OR SUPPLIER		DDESS CITY S	STATE, ZIP CODE	01/2	.2/2010
			K STREET	577112, 211 0002		
BETHAN	IY HOME	ALEXAND	ORIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 45	21015			
	past but was unsurbleach kills it.	e how the mold returned as				
	MM and the admini were unaware of th walk-in cooler and a system, procedur the walk-in cooler. need to remove all wash/clean the unit returning the stored. Review of the unda the Food Service Deservice staff shall in food service depart the cleaning schedule.	ted facility policy, Sanitation of repartment identified the food naintain the sanitation of the ment through compliance with				
	dietary manager (D procedures regardi could include a sys of equipment in a ti educate all appropr The DM could deve ensure ongoing cor quality assurance co	THOD OF CORRECTION: The M) could develop policies and ng safe storage of foods. This tem for notification and repair mely manner. The DM could rate staff on these policies. Plop monitoring systems to impliance and report to the committee the audits re ongoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21685	MN Rule 4658.1419	5 Subp. 2 Plant	21685			8/11/16

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER BETHANY HOME 1020 LARK STREET ALEXANDRIA, MN 56308 [X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL PRECULATORY OR LSC IDENTIFYING INFORMATION) 21685 Continued From page 46 Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, confort, 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, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering undermeath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER BETHANY HOME 1020 LARK STREET ALEXANDRIA, MN 56308 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21685 Continued From page 46 Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, 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, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by			00108	B. WING		07/2	2/2016
SUBMARY STATEMENT OF DEFICIENCIES DEATH OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSG IDENTIFYING INFORMATION) PREFIX TAG TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE 21685 Continued From page 46 21685 Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, 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, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by	NAME OF					01/2	2/2010
CALLEMAN HOME SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE					STATE, ZIP GODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21685 Continued From page 46 Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, 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, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by	BETHAN	RETHANY HOME			308		
Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, 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, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
including walls, floors, ceilings, all furnishings, 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, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing marroon floor tile, which measured approximately 18 inches (in) by	21685	Continued From pa	ge 46	21685			
18 in. The area was filled with dark and light gray dust and dirt particles. In addition, there was another irregular shaped area directly under the steamer and next to the missing tile area that was a dark brown, sticky, sludge material which measured approximately 6 in by 4 in. The entire floor in the food preparation area was soiled with food particles and dirty. On 7/21/16, at 1:55 p.m. the dining director (DD) confirmed the damage and dirty kitchen floor. She indicated the floor had steadily gotten worse	21685	Subp. 2. Physical princluding walls, floor systems, and equip continuous state of with regard to the howell-being of the restroutine maintenance. This MN Requirements by: Based on observation of the kitch and functional manner than the main kitchen. To affect all 80 reside the kitchen. Findings include: On 7/18/216, at 1:1 tour with cook (C)-Accovering underneat steamer and oven larea had an area of which measured ap 18 in. The area wadust and dirt particle another irregular shot steamer and next to a dark brown, sticky measured approximation floor in the food prefood particles and conformed the dama.	plant. The physical plant, rs, ceilings, all furnishings, ament must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program. The program is not met as evidenced on, document review and failed to maintain the hen floor covering in a clean ner to promote sanitation in his practice had the potential lents who received food from the and surrounding the affixed ocated in the food preparation for missing maroon floor tile, proximately 18 inches (in) by silled with dark and light gray es. In addition, there was apped area directly under the other missing tile area that was a sy, sludge material which nately 6 in by 4 in. The entire paration area was soiled with dirty. The proximated of the program is the director (DD) age and dirty kitchen floor.	21685		Dietary	

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-	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7t. Boilebiita.			
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	NY HOME		K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	this past year. DD a needed to be replace purchased another around and had prothe stated the brown st but was compacted. She confirmed the cleanable surface, housekeeping staff week, otherwise die washing the floor. On 7/21/16, at 5:30 (MM) and the admic condition of the dar floor. MM knelt to tacross the area and on his hand. MM a surface need to be agreed the damage MM and A confirme was evident on the stated it would be considered by the cleaning schedules. SUGGESTED MET The administrator of identified kitchen en corrected and monigood repair and resussessment and as perform random automatic portions.	also stated the floor is old and ced. DD indicated they had oven, moved equipment oblems with water leaking from caused the floor damage. DD icky substance was not grease I food material, dirt and grime. floor was no longer a thus dirty. She stated scrubbed the floor every other etary was responsible for the maintenance manager nistrator (A) confirmed the maged floor tile and the dirty he floor, wiped his hand divisible gray dust was evident and A confirmed the floor repaired and/or replaced and ed tile surface was unclean. It do a dark brown sticky material floor behind steamer and leaned. ted facility policy, Sanitation of epartment identified the food naintain the sanitation of the ment through compliance with	21685			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	V HOME	1020 LAR	K STREET			
DETHAN	THOME	ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 48	21685			
	days.					
	uays.					
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults		21980			8/9/16
	reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explained information to the condividual is a vulnerable the individual is adreporter is not required.	of report. (a) A mandated ason to believe that a being or has been maltreated, age that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an erable adult solely because mitted to a facility, a mandated irred to report suspected individual that occurred prior s:				
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not	as admitted to the facility from the reporter has reason to ble adult was maltreated in the nows or has reason to believe a vulnerable adult as defined to report under the required to report under the	O			
	as described above (c) Nothing in this known or suspected knows or has reason been made to the condition (d) Nothing in this reporter from also ragency.	s section requires a report of d maltreatment, if the reporter on to know that a report has ommon entry point. s section shall preclude a eporting to a law enforcement				
	reason to believe the 626.5572, subdivisi	reporter who knows or has nat an error under section on 17, paragraph (c), clause make a report under this				

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STATEME	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	subdivision. If the ratime believes that a agency will determine the reported error was the criteria under set 17, paragraph (c), of facility may provide directly to the lead a how the event mee 626.5572, subdivisi (5). The lead ageninformation when may the report under sufformation when may the report under sufformation when may the reported to the residents (R87) reversidents (R87) reversidents (R87) reversidents (R87) reversidents of daily livititled Order Summan physician dated 6/2 diagnoses to includ Parkinson's disease R87's care plan reversident is dependent emotional, intellector of the resident further than the reported to the resident of the resident o	reporter or a facility, at any n investigation by a lead ne or should determine that was not neglect according to rection 626.5572, subdivision clause (5), the reporter or to the common entry point or agency information explaining at the criteria under section on 17, paragraph (c), clause acy shall consider this raking an initial disposition of bodivision 9c. The portion of the common explaining and document review the ure injuries of unknown origin as State agency (SA) for 1 of 3	21980	Corrected per Director of Nursing		

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Minneso	Minnesota Department of Health						
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
RETHANY HOME		K STREET PRIA, MN 56	308				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE	
21980	Continued From pa	ge 50	21980				
	Lewy Bodies, unspecified psychosis".						
	identified the follow -10/24/15-"Data: re over sideways and unable to move. Refloor. residents more a tooth. no one see know what resident Action: resident was assist of 3 and EZ I -10/26/15," IDT (interfall from 10/24/15, I walker and landed abrasion under [R8 result of the fall." Sof R87's brain date following Clinical interfall, initial encoun with more confusion Nondisplaced fractions.	sident tipped merry walker was found face down on floor, esident hit head/mouth on ath was bleeding from loosing in [sik] the incident so we don't was trying to do at the time. If sident is lifted up from the floor with was trying to do at the time.					
	Adult Incident Log, reports to the SA, in	y form titled 2015 Vulnerable which logged the facility adicated a report had not been a R87's fractured jaw from an 10/24/15.					
	(DON) verified a replace the SA when R87 h 10/24/15. The DON considered it a majwas unknown that I day or two after the	8 a.m. the director of nursing port had not been submitted to ad an unwitnessed fall on I indicated she had not or injury at the time because it R87 had a fractured jaw until a fall occurred. The DON t considered to report to the					

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state agency when it became known that R87

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Minnesc	<u>ita Department of He</u>	ealth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
			D WING			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DETLIAN	VUONE	1020 LAR	K STREET			
BETHANY HOME ALEXAN			ORIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21980	Continued From particles and a fractured jaw typically report an infall when the resided. When interviewed a social services dire responsibility of over and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for allest immediately impaired fracture, SSD state guidelines." When a computer and the inobservation, reside resulting injury; SSI so" regarding R87's unwitnessed fall. Stand discussed the bear reportable inciprocedure for reportant must be report conditions are presinjury was not obsessource of the injury resident; and (2) Trof the extent of the	age 51 If from the fall; however, would njury related to an unwitnessed ent is not cognitively intact. In 7/22/16, at 1:10 p.m. the ctor (SSD) verified the ersight for abuse prevention as SA. SSD indicated training of for many staff to submit VA office of Health Facility C (Minnesota Adult Abuse including nurse managers, nurses who worked the floor. Initial report was to be made eged or suspected abuse, and all things that fall under alle adult (VA) policy. When of an unwitnessed fall of a diresident resulting in a diresident resulting in a direviewed on SSD's lap top	21980		THIAILE	DATE
	questions.	efore answering any more			ļ	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00108	B. WING	 	07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BETHAN	IY HOME		K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 52	21980			
	had been reviewed (IDT) and stated,"w injury." SSD further did not result in a hequality of life; therefore When interviewed administrator indical brought to the Qual review procedures of the facility policy tith Prevention Plan Formation Plan Fo	led Ecumen's Abuse r Minnesota Skilled Nursing /2015, identified " An injury is y of unknown source and must oth of the following conditions ne injury was not observed by source of the injury could not resident; and spicious because of the extent ocation of the injury (e.g., the an area not generally a) or the number of injuries rticular point in time or the sover time." CHOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re injuries of unknown origin state agency (SA) lirector of nursing (DON) or locate all appropriate staff on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00108	B. WING		07/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 53	21980			
	TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-one				
21995	MN St. Statute 626. Maltreatment of Vul	.557 Subd. 4a Reporting - nerable Adults	21995			8/9/16
	(a) Each facility sha ongoing written pro- applicable licensing of suspected maltre- facility has an interr mandated reporter requirements of this internally. However responsible for com- reporting requirements This MN Requirements by: Based on interview facility failed to impli- procedures to include reporting of injuries Agency (SA) for 1 of	I reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains aplying with the immediate ents of this section. The portion of the section of the section of unknown origin to the State of 3 residents (R87) reviewed.		Corrected per Director of Nursing		
	Prevention Plan For Facilities updated 7 considered an injury be reported when be are present: (1) The observed by any perinjury could not be 6 (2) The injury is sus	led Ecumen's Abuse r Minnesota Skilled Nursing /2015, identified " An injury is y of unknown source and must oth of the following conditions e source of the injury was not erson or the source of the explained by the resident; and spicious because of the extent ocation of the injury (e.g., the				

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1		(X3) DATE	SURVEY LETED	
71140 1 12/114	OF CONTILECTION	DENTI TO A TOTAL NOMBELL.	A. BUILDING:		OOWII	LLILD
		00108	B. WING	·····	07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IV HOME	1020 LAR	K STREET			
DETTIAN	ALEXAN			308		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From page 54		21995			
21995	injury is located in a vulnerable to traum observed at one pa incidence of injuries R87's annual Minim 5/11/16, identified to problems with no reunderstood and recall areas of daily livititled Order Summa physician dated 6/2 diagnoses to includ Parkinson's disease R87's care plan revresident is dependent emotional, intellectur/t [related to] Lewy The care plan further physically abusive to Lewy Bodies, unspections of the problems of the probl	an area not generally a) or the number of injuries rticular point in time or the s over time." num Data Set (MDS) dated ong and short term memory recall ability, was rarely to never juried extensive assistance for ing (ADL). The facility form ary Report signed by the 7/16, identified R87's medical e dementia with Lewy Bodies, e, and anxiety disorders. riewed 7/13/16, indicated, "The ent upon staff etc. for ual, physical and social needs Bodies, Physical Limitations" er indicated "The resident has behaviors r/t dementia with ecified psychosis".	21995			
	identified the follow -10/24/15-"Data: re	ursing progress notes ing: sident tipped merry walker was found face down on floor,				
	unable to move. Re	sident hit head/mouth on th was bleeding from loosing				
		n [sik] the incident so we don't				
		was trying to do at the time. s lifted up from the floor w/				
	assist of 3 and EZ I	ift."				
	fall from 10/24/15, I	erdisciplinary team) review of Resident tipped over merry				
		on her face. Received a small 7's] nose and lost a tooth as a				
	result of the fall." S	tudy results of an x-ray (CT) at 10/26/15, identified the				

6899

Minnesota Department of Health STATE FORM

following Clinical information: [R87] presents with

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY PLETED	
		00108	B. WING		07/2	22/2016
NAME OF I			DDEGG OITY (27ATE 7ID 00DE	1 01/2	.2/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		RK STREET DRIA, MN 56	308		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 55	21995			
21993	a fall, initial encount with more confusion Nondisplaced fractus superior most maxithe nose. Review of the facility Adult Incident Log, reports to the SA, in submitted related to unwitnessed fall on On 7/22/16, at 11:2 (DON) verified a report the SA when R87 h 10/24/15. The DON considered it a majure was unknown that I day or two after the verified she had not state agency when had a fractured jaw typically report an infall when the reside When interviewed and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for alle neglect, exploitation the facility vulnerab	ter. Nurse states -facial pain in than usual. Conclusion: ure thorough the anterior lla (upper jaw) at the base of lla (upper jaw) at the director of nursing loort had not been submitted to lindicated she had not loor injury at the time because it lla (upper jaw) at the time because it la (upper jaw) at				
	Reporting Center) social services and SSD indicated the immediately for alle neglect, exploitation the facility vulnerab given the scenario of	including nurse managers, nurses who worked the floor. nitial report was to be made ged or suspected abuse, n, and all things that fall under				

Minnesota Department of Health

STATE FORM 6899 WIMT11 If continuation sheet 56 of 58

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00108	B. WING	B. WING		2/2016
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	guidelines." When recomputer and the ir observation, resider resulting injury; SSE so" regarding R87's unwitnessed fall. SS had discussed the ibe a reportable inciprocedure for reportaging by reading ald injury is considered and must be reported conditions are presenjury was not observations are presenjury was not observations. SSD request electronic record be questions. On 7/22/16, at 1:56 had been reviewed (IDT) and stated, "winjury." SSD further did not result in a hequality of life; therefore When interviewed administrator indicates brought to the Quality of life; therefore SUGGESTED MET The director of nursidevelop, review, amprocedures to ensurare reported to the states."	d "I would have to look at the eviewed on SSD's lap top ncident included no not unable to explain and the D responded, "I would think a fractured jaw due to an SD indicated the facility staff ncident and had not found it to dent. SSD verified the usual ting an injury of unknown oud the facility policy: An an injury of unknown source ed when both of the following ent: (1) The source of the rived by any person or the could not be explained by the re injury is suspicious because injury or the location of the more time to review the effore answering any more p.m. SSD identified R87's fall with the interdisciplinary team e didn't think it was a serious explained the fractured jaw ospitalization or affect R87's fore it was not a serious injury. The T/22/16, at 1:56 p.m. the ted the report would be ity Assurance meeting to for reporting. HOD OF CORRECTION: Sing (DON) or designee could dor revise policies and re injuries of unknown origin	21995			

Minnesota Department of Health

STATE FORM 6899 WIMT11 If continuation sheet 57 of 58

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00108	B. WING	·····	07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		K STREET RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 57	21995			
21995	designee could edu the policies and pro The director of nurs develop monitoring compliance.	cate all appropriate staff on	21995			

Minnesota Department of Health STATE FORM

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:	W IIVI I
Faci	lity ID: 00108

		10 22 00::11		TILD OTTE	E SOUTH ET HOEKET		14011119 125. 00100
1. MEDICARE/MEDICAID PROVID (L1) 245434	ER NO.	3. NAME AND AI (L3) BETHANY		CILITY		4. TYPE OF ACTI	ON: 7 (L8) 2. Recertification
2.STATE VENDOR OR MEDICAID 1 (L2) 568340800	NO.	(L4) 1020 LARK (L5) ALEXANDI			(L6) 56308	3. Termination 5. Validation	4. CHOW6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Aft	9. Other er Complaint
6. DATE OF SURVEY 09/13 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	3/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR END	ING DATE: (L35)
11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds	83 (L18) 83 (L17)	Compliance1. A B. Not in Compl	equirements be Based On:	am	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: A	6. Scope of S 7. Medical D	Services Limit birector om Size
14. LTC CERTIFIED BED BREAKDO)WN	l .			15. FACILITY MEETS		
18 SNF 18/19 SNF 83	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
See Attached Remarks							
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Denise Erickson, HFE NE	EII		09/26/2016	(L19)	Mark Meath	, Enforcement Spec	ialist 10/27/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBII 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		MPLIANCE WITH HTS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Stm	*
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	·	(L30)
OF PARTICIPATION 02/01/1987	BEGINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure	<u>INVOLU</u>	· · ·
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs		Meet Agreement
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS a of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER	der Status Change e
28. TERMINATION DATE:	29). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		03001					
	(L28)	3 4 -		(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE			
	(L32)	09/01/2016		(L33)	DETERMINATION APP	ROVAL	

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

Facility ID: 00108

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5434

On September 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 9, 2016, the Department of Public Safety completed a PCR to verify the facility had achieved and maintained substantial compliance with deficiencies issued pursuant to the July 22, 2016 extended survey. We presumbed based on the facility's plan of correction that the facility had corrected these deficiencies as of September 1, 2016. We have determined based on our visit that the facility has corrected the deficiencies pursuant to the extended survey completed July 22, 2016, as of September 1, 2016.

As a result of the revisit findings, this Department is discontinuing the Category 1 remedy of State monitoring as of Septemer 1, 2016.

In addition, this Department recommended the following action to the CMS Region V Office as it relates to the remedy imposition in our letter of September 26, 2016:

Civil money penalty for the deficiency cited at F323 (S/S=J), remain in effect. (42 CFR 488.430 through 488.444)

Futher, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 22, 2016.

Refer to the CMS 2567b forms for both health and life safety code.

Effective September 1, 2016, the facility is certified for 83 skilled nursing facility beds.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245434

October 27, 2016

Mr. Matthew Fischer, Administrator Bethany Home 1020 Lark Street Alexandria, Minnesota 56308

Dear Mr. Fischer:

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 September 1, 2016 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division

Email: mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 26, 2016

Mr. Matthew Fischer, Administrator Bethany Home 1020 Lark Street Alexandria, Minnesota 56308

RE: Project Number S5434025

Dear Mr. Fischer:

On August 5, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective August 10, 2016. (42 CFR 488.422)

On August 5, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

• Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on July 22, 2016. Conditions in the facility at the time of the extended survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On September 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 6, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 22, 2016, as of September 1, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 1, 2016.

Bethany Home September 26, 2016 Page 2

However, as we notified you in our letter of August 5, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 22, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedy in our letter of August 5, 2016:

• Civil money penalty for deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us Telephone: (651) 201-4118

Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REV	/ISIT
	A. Building B. Wing		Y2	9/13/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BETHANY HOME		1020 LARK STREET			
		ALEXANDRIA, MN 56308			
,					

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

ITE Y4	М	DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix	F0225 483.13(c)(1)(ii)-(iii).	Correction (c)(2)	ID Prefix <u>F02</u>	.13(c)	Correction	ID Prefix	F0282 483.20(k)(3)(ii)		Correction
Reg. #	- (4)	Completed	Reg. #		Completed	Reg. #			Completed
LSC		08/09/2016	LSC		08/09/2016	LSC			08/09/2016
ID Prefix	F0312	Correction	ID Prefix F03	318	Correction	ID Prefix	F0323		Correction
Reg. #	483.25(a)(3)	Completed	Reg. #	.25(e)(2)	Completed	Reg. #	483.25(h)		Completed
LSC		08/12/2016	LSC		08/12/2016	LSC			08/12/2016
ID Prefix	F0334	Correction	ID Prefix F03	371	Correction	ID Prefix	F0456		Correction
Reg. #	483.25(n)	Completed	Reg. #	.35(i)	Completed	Reg. #	483.70(c)(2)		Completed
LSC		08/30/2016	LSC		08/11/2016	LSC			08/11/2016
ID Prefix	F0465	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	483.70(h)	Completed	Reg. #		Completed	Reg. #			Completed
LSC		08/11/2016	LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
REVIEWE STATE AC		EVIEWED BY NITIALS) GA/mm	DATE 09/26/2016	SIGNATURE OF	SURVEYOR 312	56		DATE 09/1	3/2016
REVIEWS CMS RO	REVIEWED BY REVIEWED BY (INITIALS)			TITLE				DATE	
FOLLOW 7/22/201	UP TO SURVEY C	OMPLETED ON		FOR ANY UNCORRECTED DEFICIENCI				YE:	s 🗆 no

	POST-C	ERTIFICA	ATION REVISIT F	REPORT			
PROVIDER / SUPPLIER / C	·		_			DATE OF RE	VISIT
IDENTIFICATION NUMBER 245434	A. Building 01 - B. Wing	NURSING HOME	Ξ		Y2	9/6/2016	Y3
NAME OF FACILITY			STREET ADDRESS, O	CITY, STATE, ZIP CO	DE		
BETHANY HOME			1020 LARK STREET				
			ALEXANDRIA, MN 56	308			
program, to show those d corrected and the date su	eficiencies previously ch corrective action w	reported on the (vas accomplished	dicare, Medicaid and/or Clinica CMS-2567, Statement of Defic I. Each deficiency should be fu lown on the CMS-2567 (prefix	iencies and Plan of ully identified using	Correct either th	tion, that have ne regulation o	been or LSC
ITEM	DATE	ITEM	DATE	ITEM		DAT	ſΕ
Y4	Y5	Y4	Y5	Y4		Y!	5

	POST-C	ERTIFIC	CATION REVISIT F	REPORT			
PROVIDER / SUPPLIER / CL	· ·					DATE OF REV	/ISIT
IDENTIFICATION NUMBER 245434	A. Building 02 B. Wing	- SUB ACUTE			Y2	9/6/2016	Y 3
NAME OF FACILITY			STREET ADDRESS, (CITY, STATE, ZIP CODE	Ξ		
BETHANY HOME			1020 LARK STREET				
			ALEXANDRIA, MN 56	308			
program, to show those de corrected and the date suc	eficiencies previously th corrective action	reported on the was accomplished	Medicare, Medicaid and/or Clinic e CMS-2567, Statement of Defic ed. Each deficiency should be f shown on the CMS-2567 (prefix	ciencies and Plan of Cully identified using ei	orrect	ion, that have ne regulation o	or LSC
ITEM	DATE	ITEM	DATE	ITEM		DAT	Έ
Y4	Y5	Y4	Y5	Y4		Y5	j
ID Prefix	Correction	ID Prefix	Correction	ID Prefix		Corre	ection

Correction

Completed

ID Prefix

Reg. #

LSC

ID Prefix

Reg. #

LSC

		POST-C	CERTIFICAT	TION REVISIT F	REPORT			
PROVID	ER / SUPPLIER / CL	IA / MULTIPLE CON	ISTRUCTION				DATE OF RE	VISIT
IDENTIF 245434	FICATION NUMBER	A. Building 03 · B. Wing	- CHAPEL AREA			Y2	9/6/2016	Y3
NAME C	F FACILITY			STREET ADDRESS, (CITY, STATE, ZIP COL	DE .		
BETHA	NY HOME			1020 LARK STREET				
				ALEXANDRIA, MN 56	308			
provisio				Each deficiency should be fi vn on the CMS-2567 (prefix				
ITE	ΕМ	DATE	ITEM	DATE	ITEM		DA	ΓΕ
Y	4	Y5	Y4	Y5	Y4		Y	5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix		Corr	ection
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #		Com	pleted
LSC	K0062	09/01/2016	LSC		LSC			

Correction

Completed

ID Prefix

Reg. #

LSC

Correction

Completed

	POST-C	ERTIFIC	CATION REVISIT F	REPORT	_			
PROVIDER / SUPPLIER / CLI					DATE OF REVISIT			
IDENTIFICATION NUMBER	D. Wine	2012 RENOVA	2 RENOVATED AREA					
245434	Y1 B. Wing				y ₂ 9/6/2016 y ₃			
NAME OF FACILITY			STREET ADDRESS, C	CITY, STATE, ZIP CODE				
BETHANY HOME			1020 LARK STREET					
			ALEXANDRIA, MN 563	308				
program, to show those def corrected and the date sucl	ficiencies previously h corrective action v	reported on the vas accomplished	Medicare, Medicaid and/or Clinica e CMS-2567, Statement of Defici ed. Each deficiency should be fu shown on the CMS-2567 (prefix o	encies and Plan of Corully identified using either	rection, that have been er the regulation or LSC			
ITEM	DATE	ITEM	DATE	ITEM	DATE			
Y4	Y5	Y4	Y5	Y4	Y5			



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 26, 2016

Mr. Matthew Fischer, Administrator Bethany Home 1020 Lark Street Alexandria, Minnesota 56308

Re: Reinspection Results - Project Number S5434025

Dear Mr. Fischer:

On September 13, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 22, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

					SIAI		NIVI: KE	/1311	REPURI				
	ER / SUPPL CATION NU			MULTIPLE CON	STRUCTIC	N						DATE (OF REVISIT
00108	CATION NO	JIVIBE		A. Building B. Wing							Y2	9/13/2	016 _{Y3}
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BETHAN	NY HOME								ARK STREET				
									ANDRIA, MN 563				
correctiv	e action wation prefix	as a	ccomplis	tate surveyor to shed. Each def usly shown on t	iciency sho	ould be	fully ident	ified u	sing either the	regulation	or LSC provision	on numbe	er and the
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D Prefix	20565			Correction	ID Prefix	20830	ı		Correction	ID Prefix	20895		Correction
Reg. #	MN Rule 4 Subp. 3	658.0)405	Completed	Reg. #	MN Ru Subp.	ile 4658.052 1	20	Completed	Reg. #	MN Rule 4658.0 Subp. 2.B	525	Completed
_SC				08/09/2016	LSC				08/12/2016	LSC			08/12/2016
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FOLLOWUP TO SURVEY COMPLETED ON 7/22/2016			Y COMPL	ETED ON					CTED DEFICIEN IES (CMS-2567)		A SUMMARY OF HE FACILITY?	F YE	s 🗆 no

Page 1 of 1 EVENT ID: WIMT12

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier	Number	Pro	ovider/Supplie	er Name				
245434		BET	THANY HOME					
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al Supervisory Re	view Hours							0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey?

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WIMT
Facility ID: 00108

M. MICHARLAM MICHAEL STATE VENTOR OR METICALINO CLIP		PARI I -	TO BE COMPI	LEIED DY	INE SIAI	E SURVEY AGENCY		Facility ID: 00108
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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

Facility ID: 00108

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

CCN: 24 5434

On July 22, 2016, an extended survey was completed at this facility by the Minnesota Department 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. The facility was not in substantial compliance and the conditions in the facility constituted both substandard quality of care (SQC) and immediate jeopardy (IJ) to resident health or safety. The Department verified the condition resulting in our notification of immediate jeopardy has been removed.

As a result of the survey findings, this Department is the facility has not been given an opportunity to correct and the following Category 1 remedy was imposed:

State Monitoring effective August 10, 2016. (42 CFR 488.422)

In addition, this Department recommended the following enforcement remedy to the CMS Region V office for imposition:

Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

Futher, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 22, 2016. Refer to the CMS 2567 forms for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 5, 2016

Mr. Matthew Fischer, Administrator Bethany Home 1020 Lark Street Alexandria, Minnesota 56308

RE: Project Number S5434025

Dear Mr.. Fischer:

On July 22, 2016, an extended survey was completed at your facility by the Minnesota Department 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. I

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care (SQC) and immediate jeopardy (IJ)** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

<u>Removal of Immediate Jeopardy</u> - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

<u>No Opportunity to Correct</u> - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate

jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Pam Kerssen, RN, APM Minnesota Department of Health 1505 Pebble Lake Road #300 Fergus Falls, Minnesota 56537

Phone: (218) 308-2127

email: pam.kerssen@state.mn.us

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

• State Monitoring effective August 10, 2016. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 22, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services Departmental Appeals Board, MS 6132 Civil Remedies Division Attention: Karen R. Robinson, Director 330 Independence Avenue, SW Cohen Building, Room G-644 Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 remedy be imposed:

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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.

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 October 22, 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 January 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Mark Meath, Enforcement Specialist
Proggram Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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

PRINTED: 08/22/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245434		B. WING			07/22/2016		
NAME OF PROVIDER OR SUPPLIER BETHANY HOME				STREET ADDRESS, CITY, ST. 1020 LARK STREET ALEXANDRIA, MN 5630			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00			
	Department of Hea July 22, 2016. The Immediate Jeopard facility's failure to confectively impleme walker which result harm or death. The and was removed of	ucted by the Minnesota Ith on July 18,2016 through survey resulted in an y (IJ) at F323 related to the emprehensively assess and nt fall interventions for a Merry ed in the high potential for IJ began October 24, 2015 on July 20, 2016 at 3:30 p.m.					
	As a result of identification of the IJ at F323, an extended survey was conducted by the Minnesota Department of Health on July 21 and 22, 2016.						
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the otance. Because you are your signature is not required if first page of the CMS-2567 nic submission of the POC will cion of compliance.					
F 225 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.13(c)(1)(ii)-(iii),	PORT	F 2	25			8/9/16
LADODATON	been found guilty of mistreating resident had a finding entere registry concerning	of employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment	IATUDE	TITLE			(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

()

Electronically Signed

08/12/2016

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

	TATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED	
		245434	B. WING		07/22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET ALEXANDRIA, MN 56308	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 225	and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must en involving mistreatm including injuries of misappropriation of immediately to the atto other officials in a through established State survey and control of the facility must haviolations are thorough established State survey and control of the facility must haviolations are thorough established State survey and control of the facility must haviolations are thorough established state survey and control of the facility must haviolations are thorough established state survey and control of the facility must haviolations are thorough established state survey and control of the facility must have a survey and control of the facility must have	appropriation of their property; wledge it has of actions by a an employee, which would or service as a nurse aide or the State nurse aide registry ties. Issure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law disprocedures (including to the ertification agency). Inve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 225	This plan of correction is submitted	d solely
	facility failed to ens	ure injuries of unknown origin e State agency (SA) for 1 of 3		to comply with all applicable state a Federal regulatory requirements. T written responses do not constitute Admission of non-compliance with requirements nor an agreement wi	and hese an any

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		SURVEY PLETED
		245434	B. WING			07/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	V.I.O.I.E			10	020 LARK STREET		
BETHAN	Y HOME			Α	LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	R87's annual Minin 5/11/16, identified liproblems with no reunderstood and recall areas of daily livitilled Order Summa physician dated 6/2 diagnoses to include Parkinson's diseas R87's care plan reversident is dependent emotional, intellection of the follow 10/24/15-"Data: residentified the follow 10/24/15-"Data: residents more at ooth. no one seeknow what resident wat assist of 3 and EZ 10/26/15," IDT (intellection: resident wa	num Data Set (MDS) dated ong and short term memory ecall ability, was rarely to never quired extensive assistance for ing (ADL). The facility form ary Report signed by the 27/16, identified R87's medical de dementia with Lewy Bodies, e, and anxiety disorders. Viewed 7/13/16, indicated, "The ent upon staff etc. for ual, physical and social needs a Bodies, Physical Limitations" er indicated "The resident has behaviors r/t dementia with ecified psychosis". Surrsing progress notes ring: Sursing progress notes ring: Sesident tipped merry walker was found face down on floor, esident hit head/mouth on uth was bleeding from loosing en [sik] the incident so we don't towas trying to do at the time. In the slifted up from the floor well.	F 2	225	Findings. It is the policy of Ecumen Bethany I that each resident receives and the provides the necessary care and set to attain or maintain the highest practicable physical mental and psychosocial wellbeing in accordant the comprehensive assessment an of care. To assure continued complete following plan has been implement. • Regarding cited residents: F225 Investigate Report allegations/individuals Per Abuse Prevention policy: An injury of unknown so and must be reported when the south injury was not observed by any or the source of the injury could not explained by the resident. A. For R87 any further falls that reaserious injury of unknown source unwitnessed and the resident is not to explain, shall be reported to OHF immediately per the abuse policy. B. All residents that are identified for falls could be affected by not regimmediately. For all incidents that reaserious injury that are unwitnessed the resident is not able to explain shreported to OHFC immediately per abuse policy. C. Education to all licensed staff andividuals responsible for reporting provided on 8-9-16 via email. The education includes the Abuse and	e facility ervices ace with d plan liance lented. ury is purce urce of person to be esult in that is t able for that is t able for the d and hall be the lind	

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	` '	SURVEY PLETED
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F 225	superior most maxithe nose. Review of the facilit Adult Incident Log, reports to the SA, is submitted related to unwitnessed fall on On 7/22/16, at 11:2 (DON) verified a rethe SA when R87 h 10/24/15. The DON considered it a maj was unknown that I day or two after the verified she had no state agency when had a fractured jaw typically report an infall when the reside. When interviewed a social services dire responsibility of over and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for allenglect, exploitation the facility vulnerab given the scenario cognitively impaired fracture, SSD state	ty form titled 2015 Vulnerable which logged the facility ndicated a report had not been a R87's fractured jaw from an	F 225	Prevention policy specifically in regreporting serious injuries of unknown origin due to unwitnessed falls and resident not able to explain what happened. Nursing incident check now includes reporting serious injuries unknown origin to OHFC, and edue on the use of the Federal Long Te Report ability Under F225 injuries unknown source. Face to face mewere also held the week of 8-8-16 provide education on reporting injuries unknown origin. The policy, check algorithm will be review at an all simeeting on 8-23-16 as an addition education opportunity. D. Audits will be completed on all beginning 8-9-16 to assure any seinjury of unknown origin is reporte OHFC per policy. Audits will be confere each reported fall for 4 week assure compliance with the Abuse Prevention policy. E. Completion date 8-9-20-16. A results will be reviewed at the Sep 21, 2016 QAPI meeting where the will determine what, in any addition education is required, and determ future frequency of audits. Directo Nursing or designee will be response.	wn dithe list that uries of cation rm Care of etings to uries of list and afficial list and included the cation rmpleted is to udit tember team and ne the riof	

-		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, 2 1020 LARK STREET ALEXANDRIA, MN 56308		
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 225	computer and the observation, resider resulting injury; SS so" regarding R87' unwitnessed fall. Shad discussed the be a reportable incorposedure for reportagin by reading a injury is considered and must be reported and must be reported injury was not obsessource of the injury resident; and (2) Tof the extent of the injury. SSD requested electronic record by questions. On 7/22/16, at 1:56 had been reviewed (IDT) and stated, "vinjury." SSD furthed did not result in a had publicated in the state of the injury. The facility policy to the facilities updated considered an injury be reported when lare present	ent unable to explain and the D responded, "I would think is fractured jaw due to an SD indicated the facility staff incident and had not found it to ident. SSD verified the usual rting an injury of unknown loud the facility policy: An id an injury of unknown source ted when both of the following sent: (1) The source of the erved by any person or the reverse of the erved by any person or the reverse of the erved by any person of the entingury is suspicious because injury or the location of the effore answering any more. Sign. SSD identified R87's fall if with the interdisciplinary team we didn't think it was a serious of explained the fractured jaw inospitalization or affect R87's effore it was not a serious injury. On 7/22/16, at 1:56 p.m. the lated the report would be allity Assurance meeting to for reporting. Ittled Ecumen's Abuse or Minnesota Skilled Nursing 7/2015, identified "An injury is ry of unknown source and must	F 2	225		

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F 225 F 226 SS=D	be explained by the (2) The injury is sus of the injury or the I injury is located in a vulnerable to traum observed at one paincidence of injuries 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and proced mistreatment, negle	source of the injury could not resident; and spicious because of the extent ocation of the injury (e.g., the an area not generally a) or the number of injuries rticular point in time or the sover time." P/IMPLMENT ETC POLICIES	F 225		8/9/16
	by: Based on interview facility failed to imply procedures to include reporting of injuries Agency (SA) for 1 of Findings include: The facility policy tith Prevention Plan For Facilities updated 7 considered an injurible reported when be are present: (1) The observed by any perinjury could not be 6 (2) The injury is sustained.	and document review the ement abuse policies and de consistent, immediate of unknown origin to the State of 3 residents (R87) reviewed. Iled Ecumen's Abuse of Minnesota Skilled Nursing (2015, identified " An injury is yof unknown source and must oth of the following conditions are source of the injury was not erson or the source of the explained by the resident; and spicious because of the extent ocation of the injury (e.g., the		F226 Develop/Implement abuse/negled etc. policies The facility does have a policy for reporting injury of unknown origin. Per Abuse Prevention policy: An injury is considered an injury of unknown source and must be reported when the source the injury was not observed by any pers or the source of the injury could not be explained by the resident. A. For R87 any further injury of unknown origin per policy will be reported and reviewed by the IDT. All major injuries the are unwitnessed and the resident is not able to explain shall be reported to OHF immediately per the abuse prevention	of on vn nat

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F 226	injury is located in a vulnerable to traum observed at one paincidence of injuries. R87's annual Minim 5/11/16, identified le problems with no re understood and recall areas of daily livititled Order Summa physician dated 6/2 diagnoses to include Parkinson's diseas. R87's care plan reversident is dependent in the lecturity of the care plan furth physically abusive became to the problems with a previous plants. In the care plan furth physically abusive became to the follow of the fall." See the follow of the fall."	an area not generally (a) or the number of injuries (articular point in time or the sover time." num Data Set (MDS) dated (a) and short term memory (a) ecall ability, was rarely to never quired extensive assistance for ing (ADL). The facility form (ADL). The facility form (ADL) ary Report signed by the (AT/16) identified R87's medical (a) dementia with Lewy Bodies, (a) e, and anxiety disorders. Ariewed 7/13/16, indicated, "The cent upon staff etc. for (a) ual, physical and social needs (a) Bodies, Physical Limitations (a) er indicated (a) "The resident has (a) behaviors r/t dementia with ecified psychosis". Aursing progress notes (a) sident tipped merry walker (a) was found face down on floor, (a) esident hit head/mouth on (a) the was bleeding from loosing (a) [sik] the incident so we don't at was trying to do at the time, (a) slifted up from the floor w/	F 2	policy. B. All residents that are i for falls could be affected immediately. For all falls the serious injury, that are unteresident is not able to reported to OHFC immediabuse policy. C. Education to all licens individuals responsible for provided on 8-9-16 via emeducation includes the Ab Prevention policy specificate reporting injuries of unknown unwitnessed falls and the able to explain what happer incident check list that now reporting serious injuries origin to OHFC, and education of the Federal Long Term ability Under F225 injuries source. Face to face meet held the week of 8-8-16 to education on reporting injuries and all staff meet as an additional education. The policy, checklist and a review at an all staff meet as an additional education. D. Audits will be complet beginning 8-9-16 to assure injury of unknown origin is OHFC per policy. Audits wafter each reported fall for assure compliance with the Prevention policy. E. Completion date 8-9-2 results will be reviewed at 21, 2016 QAPI meeting was will determine what in any will determine what in a	by not reporting nat result in a witnessed and explain shall be ately per the ed staff and reporting rail. The reporting rail. The reporting rail in regards to wn origin due to resident not resident not rened. Nursing reporting rail in reporting rail in regards to wn origin due to resident not resident not resident not rened. Nursing rail in reporting rail in reporting rail in reporting with responsible reporting will be reported to report all falls reported to reported	

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F 226	following Clinical in a fall, initial encoun with more confusion Nondisplaced fracts superior most maxis the nose. Review of the facility Adult Incident Log, reports to the SA, in submitted related to unwitnessed fall on On 7/22/16, at 11:2 (DON) verified a return the SA when R87 h 10/24/15. The DON considered it a majwas unknown that I day or two after the verified she had no state agency when had a fractured jaw typically report an infall when the reside When interviewed social services dire responsibility of over and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for allenglect, exploitation	formation: [R87] presents with ter. Nurse states -facial pain in than usual. Conclusion: ure thorough the anterior lla (upper jaw) at the base of the form titled 2015 Vulnerable which logged the facility indicated a report had not been to R87's fractured jaw from an	F 2	226	education is required, and determiture frequency of audits. Director Nursing or designee will be responsible.	of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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F 226	cognitively impaired fracture, SSD state guidelines." When computer and the inobservation, reside resulting injury; SS so" regarding R87's unwitnessed fall. Shad discussed the be a reportable inciprocedure for reportance and must be report conditions are presinjury was not obsessource of the injury resident; and (2) Thof the extent of the injury. SSD requested record be questions. On 7/22/16, at 1:56 had been reviewed (IDT) and stated, "winjury." SSD further did not result in a hquality of life; there	of an unwitnessed fall of a diresident resulting in a direction of the count unable to explain and the Diresponded, "I would think a fractured jaw due to an SD indicated the facility staff incident and had not found it to ident. SSD verified the usual tring an injury of unknown oud the facility policy: An an injury of unknown source ed when both of the following ent: (1) The source of the reved by any person or the could not be explained by the ne injury is suspicious because injury or the location of the amore time to review the effore answering any more. Sp.m. SSD identified R87's fall with the interdisciplinary team are didn't think it was a serious of explained the fractured jaw ospitalization or affect R87's fore it was not a serious injury. Ton 7/22/16, at 1:56 p.m. the lated the report would be lity Assurance meeting to	F 2	226			

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F 226	Continued From pa	ge 9	F 226		
F 282 SS=D	PERSONS/PÉR CA The services provided be accordance with ea care.	RVICES BY QUALIFIED ARE PLAN led or arranged by the facility y qualified persons in ch resident's written plan of	F 282		8/9/16
	review the facility facare for 2 of 3 reside were dependent upcares and for 1 of 1 bilateral hand control (ROM). Findings include: R78's admission M7/1/16, identified R3 impaired, required areas of daily living assistance to walk which included Parl arthritis and vision in	ion, interview and document liled to implement the plan of lents (R78, R28) reviewed who on staff for shaving and oral resident (R65) reviewed with actures and required range of linimum Data Set (MDS) dated 78 was moderately cognitively extensive assistance for all (ADL)with exception of limited in corridor and diagnoses kinson's disease, dementia, impairment.		F282 Services by Qualified Persons/p care plan Policy: Nursing care standards: to ensithat every resident receives care to reatheir highest practicable level of functioning. This includes: Assistance or supervision of shaving residents as necessary to keep them clean and well groomed. Assistance as needed with or hygiene to keep the mouth, teeth or dentures clean. Assistance with ROM placement of a device. Residents do hithe right to refuse care/assistance all refusals will be charted in the resident' record. A. For R78 shaving will be offered ar provided by staff daily. Care plan for R	ure ach with l oral or ave

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F 282	care deficit related hypertension, diabe evidenced by requiresident requires expersonal hygiene. The undated resider required assist of orgrooming. On 7/19/16, at 9:28 shave because of rethey are a little lax stubble on chin and On 7/20/16, at 7:57	to Parkinson's Disease, etes, and dementia as ring assist with ADL's -The extensive assist of 1 staff with ent care sheet, indicated R78 ne staff with dressing and a.m. R78 stated, "I can't my Parkinson, that is one thing on." At this time R78 has	F 282	,	offered es per ated to a tures. with ards to s per s uation are to d not to larified	
	(NA)-H. R78 had filip and chin area. On 7/20/16, at 1:00 room in a stationar R87 remained unsl. On 7/21/16, at 9:26 room dressed, has mustache and bear on 7/20/16, at 8:51 to shave independenceds help. NA-H facility and NA-H when interviewed verified if he was all do it every day. R75 face each morning	p.m. R78 was seated in his y chair in front of the television. naven. a.m. R78 was seated in seated in seated in his anot had face shaved, and heavy stubble. a.m. NA-H indicated R78 tries ently and will ask staff when he indicated R78 was new to the as unsure of whether R78 had		staff working with R56 will be provied education on placement of kerlix in It will be the responsibility of all nurstaff to assure kerlix is in place. The plan has been updated will be review with staff providing care for R65 in regards to placement of gauze roll: hands. B. All residents requiring assistant cares have to potential to be affect this same practice. C. Written Education was provide staff via email and on Point of Care messaging on 8-9-16 in regards to expectations related to shaving, or cares, placement of devices relate contractures and providing assista all resident per their plan of care. face education was provided to staweek of 8-8-16. Will also provide additional training opportunity at the 16 all staff meeting.	ded hands. rsing he care hewed s in heed by he d to all he care he car	

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F 282	verified his facial hat today and was unal shaved him. On 7/20/16, at 1:17 no behaviors and da walk, however, it example if his wife pain in his hip. On 7/21/16, at 9:54 unable to shave inchands. NA-E verifiet this a.m. NA-E indicated heigh and the shave this a.m. and "every so often." On 7/21/16, at 11:0 a good memory and NA-F indicated heigh R78 often, however clean shaven. NA-F assisted R78 with constitution and they can't themselv. On 7/21/16, at 11:0 shaved this morning isn't so hard to get R78 further identified was easier to keep stating "I drool." On 7/21/16, at 11:1 (LPN)-E verified R7 not been shaved. On 7/21/2016, at 1	p.m. NA-I identified R78 had id occasionally refuse to go for was usually for a reason, for was here or if he was having a.m. NA-E indicated R78 was lependently due to shaky d he/she had not shaved R78 cated R78 refused the offer to I had a routine of shaving only 0 a.m. NA-F verified R78 had d what he says is accurate. She did not provide cares for r, did believe R78 was usually indicated staff usually oral care and shaving. NA-F normally shave a person if	F 2	282	D. Audits implemented beginning on 4 residents per week x 4 weeks assure shaving, oral cares, and application of kerlix/devices are prper policy. Further education and a will be provided/conducted if compis not met. E. Completion date 8-9-2016. Auresults will be reviewed at the Sep 21, 2016 QAPI meeting where the will determine what, in any addition education is required, and determifuture frequency of audits. Director Nursing or designee will be responsible.	ovided audits diance dit team hal he the	

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	PROVIDER OR SUPPLIER Y HOME			10	REET ADDRESS, CITY, STATE, ZIP CODE 120 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	ADL's due to has Falthough his abilitie was not able to sha electric razor. RN-A expected to shave not expect resident assistance. When interviewed of director of nursing of that staff follow the require assistance care and not expect R28's care plan data required extensive with personal hygie plan indicated R28 Staff were to assist offer R28 mouth swand while getting residence.	Parkinson's Disease and so change from day to day, R78 are independently with an a identified staff were male residents daily and would so to have to ask for the an 7/22/16, at 11:25 a.m. the DON) verified the expectation care plan and residents who with ADL's be provided the sted to ask for assistance. The ded 7/15/16, identified R28 assistance to total assistance in and oral cares. The care had upper and lower dentures, with cleaning dentures and to rab and mouth was in the AM andy for bed, and staff were to spection with cares and as	F 2	282			
	did not wear the de	nt care sheet, indicated R28 ntures. The resident care rection regarding oral cares					
	from 8:23 a.m. to 8 assisted R28 with p washing her face, p During the observa offered the opportu cares. R28's oral c dryAt 8:57 a.m. NA-A	of morning cares on 7/20/16, :54 a.m. NA-A and NA-G personal cares which included perineal cares and dressing. Ition, R28 was not assisted nor nity for completion of oral avity and lips appeared very assisted R28 with breakfast tioned in bed. R28 was not					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING	_	` '	E SURVEY PLETED
		245434	B. WING			07/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 1020 LARK STREET ALEXANDRIA, MN 563	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD ED TO THE APPROPF FICIENCY)	BE	(X5) COMPLETION DATE
F 282	wearing any denture breakfast food item consume the strawlest - At 9:01 a.m. NA-A shut off the bedroor are good with feeding just like today. NAtray to the kitchen, offered the opportuncares. During interview on reported R28 no lor stated she was goin breakfast to provide swabbing out the management of the waste of	es, and R28 refused the s and juice offered. R28 did perry supplement. gathered the breakfast tray, in lights and stated some daysing, and some days are not, A then delivered the breakfast R28 was not assisted nor nity for completion of oral. 7/20/16, at 8:45 a.m. NA-A ager wears dentures, and age to wait until after R28 ate e oral cares which included bouth with a toothette. confirmed R28 had finished the nor offer oral cares which the mouth with a toothette or er, NA-A confirmed she did not with cares. 7/21/16, at 10:35 a.m. RN-B anger wore dentures. RN-B apected to swab R28's mouth, or at least attempting as R28 RN-B confirmed R28 has a ps with the oral cavity open, must be attempted. 7/22/16, at 10:08 a.m. the ff are expected to provide or all resident twice per day as	F 2	82			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING		0	7/22/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	2010, directed staff plan for any special assemble the equip Review of R65's qu (MDS) dated 4/27/1 cognitive impairmer included Parkinson disease and cerebrhemiplegia. The M totally dependent or living (ADL's) and honorractures. Review Assessment (CAA) had severe cognitive Alzheimer's disease staff for ADL's and Review of R65's cardientified R65 had a upper and lower exdependent on staff range of motion with rolls in both hands 30 minutes twice day hand contractures. On 7/18/16, at 5:38 in space wheelchait station prior to the exhands were held in bent and hands restrested near her heat her left upper chest placed in her hands seated in a tilt in spanurses station followers.	to review the resident's care needs of the resident. and oment and supplies as needed. Tarterly Minimum Data Set 16, identified R65 had severe not and had diagnoses which 1's disease, Alzheimer's avascular disease with DS further identified R65 was no staff for activities of daily and bilateral upper extremity and bilateral upper extremity and the set of the s	F 2	282		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		MPLETED
		245434	B. WING _		07	7/22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	against her back, becover R65 to mid to fisted position, arm fisted hands rested have kerlix in her her have kerlix in space wheelchaid elbows, hands were were clenched fisted clenched hand was left clenched hand chest, no kerlix was when interviewed are gistered nurse medid not have kerlix care planned and wonot in use. RN-A st were responsible for R65's kerlix were in contractures. RN-A were too contracted out, nor could R65 independently. RN contracted and had a licensed practical. On 7/21/16, at 5:13 open R65's right had contracted, fisted processed in the contracted of the	ed to her right side with pillows plankets were observed to orso. R65's hands were in a newere bent at the elbow, against her chest. R65 did not ands. 7 p.m. R65 was seated in a tilt in with both arms bent at the eresting on her chest and ed position. R65's right is resting over her heart and her was resting on her upper left is observed in R65's hands. on 7/21/16, at 5:09 p.m. anager (RN)-A confirmed R65 in her contracted hands as was unsure why the kerlix was ated the medication nurses or checking to make sure in both hands for bilateral hand a stated she felt R65 hands of for the kerlix to have fallen remove the kerlix stated R65's hands were fully it been for years. RN-A directed I nurse (LPN)-D to apply kerlix.	F 28	·		
	roll into R65's hand was hurting her find stopped opening R stated there were to needed to be soake	I. R65 stated it hurt and she gers, LPN-D immediately 65's hand. At that time, LPN-D imes when R65's hands ed in warm water to help open A and NA-B then wheeled				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCT	ION		TE SURVEY MPLETED
		245434	B. WING			07.	/22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRES 1020 LARK STF ALEXANDRIA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	R65's to her room her bathroom, while out of the faucet. Neeld it under the was opened R65's hand the kerlix. NA-B the under the water who washed, dried and NA-B assisted R65 her wheelchair and station. On 7/21/16, at 5:12 supposed to have at all times. NA-B sthem in after R65's stated she felt abokerlix were not in high place the kerlix into hard time doing so R65's hands were could not fall out at unable to remove the she felt R65's hand last few years. On 7/22/16, at 10:2 required total assistated on average not have the cloth NA-C would then prontracted hands. On 7/22/16, at 10:3 not had a recent of though had one at R65 had complete RN-A confirmed R65.	age 16 and NA-B wheeled R65 into e RN-A started to run the water IA-B took R65's right hand, arm water while RN-A slowly d, washed, dried and applied en took R65's left hand, held it file RN-A opened R65's hand, applied another roll of kerlix. Is back out of the bathroom in I wheeled R65 back to nursing I wheeled R65 was the kerlix in both of her hands stated the nurses usually put to hands were washed. NA-B tut 3-4 times a week R65's er hands and often had a to NA-B further stated she felt fisted very tightly so the kerlix and she felt R65 would be the kerlix herself. NA-B stated dis had not worsened over the I was a week R65 thance with all ADL's, NA-C a few days a week R65 would rolls, (kerlix) in her hands and alace the kerlix in R65's I a.m. RN-A stated R65 had becupational therapy evaluation, ew years ago which identified contractures of both hands. I was a week R65 had becupational therapy evaluation, ew years ago which identified contractures of both hands. I was a week R65 had becupational therapy evaluation, ew years ago which identified contractures of both hands. I was a week R65 had kerlix I was a was a week R65 had kerlix I was a was a week R65 had kerlix I was a week R65 had kerlix I was a was a week R65 had kerlix I was a was a week R65 had kerlix I was a was a week R65 had kerlix I was a wa	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245434	B. WING _		07/	22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	placed in both conting removed when was the licensed nurses R65 had the kerlix in the kerlix on the (T/expected the kerlix staff could apply the fully contracted hand On 07/22/16, at 11: (DON) stated shee be implemented as not feel that R65's hand contractures had control. The DON cophysician orders in medical record ider was ordered for hand the care of care from admission to the facility's Care F 2010, indicated the enhance the optimal and/or aid in prever	racted hands and only to be thed twice daily. RN-A stated were responsible to ensure in place and would document AR.) RN-A stated she to be in place as any care exertise. RN-A stated R65 had ids and fingers. 13 a.m. the director of nursing expected resident care plans to directed. DON stated she did kerlix treatment was for her out were more for moisture confirmed R65's current point click care electronic ntified R65's kerlix treatment and contractures. Eled Resident MDS 3.0 an of Care revised 03/12, olan was to provide continuity	F 28	32		
F 312 SS=D	DEPENDÊNT RES	ARE PROVIDED FOR IDENTS The provided HTML in the p	F 31	2		8/12/16
	daily living receives	the necessary services to tion, grooming, and personal				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
		245434	B. WING		07/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	Continued From pa	ige 18	F 312			
	by: Based on observareview the facility faremoval of facial h R28) reviewed who for grooming and p Findings include: R78's admission M7/1/16, identified Rimpaired, required areas of daily living assistance to walk which included Pararthritis and vision M78's undated care care deficit related hypertension, diabe evidenced by requires expersonal hygiene. The undated residerequired assist of orgrooming. On 7/19/16, at 9:28 shave because of rathey are a little lax of stubble on chin and On 7/20/16, at 7:57 his room to the dini	Minimum Data Set (MDS) dated 78 was moderately cognitively extensive assistance for all (ADL)with exception of limited in corridor and diagnoses kinson's disease, dementia, impairment. It plan, identified R78 had a self to Parkinson's Disease, etes, and dementia as ring assist with ADL's -The extensive assist of 1 staff with ent care sheet, indicated R78 ne staff with dressing and B a.m. R78 stated, "I can't my Parkinson, that is one thing on." At this time R78 has		F312 ADL care provided for deper residents Policy: Nursing care standards: to that every resident receives care to their highest practicable level of functioning. This includes: Assistar or supervision of shaving residents necessary to keep them clean and groomed. Assistance as needed whygiene to keep the mouth, teeth of dentures clean. Assistance with RC placement of a device. Residents of the right to refuse care/assistance refusals will be charted in the residing record. A. For R78 shaving has been offer and provided by staff daily. Care planged by staff daily. Care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff at least 2 times per care planged by staff providing care for R28 in regard providing oral cares at least 2 times day. b. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation. R65 has had fixed contractures (irreversible) for years per OT evaluation.	ensure o reach nce with as well ith oral r DM or do have all ent's ered an for to red and er day. o ntures. with rds to s per s uation are to d not to	

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		245434	B. WING		07/2	22/2016
	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	lip and chin area. On 7/20/16, at 1:00 room in a stationary R87 remained unsh On 7/21/16, at 9:26 room dressed, has mustache and bear On 7/20/16, at 8:51 to shave independented help. NA-H facility and NA-H whether with the shaviors or refuse When interviewed overified if he was also it every day. R78 face each morning electric razor but so verified his facial hat today and was unal shaved him. On 7/20/16, at 1:17 no behaviors and da walk, however, it example if his wife pain in his hip. On 7/21/16, at 9:54 unable to shave inchands. NA-E verified this a.m. NA-E indicated.	p.m. R78 was seated in his y chair in front of the television. naven. a.m. R78 was seated in sont had face shaved, and heavy stubble. a.m. NA-H indicated R78 tries ently and will ask staff when he indicated R78 was new to the as unsure of whether R78 had	F 312	and plan of care has been revised staff working with R56 have been provided education on placement in hands. It will be the responsibili nursing staff to assure kerlix is in The care plan has been updated reviewed with staff providing care in regards to placement of kerlix rhands. B. All residents requiring assistat care have been reviewed to deter they have been affected by the sarpractice. C. Written education has been provided to all staff via email and on Point of messaging on 8-9-16 in regards to expectations related to shaving, of cares, placement of devices related contractures and providing assistational training opportunity at the face education was also provided the week of 8-8-16. Will also provide	of kerlix ty of all place. will be for R65 olls in nce with mine if me provided of Care ocare ral ed to ance to Face to to staff ide ne 8-23- eginning 4 weeks I rovided Audit otember e team nal ine the or of	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	_ (:	X3) DATE SURVEY COMPLETED
		245434	B. WING			07/22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, ST 1020 LARK STREET ALEXANDRIA, MN 563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIN CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD B ID TO THE APPROPRI ICIENCY)	
F 312	a good memory and NA-F indicated he/s R78 often, however clean shaven. NA-F assisted R78 with o sated, "We would reflect the work they can't themselv." On 7/21/16, at 11:0 shaved this morning isn't so hard to get of R78 further identified was easier to keep stating "I drool." On 7/21/16, at 11:13 (LPN)-E verified R7 not been shaved. On 7/21/2016, at 1 (RN)-A verified R78 ADL's due to has Falthough his abilities was not able to shate electric razor. RN-A expected to shave in not expect residents assistance. When interviewed of director of nursing (that staff follow the require assistance of the require asi	d what he says is accurate. She did not provide cares for T, did believe R78 was usually F indicated staff usually Iral care and shaving. NA-F Thormally shave a person if	F 3	12		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY IPLETED
		245434	B. WING			07/	22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			102	REET ADDRESS, CITY, STATE, ZIP CODE 20 LARK STREET .EXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 312	cognitively impaired included: Alzheimel arthritis. The MDS extensive assistant hygiene tasks. R28's care plan dat required extensive with personal hygie plan indicated R28 Staff were to assist offer R28 mouth swand while getting re	ge 21 R28 was moderately I and diagnoses which I's, psychotic disorder and indicated R28 required indicated R28 assistance to total assistance indicate and oral cares. The care indicated upper and lower dentures with cleaning dentures and to rab and mouth was in the AM ady for bed, and staff were to spection with cares and as	F3	12			
	did not wear the de sheet lacked any di for R28.	nt care sheet, indicated R28 ntures. The resident care rection regarding oral cares sessment dated 6/13/16,					
	indicated R28 had r fragments, and indi dentures. The asse	no natural teeth or tooth cated R28 chose not to wear essment identified R28 had a wing problem and received a					
	from 8:23 a.m. to 8 assisted R28 with p washing her face, p During the observa offered the opportu cares. R28's oral c dryAt 8:57 a.m. NA-A	of morning cares on 7/20/16, 54 a.m. NA-A and NA-G ersonal cares which included erineal cares and dressing. tion, R28 was not assisted nor nity for completion of oral avity and lips appeared very assisted R28 with breakfast tioned in bed. R28 was not					

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		245434	B. WING			07/	22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			1020 L	ET ADDRESS, CITY, STATE, ZIP CODE LARK STREET (ANDRIA, MN 56308	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 312	wearing any dentur breakfast food item consume the straw -At 9:01 a.m. NA-A shut off the bedroor are good with feedi just like today. NAtray to the kitchen, offered the opportucares. During interview on reported R28 no lor stated she was goir breakfast to provide swabbing out the management of the provided swabbing out the management of the provided swabbing and the provided swabbing mouthwash. Further inspect her mouth with the breakfast of the provided swabbing mouthwash. Further inspect her mouth with the provided swabbing mouthwash. Further inspect her mouth with the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse. It is described by the provided staff are exwith morning cares will at times refuse.	es, and R28 refused the s and juice offered. R28 did berry supplement. gathered the breakfast tray, m lights and stated some days ng, and some days are not, A then delivered the breakfast R28 was not assisted nor nity for completion of oral 7/20/16, at 8:45 a.m. NA-A nger wears dentures, and ng to wait until after R28 ate e oral cares which included touth with a toothette. confirmed R28 had finished neal and confirmed she had cares for R28. NA-A verified te nor offer oral cares which the mouth with a toothette or er, NA-A confirmed she did not with cares. 7/21/16, at 10:35 a.m. RN-B onger wore dentures. RN-B pected to swab R28's mouth, or at least attempting as R28 RN-B confirmed R28 has a ps with the oral cavity open, must be attempted. 7/22/16, at 10:08 a.m. the ff are expected to provide or all resident twice per day as	F3	12			

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		245434	B. WING		07/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		D BE	(X5) COMPLETION DATE
F 312	2010, directed staff plan for any special assemble the equip The purpose is to k tissues moist, to cle resident's mouth, a mouth. 483.25(e)(2) INCRE	to review the resident's care needs of the resident. and ment and supplies as needed. eep the resident's lips and oral canse and freshen the nd to prevent infections of the EASE/PREVENT DECREASE	F 3			8/12/16
SS=D	resident, the facility with a limited range appropriate treatme	rehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further				
	by: Based on observat review the facility fa interventions for ide resident (R65) revie (ROM.) Findings include: Review of R65's qu (MDS) dated 4/27/1 cognitive impairmer included Parkinson' disease and cerebrahemiplegia . The M totally dependent or	ion, interview and document iled to implement entified contractures for 1 of 1 ewed for range of motion arterly Minimum Data Set 6, identified R65 had severe at and had diagnoses which is disease, Alzheimer's evascular disease with DS further identified R65 was a staff for activities of daily ad bilateral upper extremity		F318 Increase/Prevent decrease Range of Motion Per Policy: to promote each reside ability to adapt to attain his or her maximum functional potential. To each resident's highest practicabl of physical, mental and psychosof functioning. A. R65 admitted to Bethany with contractures. Per OT assessment 12 contractures in hands are in a position. Kerlix placed in hands deprevent moisture associated damand/or skin breakdown. MD order been clarified to state such and R of care has been updated.	promote e level cial : 11-17- fixed aily is to age has	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245434	B. WING		07/:	22/2016	
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 318	Review of R65's ar (CAA) dated 8/19/1 cognitive impairme was totally dependent contractures. Review of R65's caidentified R65 had upper and lower exdependent on staff range of motion with rolls in both hands 30 minutes twice of hand contractures. Review of R65's canded and contractures. Review of R65's canded and contractures which additional gauze be and gauze when so for contractures. The staff to wash R65's instruction sheet. Review of R65's pr 5/27/16, revealed Froutine visit in which contractures which and hands. Review of R65's matherapy (OT) assess revealed R65 had which were in a fixed evaluation directed.	nnual Care Area Assessment 5, identified R65 had severe nt due to Alzheimer's disease, ent on staff for ADL's and had are plan print dated 2/25/16, bilateral contractures of the attremities, was totally for all ADL's, required gentle th daily care, required gauze 23/hrs/day: to be removed for aily for hygiene for bilateral	F 318	B. All resident's with devices for and or contractures has the poter affected by the same practice. C. All resident's that have device ROM and/or contractures will be to assure the device is being use appropriate reasons and that the are being placed per MD orders, the care plan and care sheets are D. Audits for devices to assure is correct, care plan is correct, debeing applied and care sheets are will be done on each resident with device until all residents with a device until determine date 8-12-16. Audits will be reviewed at the Secondard Cappelling where the will determine what, in any additive ducation is required, and determine the frequency of audits. Direct Nursing or designee will be responsible to the provious designee will be responsible.	es for reviewed and for the devices and that e current. MD order evices are e current h a evice adit ptember e team onal nine the or of		

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED
	245434	B. WING		07	7/22/2016
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1020 LARK STREET ALEXANDRIA, MN 56308	O7/2 REET ADDRESS, CITY, STATE, ZIP CODE	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
Review of R65's Judininistration reconnected the treatment was in Review of R65's treatment was in Review of R65's cast and sthree times as that code legend whe treatment was in Review of R65's cast and for the treatment was in Review of R65's cast and the treatment was the treatment was to the treatme	ord lacked any further OT d contractures. Ily 2016, treatment rd (TAR) revealed a check tment of kerlix rolls in both a day. The TAR revealed a which a check mark indicated in place on all days. The conference note dated and the continued to have hands and extremities. The end staff were to continue to be a staff were to continue to be continue. The conference from 1/23/16, to me following: The continue to continue to continue to the following: The continue to continue to the following: The continue to continue to required vigilant monitoring the contractures to required vigilant monitoring the contractures, staff continued to both contracted hands daily. The contractures to required vigilant monitoring the contractures, staff continued to both contracted hands daily.		18		
COLOR REPUBLICATION CONTRACTOR	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From parameters. R65's medical recovaluations for handle and three times a chart code legend where treatment was in the	ADVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 contractures. R65's medical record lacked any further OT valuations for hand contractures. R65's medical record lacked any further OT valuations for hand contractures. R65's treatment of kerlix rolls in both ands three times a day. The TAR revealed a chark for R65's treatment of kerlix rolls in both ands three times a day. The TAR revealed a hart code legend which a check mark indicated he treatment was in place on all days. Review of R65's care conference note dated /17/16, revealed R65 continued to have contractures of her hands and extremities. The ote further revealed staff were to continue to pply gauze to R65's hands daily. The note indicated that was to continue. Review of R65's progress notes from 1/23/16, to /13/16, revealed R65 had contractures to illateral hands and required vigilant monitoring and gauze rolls placed in both hands, extra care to keep R65's hands clean. Review R65's hands clean.	DOUBER OR SUPPLIER HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 25 Contractures. R65's medical record lacked any further OT valuations for hand contractures. Review of R65's July 2016, treatment diministration record (TAR) revealed a check nark for R65's treatment of kerlix rolls in both ands three times a day. The TAR revealed a hart code legend which a check mark indicated he treatment was in place on all days. Review of R65's care conference note dated /17/16, revealed R65 continued to have ontractures of her hands and extremities. The ote further revealed staff were to continue to pply gauze to R65's hands daily. The note idicated that was to continue. Review of R65's progress notes from 1/23/16, to /13/16, revealed R65 had contractures to illateral hands and required vigilant monitoring and gauze rolls placed in both hands, extra care to keep R65's hands clean. Review of R65's hands clean. Review of R65's hands clean. Review of R65's progress notes from 1/23/16, to /13/16, revealed R65 received passive range of rotion (PROM) to both upper and lower extremities due to contractures, staff continued to pply gauze rolls in both contracted hands daily. Review of R65 had bilateral hand contractures and required total assistance from staff for all	DEFICIENCY 245434 245434 DIVIDER OR SUPPLIER HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY COntinued From page 25 Contractures. R65's medical record lacked any further OT valuations for hand contractures. Review of R65's July 2016, treatment dministration record (TAR) revealed a check lark for R65's treatment of kerlix rolls in both ands three times a day. The TAR revealed a hart code legend which a check mark indicated le treatment was in place on all days. Review of R65's care conference note dated /17/16, revealed R65 continued to have ontractures of her hands and extremities. The ote further revealed staff were to continue to pply gauze to R65's hands daily. The note idicated that was to continue. Review of R65's progress notes from 1/23/16, to /13/16, revealed the following: 1/24/16, revealed R65 had contractures to illateral hands and required vigilant monitoring and gauze rolls placed in both hands, extra care to keep R65's hands clean. 2/5/16, revealed R65 received passive range of notion (PROM) to both upper and lower xtremities due to contractures, staff continued to pply gauze rolls in both contracted hands daily. 3/5/16, revealed a monthly charting note which lentified R65 had bilateral hand contractures.	DVIDER OR SUPPLIER ### A BUILDING 245434

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING _	 	07	/22/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1020 LARK STREET ALEXANDRIA, MN 56308	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 318	and required total a ADL's. -4/23/16, revealed R65 required total a to contractures and which identified R6 contractures and si both hands to help skin integrity. -5/20/16, revealed identified R65 had required total assis -5/28/16, revealed which revealed star R65's hands due to hands. R65's progregarding inability thands. R65's progregarding inability thands. R65's progregarding inability thands. R65's hands due to hands. R65's progregarding inability thands. R65's progregarding inability thands. R65's progregarding inability thands. R65's hands due to hands. R65's progregarding inability thands. R65's had required total assis -6/27/16, revealed identified R65 had required total assis -7/13/16, revealed identified R65 had required total assis	assistance from staff for all a ADL note which identified assistance with all ADL's due				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING _		07	/22/2016
	ETHANY HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 318 Continued From page 27 required total assistance from staff for all ADL On 7/18/16, at 5:38 p.m. R65 was seated in a in space wheelchair across from the nurses station prior to the evening meal. Both of R65 hands were held in a fisted position, elbows when the angle of the properties of the nurses seated in a tilt in space wheelchair near the nurses seated in a tilt in space wheelchair near the nurses station following the evening meal. Referemained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R6 was lying in bed tilted to her right side with pil against her back, blankets were observed to cover R65 to mid torso. R65's hands were in fisted position, arms were bent at the elbow, fisted hands rested against her chest. R65 did have kerlix in her hands. On 7/21/16, at 4:57 p.m. R65 was seated in a in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and left clenched hand was resting on her upper lichest, no kerlix was observed in R65's hands When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed I did not have kerlix in her contracted hands as care planned and was unsure why the kerlix vent in use. RN-A stated the medication nurses.			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 318	required total assis On 7/18/16, at 5:38 in space wheelchai station prior to the chands were held in bent and hands res rested near her hea her left upper chest placed in her hands seated in a tilt in sp nurses station follor remained without k On 7/19/16, from 8 was lying in bed tilt against her back, b cover R65 to mid to fisted position, arm fisted hands rested have kerlix in her h On 7/21/16, at 4:57 in space wheelchai elbows, hands were were clenched fiste clenched hand was left clenched hand chest, no kerlix was When interviewed or egistered nurse m did not have kerlix care planned and w not in use. RN-A st were responsible fo R65's kerlix were ir contractures. RN-A	tance from staff for all ADL's. Ip.m. R65 was seated in a tilt r across from the nurses evening meal. Both of R65's a fisted position, elbows were sted on her chest, right hand art and her left hand rested on the R65 did not have kerlix. In R65 did not have kerlix. In R65 did not have kerlix. In R65 was seated in a tilt rest and to her right side with pillows lankets were observed to borso. R65's hands were in a man were bent at the elbow, against her chest. R65 did not ands. In p.m. R65 was seated in a tilt resting on her chest and and position. R65's right aresting on her upper left is observed in R65's hands. In R65 was seated in a tilt resting on her upper left is observed in R65's hands. In R65's hands was resting on her upper left is observed in R65's hands. In R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands. In R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands. In R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands. In R65 was seated in a tilt resting over her heart and her was resting on her upper left is observed in R65's hands.	F 31	8		

-	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		245434	B. WING		 	07/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			10	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET LLEXANDRIA, MN 56308		
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F 318	contracted and had a licensed practical on 7/21/16, at 5:1 open R65's right had contracted, fisted papproximately an irroll into R65's hand was hurting her fine stopped opening R stated there were to needed to be soak the hands up. RN-AR65's to her room her bathroom, whill out of the faucet. Note held it under the was opened R65's hand the kerlix. NA-B the under the water who washed, dried and NA-B assisted R65 her wheelchair and station.	stated R65's hands were fully dibeen for years. RN-A directed I nurse (LPN)-D to apply kerlix. 3 p.m. LPN-D attempted to and fingers from the	F3	318			
	supposed to have at all times. NA-B sthem in after R65's stated she felt aboverlix were not in hard time doing so R65's hands were could not fall out at unable to remove to	the kerlix in both of her hands stated the nurses usually put hands were washed. NA-B ut 3-4 times a week R65's hands and she would then to R65's hands and often had a . NA-B further stated she felt fisted very tightly so the kerlix and she felt R65 would be he kerlix herself. NA-B stated ds had not worsened over the					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245434	B. WING			07/	22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			102	REET ADDRESS, CITY, STATE, ZIP CODE 20 LARK STREET .EXANDRIA, MN 56308	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 318	On 7/22/16, at 10:2 required total assist stated on average a not have the cloth r NA-C would then please contracted hands. On 7/22/16, at 10:3 not had a recent on though had one a fermation of the kerlix on the (Treatment was one resident care plans stated she did not fermation of the ferm	3 a.m. NA-C stated R65 tance with all ADL's, NA-C a few days a week R65 would olls, (kerlix) in her hands and lace the kerlix in R65's 7 a.m. RN-A stated R65 had cupational therapy evaluation, ew years ago which identified contractures of both hands. S5's current physician orders aff to ensure R65 had kerlix racted hands and only to be shed twice daily. RN-A stated were responsible to ensure in place and would document AR.) RN-A stated she to be in place as any care exertix. RN-A stated R65 had add and fingers. 13 a.m. the director of nursing expected physician orders and to be implemented. DON eel that R65's kerlix treatment ontractures but were more for the DON confirmed R65's reders in point click care record identified R65's kerlix tred for hand contractures. policy titled, Restorative eviewed 5/2011, revealed a promote each residents	F3	318			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	G	(X3) DATE SU COMPLE	
		245434	B. WING _		07/22/	2016
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F 318 F 323 SS=J	physician orders, tra	eatments and contractures; I. FACCIDENT	F 31		8/-	12/16
	The facility must en environment remain as is possible; and	sure that the resident ns as free of accident hazards each resident receives on and assistance devices to				
	by: Based on observative review, the facility facility facility facility facility facility facility facility facility for 1 of who sustained multinjury while utilizing combination type dimmediate jeopardy failed to investigate the resident's falls was to determine wheth have been implementative.	ion, interview and document ailed to comprehensively equate supervision and tions, to decrease the risk of 3 residents (R87) reviewed iple falls. R87 experienced an a Merry walker (a walker/chair evice), resulting in an (IJ) situation. The facility and comprehensively assess while utilizing the Merry walker er new interventions should ented, and the facility failed to s currently in place were istently implemented to r further falls.		F323 Free of accident hazards/supervision/devices A. On 7-20-2016 the following was implemented immediately for R87. 1. Current Merry Walker was discontinued; 1-1 staff implemented was in place until all assessments completed and new plan for safety initiated. 2. We immediately implemented a written assessment for all falls. The Post-Fall assessment includes root analysis and intervention options to prevent further falls. A new Progres type was created in the electronic of	d and were was new cause s note	
	when R87 sustaine walking in the Merry	pardy (IJ) began on 10/24/15, d a fall with injury while y walker. The facility's irector of nursing (DON) were		and titled fall which triggers the use review the care plan and make modifications and revise intervention needed.	er to	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY PLETED
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F 323	notified of the immon 7/19/16, at 7:05 7/20/16, however, I lower level of G, iso actual harm that is Findings include: R87 was observed gait belt fastened a Merry walker made had been fastened the walker on three was attached to the attached to the fror located between Riwandered about the Merry walker. I a shuffling gait and abrasion near her redoorway to the dinithe Merry walker for stationery in the donursing assistant (I around in the Merry ambulate in the opto move around the nurses' desk, bump R87 was again obside walking in the Merry hallway with a shufbumping into walls, wheelchairs while walker devictions walker to strafew minutes later, I was a trained to the immediate of the immedi	age 31 ediate jeopardy (IJ) situation p.m. The IJ was removed on noncompliance remained at a plated scope, with severity of not immediate jeopardy. on 7/18/16, at 5:31 p.m. with a round her waist, standing in a cof PVC pipe. Cloth weights with zip ties to the bottom of sides and a cloth type strap at seat of the walker. The strap at of the walker and was 87's legs. R87 independently a Darling Springs unit utilizing R87 was observed to walk with was noted to have an ight eye. When she got to the ng room, R87 couldn't move orway to the dining room until NA)-D assisted R87 to turn y walker so R87 could cosite direction. R87 continued a area of the Darling Springs bing into walls and doorways. Berved on 7/18/16, at 6:48 p.m. y walker in the Darling Springs fled gait. R87 was observed a doorways and residents in walking down the hallway in the earling springs are to grasp a corner of the aighten R87's navigation. A R87 was observed to right front corner of the Merry	F 3:	3. Physician reviewed the cand provided directives for Consulting pharmacy revier regime. Physical Therapy rassessed for recommendated. 4. Interventions for all falls the facility will be reviewed appropriateness at IDT me 5. Education was provided staff on new written assess progress note types on 7-via email and postings at na Alert messages with new part to direct care givers viewed. 6. R87 will be audited for a occur in the next 6 week to written assessments and in have been implemented. We QAPI monthly. Will continuated needed. B. All resident who are at rishave the potential to be affect. The new fall note and performed assessment was put in plant for all residents in the facility fall. Education was provided Face to face education proof 8-8-16. Additional econoportunity will be provided all staff meeting. Will also for the provide education on 8-25-16. Ecumen QI nurse provide education on 8-25-16. Ecumen QI nurse and assessment and assessmen	care. wed medication reviewed and tions. that occur in each time for reting. to all licensed sment and 20-16, verbally, urse's stations. Idan of care was ia PCC. ny falls that assure that retrventions Vill report to e to audit as isk for falls ected. ost fall ce on 7-20-16 ty that sustain a id on 7-20-16. vided the week ducational at the 8-23-16 have Ecumen in on this topic rse will also	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3	B) DATE SURVEY COMPLETED
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F 323	walker, bounced bathe seat of the Meributtock positioned then stood and conthe hallway while at walker. On 7/19/16, at 10:4 guide R87, who wather room to the hall independently walk observed to walk will located in the short not within staff view the corner of the stranger the door handabeled B-13 and jight turned her body to walker, moved the out from the corner nurses' desk located the dining room. At move about in the I gait. She navigated located near her roside of the nurses' area. At 10:47 a.m. (technician) and twiside of the nurses' None of these three of R87 as they walk a.m. licensed pract the nurses' station medication cart which direction from R87, area where R87 cotime, R87 was obsewithin the Merry was	ge 32 ackward and came to rest on ry walker with half of her on the seat of the walker. R87 tinued to wander throughout tempting to navigate the Merry 2 a.m. NA-E was observed to s in the Merry walker, out of lway. NA-E then left R87 to in the Merry walker. R87 was ith a shuffled gait. She was hall outside of her room, but with the Merry walker in fort hall, R87 was able to dele to the bathroom door agle the handle. R87 then the right side of the Merry walker in a sideways direction and moved toward the don the opposite side from 10:46 a.m. R87 continued to werry walker with a shuffled to and from the short hallway om which was located on the station desk without staff in the a lab (laboratory) tech of facility staff walked near the station facing the dining room. The staff looked in the direction sed past this area. At 10:47 ical nurse (LPN)-C returned to area and approached the ch faced the opposite LPN-C did not move to an uld be supervised. During this lerved to have turned herself liker to face backwards, and appelifted her right knee onto	F 3	month x 3 months. D. 8-9-16 we will begin au and post fall assessment tare appropriately completi note/assessment and add interventions as needed. A done on all falls x4 weeks compliance. E. Completion date for 8-1 results will be reviewed at 21, 2016 QAPI meeting will determine what, in any education is required, and future frequency of audits. Nursing or designee will be	to assure stang the ing new Audits will be to assure 2-16. Audit the Septemhere the tear additional determine to Director of	ber m

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
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F 323	observed in the hal water mugs were re Neither NA looked once again maneur corner of the hall are forward. At 10:51 a the Merry walker. The Merry walker were walls in the short havicinity nor in view of At 10:55 a.m. R87 the corner with the feet, one at a time, bar of the Merry waright knee onto the a.m. R87 shuffled to location of the nurs Merry walker bar, sforward with little shad to resident rooms be direction. At 11:00 ambulate with small walker toward the resident rooms be direction. At 11:00 ambulate with small walker toward the ragainst the nurses' R87 stood up in the caught against the noted on the dining. At 11:11 a.m. on 7/female resident seat the vicinity of the nupushed her Merry was stored on the Merry	_	F 323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION ING	` '	(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308			
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F 323	walker and shook it while R87 continued the resident located R87's left wrist and R87 made no responsive the walker. At 11:1 through the area pure onto the elevator, worder from the elevator, worder from the seated on the Merry walker buttock seated on the Merry walker remainder from the seat, and a walker. The resident walker. The resident you want me to span wrist. At that time, the two residents. R87's annual Minim 5/11/16, identified From the seat and facility form, Order the physician 6/27/1 diagnoses included Parkinson's disease R87's Care Area As 5/11/16, included: "Green functional from the control of the physician form order the physician form or order the physician form order	ge 34 grasped the top bar of the back and forth. At 11:17 a.m., d to shake the Merry walker, in the wheel chair grasped stated "go tell your mother". Inse but continued to shake a.m. facility staff walked without looking in the direction m. R87 finally seated herself with only the right side of her he Merry walker seat. The ned in contact with the other air. At 11:19 a.m. R87 stood again began shaking the net in the wheelchair stated, "do ank you?" and grasped R87's he surveyor summoned staff. Hered nurse (RN)-A separated with no recall ability, was rarely d, and required extensive ctivities of daily living (ADL). A Summary Report signed by 16, indicated R87's medical: dementia with Lewy Bodies, and anxiety disorders. Seessment (CAA) dated Cognitive loss /Dementia: w(with)/cognition triggered dx [diagnosis] of dementia with Lewy Bodies, and mobilities r/t Parkinson's with Lewy Bodies, HTN exarthritis and Hx [history of	F3	23			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING	····	07	/22/2016	
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP COD 1020 LARK STREET ALEXANDRIA, MN 56308			
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F 323	falls]. See CP [care interventions are in Noted to have 2 fall monitor and implem [as needed]. Reside times will wander in Wander guard is in attempts to wander put across other resident of entering times. Is at risk for [related to] Dement Speech is mumbled right words. Responsense. Is sometime understands commat this time." Behave to have behaviors of others and wander with PRN pain med showing aggression ram into things with PRN pain med showing aggression ram into things with PRN pain med showing aggression ram into things with PRN pain meds have behaviors." R87's care plan reversident was "at risk Lewy Bodies, and Finterventions included appropriate footweam obilizing in wheel protocol. Physical threat as ordered or information on past cause of falls. Reconstitutions: (1) Login bed. (2) Shoes of the same interventions: (1) Login bed. (2) Shoes of the same interventions in the same interventions: (1) Login bed. (2) Shoes of the same interventions in the same interventions: (1) Login bed. (2) Shoes of the same interventions: (1) Login bed. (2) Shoes of the same interventions: (1) Login bed. (2) Shoes of the same interventions: (2) Shoes of the same interventions: (1) Login bed. (2) Shoes of the same interventions: (1) Login bed. (2) Shoes of the same interventions in the same interventions: (1) Login bed. (2) Shoes of the same interventions in the same interventions: (1) Login bed. (2) Shoes of the same interventions in	plan] for details. Safety place to prevent falls/injuries. It is since previous MDS. Will nent safety interventions PRN ent does wander about unit. At a to other resident's rooms. place to alert staff if resident outside. Velcro sashes are sidents' doorways to detour room. Does help detour at impaired communication r/t is and Parkinson's Disease. If and has difficulty finding the nee does not always make as understood and sometimes unication. No referral needed vioral Symptoms: "Observed of physical abuse towards ng. Staff will provide [R87] is [medications] when is in her face. [R87] will also her Merry walker repetitively. We shown to redirect this riewed 7/13/16, indicated the key for falls due to dementia with Parkinson's disease." Jed: "Ensure [R87] is wearing ar when ambulating or chair. Follow facility fall nerapy eval [evaluation] and	F 3.	23			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 323	Merry walker. Bath resident is not usin on base of Merry walker in case one supervision when it light to resident at I she moves or gets (8) Staff will monitor minutes and PRN. sitting in recliner." R87's NA care she regarding specific of identified safety into (1) to ensure to tak assisting to the recolosed, (3) clip call low bed and safety when not in bed), (4) (close to resident), when ambulating, of dining room, use be wanderguard worn indicated in the cortisee purple sheet in directed staff to "obtate NA care sheet of the Merry walker, in given even though monitor R87's when PRN. When interviewed of stated R87 was saft Merry walker and shalf hour".	ge 36 evening when [R87] is in room door to be closed when g the bathroom. (4) Weights alker to increase stability. (5) up [SIK] slippers in Merry falls off. (6) 1:1 staff assist/ in the dining room. (7) Clip call NOC [night] to alert staff when up (has soft touch call light). It whereabouts every 30 (9) Bring to bathroom before et (a reference NAs used care for residents) undated, erventions for R87 to include: e R87 to the bathroom before liner, (2) keep bathroom door light on R87 at bed time, (4) mat (put mat against wall 5) keep gait belt on walker (6) Follow with wheel chair one to one assist when in ody pillow to position in bed, and The NA care sheet also ment section: "Merry Walker in NA book]." The purple sheet directed staff to observe R87 in o specific time frame was the care plan indicated staff to reabouts every 30 minutes and con 7/19/16, at 11:22 a.m. RN-A fe to be unsupervised in the tated, "we check on her every	F3	323		

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD TO THE APPROPE	BE	(X5) COMPLETION DATE
F 323	in the Merry walker "We try to keep her job of keeping her of although she had n involving the Merry had stepped on the it to fall over and can NA-E pointed to the A review of R87's considered for the following 27 docum involved the use of was admitted on Mary Walker; No apparer Care plan and mult being followed at timember (F)-A. Discount the Merry walker, Fwalker continues to a greater risk of injumerry walker and swill continue with 30 Merry Walker guided plan). (2) 5/17/15- found of walker; head up ag bruising on RUE (riprevious fall; No oth was crying but able Unwitnessed. Will pwhen not in bed to on mat or wheeling also continue Q (eventally walker) and the provious Q (eventally walker) and Q (eventally walker) and Q (eventally walker) and Q (eventally walker) and Q (eventally Q (ev	ow R87 to walk around while unsupervised. NA-E stated, safe, the nurses do a good close." NA-E verified that ot witnessed R87's falls walker, she'd heard that R87 bottom of the walker causing a cut to R87's face. The temple area. Inical record identified the ented fall incidents which the Merry walker since R87 arch 2015:	F3	323			

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F 323	Merry walker around back into Merry wa (mechanical device of IDT (interdiscipling) (4) 5/30/15- found on with one leg around injuries noted. Will (5) 6/20/15- found on Merry walker. Sitting injuries. (6) 6/23/15- found on the staff removed Merry walker. Sitting injuries. (6) 6/23/15- found on the staff removed Merry resident began soon No injuries noted. On injuries noted. On injuries noted. On the staff removed Merry resident began soon injuries noted. On injuri	eg still around the strap of ad 4:00 p.m. Resident assisted liker with 2 staff and EZ et lift. No further documentation nary team) review of fall. On the floor in her Merry walker di Merry walker strap. No continue current interventions. Sitting opposite direction in g on floor. No apparent On floor in Merry walker. When y walker to assist off the floor, oting on her butt on the floor. OP being followed. They walker, stumbled to the left end over left leg and resident ation cart to catch herself and and Merry walker to fall to the leand right foot rotated inward. If head and above left eye, arded movement to the right lepartment (ED). They walker when lost her the floor, tipping Merry walker er (emergency room) and actures or injuries. CP being leights added to base of merry	F 32	23			

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(10) Mer beir inte (11) ano hea at ti bac (12) stat note (13) app grim pair beir scherest (14) Mer betv in p che prio (15) Mer fron (16) roor Mer	rry walker. No ing followed. Will rventions. 8/4/15- found of ther resident's ind. Was wearing me of occurrent in Merry walk. 8/4/15- found ion in Merry walk. 8/4/15- found ion in Merry walk. 8/5/15- had 2 in ears to be more acing. Is not all in with staff. No ing followed. Accedule pain mediclessness. 9/15/15- found in the pain in the pain in her pain in her pain in the pain in the pain in fall. CP being in 9/19/15- obserm, was lying untry walker was in the pain in t	on the floor of bedroom in njuries noted from fall. CP was I continue current on floor at 11:30 a.m. in room with no injuries or hitting g slippers and in Merry walker ce. Action: Up off floor and er. on floor in front of nurses' lker and slipper on. No injuries urrent CP. falls in one day. Resident e restless and has facial lways able to communicate injuries from either fall. CP was tion: Physician referral out to is to see if this helps with d sitting on floor backwards in room, leg strap still attached off at this time, gripper socks ted at the time. Staff last shortly before, less than hour	F3	23			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	A. BUILD	NG	(X3) DATE SURVEY COMPLETED		
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F 323	the time of fall. No if followed. Resident signs of pain and har related to pain. Fentoday; Will also consinterventions. (18) 9/22/15- found underneath Merry was hooked around her back. A small qon right buttock. Bureturned to bed. (19) 9/23/15- found interview, [R87\ ass Received a small be the fall. Action: Fen was recently incread monitor pain and efficience pain causes [R87] to increased her risk for the fall of the fall increased her risk for the fall increased her fa	on floor, in Merry walker at njuries noted. CP being has been showing increased as been more anxious, likely tanyl patch was increased tinue with current in room on the floor valker at 7:00 p.m. The strap I R87's foot and was lying on warter sized bruise was found rought to the bathroom and on the floor in room per staff isted just prior to fall. The ruise to buttocks as a result of tanyl patch (pain medication) sed on 9/21. Will continue to fects of Fentanyl patch as to be more anxious and	F3	23			

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F 323	decreased last Wersince then. Per dai like Seroquel increastates she has see behaviors and woultired than anxious a for MD (medical do the back of the merintervention of addemerry walker was it sustained a fall on 10/26/15, at 13:39 face continues to b scabbed. Call plac xray to face. RN U coordinator] aware. after talking to CNF Subsequent nursing had ordered a head tomography X-ray] from 16:53 (4:53 p. scan results from the had presented with confusion than usu Conclusion: 1. Nor anterior superior messes of the nose. If from 10:49 a.m. on resident required at Despite the number utilizing the Merry wassess R87's fall (21) 1/6/16- found of still in Merry-walker intact. Resident was wall in the bathroor	dnesday, [R87] more active ughter's request, she would ased to the previous dose, she in her mom have more added do like her mom to be more and falling. Referral filled out ctor). Also, weights added to try walker to balance it. (The ed weights to the base of the initiated after R87 had 6/28/15). A nurses' note dated (1:39 p.m.) included:"Res. is swelled and abrasion is ed to [MD] to inquire about C [registered nurse unit [MD's] nurse will call back of [certified nurse practitioner]. In genotes indicated the physician do CT scan [computed for that date. Documentation m.) 10/26/15 indicated CT that date, indicated the resident facial pain and more al. The report further included: indisplaced fracture through the lost maxilla (upper jaw) at the Additionally, a nurse's note 10/27/15 indicated the in oral surgery consult. In of falls and fracture while walker, the facility failed to risk and interventions. In the floor in the bathroom of the floor in the bat	F 323				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
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F 323	bed. Then placed in further review of the (22) 1/8/16- found of Merry walker; Merry injuries from fall. Coassisted to the bath to the fall, not attenthe time of the fall. The bathroom door wanders into her refurther IDT review of (23) 2/2/16- on floom 7:30 a.m. in Merry foot wear on at time (24) 4/16/16- found activity room close still in the Merry was assisted back into the lift and 3 staff assist continue to feel the and continues to be A physician visit for R87 was seen for a "Nursing has no cobeen stable." (25) 5/13/16- found was tipped over on next to bed, feet still Was trying to get to Merry walker and fled found resident Staff educated to merce to the staff educated to the staff educ	of dy lift) off of the floor and into a merry walker for meals. No e fall by the IDT. on the bathroom floor, still in y walker did not tip over. No P was being followed. Was aroom less than 2 hours prior apting to go to the bathroom at Action: intervention to keep closed when not using it, [R87] om through out the day. No of the fall documented. It in front of nurses' station at walker. No injuries noted. Had a of occurrence. Continue CP. sitting on the floor in the to Turtle Beach (resident unit) liker; walker was still upright; the Merry walker with the EZ t. Continue with CP; Family Merry walker is safest option	F3	23		

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F 323	to remind staff to pi bed. (26) 6/26/16- found room in Merry Walk seat. No injuries no with family at all carthis is her safest op gives her the freedd independent. Will crinterventions. CP for (27) 6/27/16- found Merry walker outsid back and holding he sleeping. No injuries continue with these When interviewed of director of nursing (reviewed resident fall, current interver interventions and properties in the electronic recommendation of the facilitation of th	on floor of other resident's ter on floor with feet on the sted. Merry walker discussed the conferences and they feel tion to avoid injury and also of to ambulate and be more ontinue with current followed. Ilying on floor underneath the of room in hallway, lying on the ead up, appeared to be so the compact of the property of the pr	F3	223			

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F 323	-6/27/16-witness-normaltreatment, care Resident has nume Will continue with the The Incident Log didocumented falls the selected time frame documentation of a re-assessment of Formal for any additional intervent re-occurrer R87's electronic and evidence of physical (OT) evaluations and Morse Fall Scale do 8/28/15, 10/26/15, each identified R87 walker, and identified weak gait, stooped with, "steps are shown as a standard the reside anything above 45 None of the docum specific assessment on 7/19/16, at 4:19 reviewed the progrefalls involved the Massessments and reconsistently complefalls in the follows: (1) review (2) interviews staff to do, (3) if interviewal reassess fall risk and reconsistently complefalls involved the Massessments and reconsistently complefalls involved the Mass	one, interventions-No plan was being followed. Frous fall interventions in place. Increases interventions. In the log also lacked comprehensive and lacked documentation erventions implemented to increase falls. In addition, or occupational therapy ind/or treatment. In addition, ocuments completed on and lacked the resident as having a posture and described gait out, resident may shuffle." In a fall scale documents and the score of 80 with indicating a high risk for falls.	F3	323		

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F 323	documented as a from RN-A verified that if and that it was difficable fall because R87 continues actions. RN-A furth many planned interidentify any new on assessments were each fall. A facility Restraint/ Physical dated 2/17/16. RN-current assessment for R8 been involved with a Merry walker and admitted. RN-A als included all of the confirmed it was arthe care plan. RN-A responsible to checand to document so walker currently util obtained from stora facility, and stated so written copy of the instructions/recomments and the instruction of	Is would have been collow-up note after each fall. R87 was cognitively impaired cult to identify a cause for each culd not express her needs or er identified there were so ventions it was difficult to es, and RN-A also stated fall completed quarterly, not after document was provided titled (Quarterly/Annual Evaluation) A verified this was the most t form and verified there were not forms related to a fall risk range in the assessment for the use of had been assessed when so stated the current CP current interventions and a expectation that staff follow a also stated the nurse was sek on R87 every 30 minutes such. RN-A explained the Merry ized by R87 had been age in the basement of the she did not believe they had a manufacturer's mendations. RN-A indicated omplete a "Google" search to	F 323			

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F 323	walker was approp was the only Merry completed. The DC and family were aw remained at risk for walker. The DON of the family wishes a Merry walker, she was it properly. The DC expectation for care walker included free when walking by. To trying to crawl out of lay the resident in beneated to follow they had tried number of the Merry walker manufacturer's recompleted out recommended in the property. The DC expectation for care walker included free when walking by. To trying to crawl out of lay the resident in beneated to follow they had tried number follow family wishes of the Merry walker was less than the merry walker was less to manufacturer's recomplete out recommended out recommended out recommended out recommended out the bottom and each fitted to the resident should be at the help good posture." However, and the property walker is constructed to the resident should be at the help good posture." However, and the property walker is constructed to the resident should be at the help good posture." However, and the property walker is constructed to the resident should be at the help good posture." However, and the property walker is constructed to the resident should be at the help good posture." However, and the property walker is constructed to the resident should be at the help good posture." However, and the property walker is constructed to the resident should be at the help good posture. The property walker is constructed to the resident should be at the help good posture. The property walker is constructed to the resident should be at the help good posture. The property walker is constructed to the resident should be at the help good posture the property walker was less than the property walker was less	riate. The DON verified this walker assessment on further explained the staff are that R87 was not safe and falls while in the Merry onfirmed they were honoring ince R87 was not utilizing a would have to be placed into a ing wheel chair). The DON ementation of interventions e completed if staff identified Merry walker, identifying not walking with it, or not using N further indicated the e of a resident utilizing a Merry quent observations by all staff he DON said if a resident were of the Merry walker, staff may be dwith a safety mat placed end by the DON reiterated staff were the CP. The DON indicated erous interventions but would a related to the continued use of the DON stated the commendations for use of the coated in the storage area. p.m. RN-A provided commendations for use of a cout from the Internet. These mendations included: "The end of metal and weighted at the one should be individually to the height of the top frame ight of the pelvis to promote wever, the Merry walker R87 as constructed of PVC pipe to the period of the walker. In the part of the walker. In	F 323			

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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 323	of the Merry walker height of the pelvis On 7/20/2016, at 9: (PT)-A was intervied duties included screresidents related to and determination of individual residents is not something we functional walking widentified resident of Merry walker would balance and streng and ability to prope also verified that Mover. PT-A indicate to the facility, a quietherapy services we PT-A indicated that been determined to order for treatment confirmed R87 had services any time sand confirmed R87 for the use of the More than the individual is in the individual is in the preceding as physician will identification.	ed the height of the top frame R87 utilized was not at the but above the pelvis. 33 a.m. physical therapist wed. PT-A confirmed therapy sening and treatment of transfers, balance, walking of the most appropriate lifts for . PT-A stated, "[Merry walker] e recommend, we want it to be with a walker or cane." PT-A considerations for use of a linclude: look safe, maintain th, have a good gait pattern forward without tripping. PT-A erry walkers were able to tip d that when R87 was admitted ck screen to evaluate if the required was conducted. At that time services had not be needed so no physician had been requested. PT-A not been provided therapy ince admission (March 2015) had not been evaluated by PT lerry walker. Itled, Falls- Clinical Protocol 2012, Assessment and ed the following: #5 The staff ocument falls that occur while he facility: for example, when open, and observations of the ent/Management: #1- Based assessment, the staff and fy pertinent interventions to try ent falls and to address risks	F 323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING			07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER Y HOME			10	REET ADDRESS, CITY, STATE, ZIP CODE 120 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORREC' PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		BE	(X5) COMPLETION DATE
F 323	and identified on 7/ removed on 7/20/16 be verified by observerified by ob	pardy that began on 10/24/15, 19/16, at 7:05 p.m, was 6, at 3:30 p.m. when it could reation, record review and staff facility had implemented ing: use of the Merry walker for R87 mented for R87 until ments could be completed an initiated armacist reviewed R87's was conducted and a chair/walker with 18" wheels ered e-assessment of the new to determine appropriateness of was conducted fall assessment was f were educated to implement st fall assessment, including note, was created in the rigger a review of the care diffications and review of aff were educated either and/or by written postings at As, RNs, case managers, and PT staff were interviewed	F3	323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G		TE SURVEY MPLETED	
		245434	B. WING _		07	/22/2016
NAME OF I	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		, ==, == .
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 334 SS=E	IMMUNIZATIONS The facility must de that ensure that (i) Before offering the each resident, or the representative recebenefits and potentimmunization; (ii) Each resident is immunization Octohannually, unless the contraindicated or timmunized during to (iii) The resident or representative has immunization; and (iv) The resident's redocumentation that following: (A) That the resident representative was the benefits and poinmunization; and (B) That the resident influenza immunization influenza immunization of the facility must detatt ensure that (i) Before offering the immunization, each legal representative the benefits and poinmunization; (ii) Each resident is immunization, unless immuni	offered an influenza over 1 through March 31 over 1 th	F 33	4		8/30/16

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245434	B. WING			07/2	22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			10	TREET ADDRESS, CITY, STATE, ZIP CODE D20 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		BE	(X5) COMPLETION DATE
F 334	representative has immunization; and (iv) The resident's documentation that following: (A) That the resid representative was the benefits and population of the pneumococcal immunity of the pneumococcal impulation or (v) As an alternative and practitioner reconstruction of the pneumococcal impulation or the pneumococcal impulation, unlease following the immunization, unlease documents and practition.	inized; the resident's legal the opportunity to refuse medical record includes t indicated, at a minimum, the ent or resident's legal provided education regarding otential side effects of nunization; and ent either received the nunization or did not receive immunization due to medical refusal. e, based on an assessment commendation, a second nunization may be given after 5 first pneumococcal ss medically contraindicated or resident's legal representative	F3	34			
	by: Based on interview facility failed to ensemble Conjugate Vaccine offered to 4 of 5 reas recommended & Control (CDC) who reviewed and faile PCV13 as recommended as reco	NT is not met as evidenced v and document review, the sure the Pneumococcal -13 (PCV13) vaccines were sidents (R20, R71, R91, R94) by the Centers for Disease use vaccination histories were d to develop guidelines for the ended by the CDC.			F334 Influenza and Pneumococca immunization Guidelines for administration of the PCV13 have been obtained. Medic Director's order obtained, and staff education on new guidelines comp on 8-4-16.	use of al leted	
	Findings include:				A. R20, R71, R91, R94 will be offer PVC13 according to the CDC guide		

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		245434	B. WING		07/2	22/2016	
NAME OF I	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, ZIP C 1020 LARK STREET ALEXANDRIA, MN 56308	ODE		
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F 334	indicated the 91 year Pneumovax dose 1 medical record lack offered the PCV-13 by the CDC. R71's Immunization indicated the 95 year Pneumovax dose 1 medical record lack offered the PCV-13 by the CDC. R91's Immunization indicated the 102 year Pneumovax dose 1 medical record lack offered the PCV-13 by the CDC. R94's Immunization indicated the PCV-13 by the CDC. R94's Immunization indicated the 96 year Pneumovax dose 1 medical record lack offered the PCV-13 by the CDC. When interviewed or registered nurse (R the facility's infection the facility was aware recommendation rewas not a standard the vaccination to the physician specifical verified the CDC's in the facility was aware iffed the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware iffed the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination to the physician specifical verified the CDC's in the facility was aware the vaccination the v	a Audit Report dated 7/22/16, ar old had received on 1/1/07; however, the sed evidence R20 was also a vaccination as recommended an Audit Report dated 7/22/16, ar old had received on 6/22/11; however, the sed evidence R71 was also a vaccination as recommended an Audit Report dated 7/22/16, ar old had received on 10/1/90; however, the sed evidence R 91 was also a vaccination as recommended an Audit Report dated 7/22/16, ar old had received on 9/17/09; however, the sed evidence R 91 was also a vaccination as recommended on 9/17/09; however, the sed evidence R94 was also a vaccination as recommended on 7/22/16, at 1:42 p.m. N)-D who was responsible for an control program confirmed	F 3	B. All resident have the poraffected by this practice. Up residents will be assessed for the pneumococcal vaccination as per the CDC guidelines. Offered first per the CDC guidelines. Offered first per the CDC guidelines and the fer of the vaccination exployed by the vaccination will be given at the offer of the vaccination exployed by the vaccination will be provided by the providence. All residents currently residing building and that have previdence previdence who qualify for the vaccination will be offered a will be administered if the redesires. C. Audits on all new reside administration of the PCV13 completed on the next 20 accompleted on the next 20 accompleted on all current LTC assure the PVC13 was given they qualify according to the guidelines. E. Completion for the admithe PVC 13 8-30-16. Results will be reported to minimize the provided on the signee of the provided on the signee of the provided on the provided on the provided on the guidelines. E. Completion for the admithe PVC 13 8-30-16. Results will be reported to minimize the provided on the provided on the provided on the provided on the guidelines. E. Completion for the admithe PVC 13 8-30-16. Results will be reported to minimize the provided on the guidelines. E. Completion for the admithe PVC 13 8-30-16.	on admission or the need of on (PCV13) PCV13 will be idelines and so desires. In the aining the risk on. Will follow ation per ong in the ously had the edines. All e PCV 13 and vaccination esident so ents for the dissions, to followed. C residents to n/offered if e CDC inistration of monthly QAPI		

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		245434	B. WING		07/2	22/2016	
NAME OF F	PROVIDER OR SUPPLIER Y HOME		1	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET ALEXANDRIA, MN 56308			
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F 334	The facility's Pneun December 2012, in- offered the Pneumo to aid in preventing The policy, howeve	nococcal Vaccine Policy dated dicated all resident would be ovax (pneumococcal vaccine) pneumococcal infections. r, did not incorporate the new ensure residents were offered	F 334				
F 371 SS=F	483.35(i) FOOD PF STORE/PREPARE. The facility must - (1) Procure food fro considered satisfac authorities; and	OCURE, 'SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food	F 371			8/11/16	
	by: Based on observate review the facility factleanliness of the wanitation and food This practice had the received food from Findings include: During the initial kite 7/18/16, at 1:14 p.m. the walk-in refrigerate door to the refrigerate frost and the stainled dark brown substantial to the review of the refrigerate frost and the stainled dark brown substantial to the review of the refrigerate frost and the stainled dark brown substantial to the review of the refrigerate frost and the stainled dark brown substantial the review of the review o	ralk-in cooler to promote safety in the main kitchen. ne potential to affect all 80 who		F371 Food Procure, Store/Prepare/Serve-Sanitary The Walk in cooler has been further cleaned and sanitized by dietary state order to store, prepare and distribute under sanitary conditions per regulation. Current walk in cooler will be further current walk in cooler will be further cased with an entirely brand new as of 10/1/2016 by Alexandria Refrigeration. A full cleaning schedule to incluentire current walk in cooler has be into place to allow for and promote sanitation and food safety. All dietary staff have been educed.	aff in te food ation. illy unit ude the en put		

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NAME OF I	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308		
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F 371	there was a signific shaped areas of blabetween the secon vegetables (leaf let tomatoes) were sto tomatoes and leaf I without any coverin Throughout the entand chipped paint vinterior walls of the but the walls had bowas evident as the interior walls. Local stored vegetables vapples. These fruit of the dark colored On 7/21/16, at 1:55 stated she had a deaid (DA)-A who clead Monday which included the confirmed the most had been related to week. It was observed on was placing grocer the walk-in cooler/related to week.	and the south wall of the cooler ant number of irregular ack colored substance located d and third shelves. Fresh tuce, cabbage, spinach and red on these shelves. The ettuce were open to air, g of these food items. ire unit large areas of missing were noted. It appeared the walk-in cooler had been silver een painted a white color. This paint was peeling from the ted adjacent to the shelves of were stored fresh oranges and items were next to the areas	F 371	as of 8/11/2016 on the proper cl schedule and process per Ecum Bethany cleaning policy. • Audits of Cleaning schedule completeness and cleanliness of cooler will be completed by Cert Dietary Manger or designee for results will be provided to QAPI review.	f walk in ified 4 weeks,	

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 1020 LARK STREET ALEXANDRIA, MN 56308	ODE		2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 371	C-A stated it had be maintenance many week ago, indicating working properly. broken gray seal he thus not working productions inside the was responsible for confirmed that most frame. He stated make sure the dood door was sweating was evident due to humidity level. When away from the wall there was black continuity the length of the selength of the her fingers. A dark fingers. Both C-A address and stream to 1-1/2 inches and stream to 1-1/2 inches and stream to 1-1/2 inches and black patch of the her fingers. Both C-A address and stream to 1-1/2 inches and black patch of the her fingers. Both C-A address and stream to 1-1/2 inches and black patch of the her fingers. Both C-A address and sevident with the shelf with a cardboard both and leaked liquid of C-A indicated both onto the floor. C-A floor in the walk-in and had rusted. His significant rust local significant r	with the excessive humidity. Deen discussed with the lager (MM) approximately a lang the door seal was not. The MM had confirmed the lad separated from the door, roperly to maintain the lad separated from the door, roperly to maintain the lad separated from the door cleaning the door seals and lid was evident along the door they just had to be careful to or was shut tight but verified the land consequently, moisture of the broken seal and the land consequently, moisture of the broken seal and the land consequently in the land lored mold extending across the line and down the entire lit extended from above the last shelf down to the floor. There was shelf down to the floor. There was shelf down to the floor. There was substance (mold) with the residue remained on her land DD confirmed a strong while in the cooler. C-A stated to be a cooler was standing liquid in the cooler was standing liquid in the confirmed the frozen roast onto the floor during thawing. The pork and fish tend to leak a stated they have a galvanized cooler, which was damaged le confirmed the floor had lated in front of the meat nextended approximately 6 in.	F3	71			

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F 371	vegetables from the top of a stainless cooler on his knees bucket containing brag. C-A indicated hinside the cooler, and it had been washed substance was preselved in the cooler. On oticed the black misurveyor made their black substance off bleach solution, grawall as it was wash. On 7/21/16, at 3:45 scheduled to clean a.m. but confirmed inside the walk-in cher scheduled hour wash the wall and wisince they had been who was assigned indicated only received they had been who was assigned indicated only received they had been who was assigned indicated only received they had been who was assigned indicated only received they had been who was assigned indicated only received they had been who was assigned indicated only received they had been who was assigned indicated only received they had been who was unsured they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was unsured to the black stainless they had been was u	p.m. C-A removed the e shelving and placed them on eel cart located in the cooler. It C-A was inside the walk-in and had a small white plastic bleach solution and a cleaning he had never washed the walls and was unsure of the last time. It He stated the black sent due to the high humidity C-A indicated he had never old substance until the maware. As C-A wiped the the wall of the cooler with the sy colored water ran down the	F3	371			

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F 456 SS=F	schedule for the wastated staff need to and wash/clean the prior to returning the Review of the undathe Food Service Deservice Staff shall in food service depart the cleaning schedule Review of the dieta 4/08 identified refrigweekly. 483.70(c)(2) ESSE OPERATING CONTINE facility must many control of the dietal staff of the dietal schedule.	orocedure and cleaning alk-in cooler. The administrator remove all of the food items unit, including the shelves e stored food items. ted facility policy, Sanitation of epartment identified the food naintain the sanitation of the ment through compliance with ule. ry cleaning schedule, dated gerators would be cleaned NTIAL EQUIPMENT, SAFE DITION aintain all essential cal, and patient care	F 371			8/11/16
	by: Based on observation review the facility fathe walk-in cooler to was properly maintalevel and ensure the food. This practice 80 residents who refindings include: During the initial kit 7/18/16, at 1:14 p.m.	ion, interview and document alled to ensure the condition of located in the dietary kitchen ained to control the humidity e proper storage of perishable had the potential to affect all exceived food from the kitchen.		F456 Essential Equipment, Safe Operating Condition The Walk in cooler has been fur cleaned, sanitized and maintained dietary staff in order to store, prepared distribute food under sanitary conditional safe operation condition per regulation. Current walk in cooler will be fur replaced with an entirely brand new as of 10/1/2016 by Alexandria Refrigeration. A full cleaning schedule to include	by re and tions illy unit	

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F 456	door to the refriger frost and the stainl dark brown substa strong sour odor a inside the unit. Alo there was a signific shaped areas of bl between the seconvegetables (leaf letomatoes) were stomatoes and leaf without any covering Located adjacent to vegetables were stapples. These fruit of the dark colored On 7/21/16, at 1:55 stated if any kitcher epairs, a work order entered pallet sent the previous placing grocer the walk-in cooler/of the surveyor re-entered presence of the mand DD indicated to the walk-in cooler of the	ator had a thick layer of white ess steel door frame had a nce evident when opened. A nd garbage smell was evidenting the south wall of the cooler cant number of irregular ack colored substance located and third shelves. Fresh attuce, cabbage, spinach and ored on these shelves. The lettuce were open to air, ag of these food items. To the shelves of stored ored fresh oranges and titems were next to the areas substance. 5 p.m. dining director (DD) n equipment required any er would be entered into the confirmed the most recent I had been related to a storage	F4	156	entire current walk in cooler has be into place to allow for and promote sanitation and food safety. • All dietary staff have been educe as of 8/11/2016 on the proper clear schedule and process per Ecumen Bethany Community cleaning policity. • Audits of Cleaning schedule completeness and cleanliness of we cooler will be completed by Certifice Dietary Manger or designee for 4 we results will be provided to QAPI tear review.	cated ning y.	

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F 455 SS=C	cooler. MM had inscareful to make surverified the door ware moisture was evide the humidity level. evident between the the shelving away fraces of dark colore the wall from the arthe floor of the refrigularized floor in the damaged and had reformed to the high humidity. On 7/21/16, at 2:10 vegetables from the top of a stainless stated the black to the high humidity. On 7/21/16, at 3:45 noticed the black supast. When interviewed of MM stated he was at the door to the walk evidence of the humidity walk-in cooler door. 483.70(h) SAFE/FUNCTIONALE ENVIRON	structed they just had to be e the door was shut tight but as sweating and consequently, nt due to the broken seal and C-A confirmed the mold was e shelves and when he pulled rom the refrigerator wall, ed substance extended down ea above the second shelf to gerator. He stated they have a he walk-in cooler, which rusted. p.m. C-A removed the e shelving and placed them on eel cart located in the cooler. substance was present due relevel in the cooler. p.m. DA-A stated she had abstance on the racks in the con 7/21/16, at 5:30 p.m. the unaware of the broken seal on a-in cooler and confirmed the midity/moisture problem on the and walls inside the cooler AL/SANITARY/COMFORTABL	F 4			8/11/16
		ortable environment for				

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NAME OF F	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	This REQUIREMENT by: Based on observatinterview the facility condition of the kitch and functional man the main kitchen. To affect all 80 reside the kitchen. Findings include: On 7/18/216, at 1:1 tour with cook (C)-Acovering underneat steamer and oven larea had an area of which measured ap 18 in. The area wadust and dirt particle another irregular shate a dark brown, sticky measured approxing floor in the food prefood particles and compared the dama She indicated the flethis past year. DD an eeded to be replace purchased another around and had protested the brown stout was compacted She confirmed the still the steamer which is stated the brown stout was compacted She confirmed the still the steamer which is stated the brown stout was compacted She confirmed the steamer which is stated the brown stout was compacted She confirmed the stated the steamer which is stated the steamer which is stated the brown stout was compacted She confirmed the steamer which is stated the steamer which is stated the brown stout was compacted She confirmed the steamer which is stated the steamer which is stated the brown stout was compacted She confirmed the steamer which is stated the steamer which is stated the brown stout was compacted She confirmed the steamer which is stated the stated the steamer which is stated	ion, document review and railed to maintain the hen floor covering in a clean ner to promote sanitation in his practice had the potential lents who received food from 4 p.m. during the initial kitchen at it was noted that the floor h and surrounding the affixed ocated in the food preparation f missing maroon floor tile, proximately 18 inches (in) by s filled with dark and light gray es. In addition, there was apped area directly under the othe missing tile area that was y, sludge material which nately 6 in by 4 in. The entire aparation area was soiled with	F 4	.65	F465 Safe/Functional/Sanitary/Comfortatenvironment Kitchen Floor Tile has been ful cleaned throughout entire Kitchen provide a safe, functional, sanitary comfortable environment for reside and staff. Damaged Tile in kitchen has b replaced and repaired as of 8/23/2 A full floor cleaning schedule to include the entire kitchen area flood been put into place All dietary staff have been edu as of 8/11/52016 on the proper cleschedule and process per Ecumer Bethany Community cleaning police Audits of cleaning schedule completeness and cleanliness of k floors with be completed by Certific Dietary Manger or designee for 4 v results will be provided to QAPI teareview.	ly area to and ents een 016 or shas cated aning 1 y. itchen ed veeks,	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245434	B. WING			07/22/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			STREET ADDRESS, CITY, STATE, 2 1020 LARK STREET ALEXANDRIA, MN 56308	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 465	housekeeping staff week, otherwise die washing the floor. On 7/21/16, at 5:30 (MM) and the admit condition of the dan floor. MM knelt to t across the area and on his hand. MM a surface need to be agreed the damage MM and A confirme was evident on the stated it would be conservice of the undat the Food Service D service staff shall metal in the floor.	scrubbed the floor every other stary was responsible for the maintenance manager nistrator (A) confirmed the naged floor tile and the dirty he floor, wiped his hand divisible gray dust was evident and A confirmed the floor repaired and/or replaced and did tile surface was unclean. If a dark brown sticky material floor behind steamer and leaned. Ited facility policy, Sanitation of epartment identified the food naintain the sanitation of the ment through compliance with	F 4	65		

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TATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 01 - NURSING HOME	(X3) DA	TE SURVEY MPLETED
		245434	B WING		07	/21/2016
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
K 000	INITIAL COMMEN	TS	K 000			
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT TI PAGE OF THE CM	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL COREGULATIONS HA	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT DMPLIANCE WITH THE AS BEEN ATTAINED IN VITH YOUR VERIFICATION.				
	Minnesota Departr Fire Marshal Divisi Bethany Home Bui substantial complia participation in Me Subpart 483.70(a), 2000 edition of Nat Association (NFPA	e Survey was conducted by the ment of Public Safety, State on. At the time of this survey, ilding 01 was found not in ance with the requirements for dicare/Medicaid at 42 CFR, Life Safety from Fire, and the tional Fire Protection Standard 101, Life Safety ter 19 Existing Health Care.				
	1		1			
	DEFICIENCIES TO	OR THE FIRE SAFETY		EPO		

Electronically Signed

08/12/2016

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

Facility ID: 00108

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG 01 - NURSING HOME		TE SURVEY MPLETED	
		245434	B. WING		07	/21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1020 LARK STREET ALEXANDRIA, MN 56308	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUSE FOLLOWING INFO 1. A description of to correct the deficit 2. The actual, or pr 3. The name and/oresponsible for corprevent a reoccurre The Bethany Home buildings as follows Building 01 - The Nin 1962 and 1977, and was determined construction. Building 02 - The Sconstructed in 2003 with full basement Type II (111) construction in separated by a 2 h Building 02 is also occupancy that was assisted living facil Sub Acute building	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency.	KO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION - NURSING HOME		E SURVEY MPLETED
		245434	B. WING			07.	/21/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			102	EET ADDRESS, CITY, STATE, ZIP CO D LARK STREET EXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	basement that was (Heavy Timber) Building 04 - The 2 floor of the east side building 01 and two and dining area adjuding 02. This was a factor of the facility is prote automatic fire spring accordance with NI installation of Spring The facility has a fix smoke detection where the facility has a fix monitored for fire of the Hazardous areas in that is on the fire a with the Minnesotal edition). The facility has a light facility facility has a light facility fa	2, is a 1-story building with no determined to be of Type IV 012 Renovation, is the 1st le of the Nursing Home of floors of the Main entrance facent to the Sub Acute as a full renovation. cted throughout be an likler system installed in FPA 13 Standard for the likler Systems 1999 edition. The likler Systems 1999 edition and is lepartment notification and is lepartment notification. It is a code a lepartment in accordance of the State Fire Code (2007) censed capacity of 83 beds of 78 at the time of the survey.	K	000			
K 018 SS=E	NOT MET as evide NFPA 101 LIFE SA Doors protecting or required enclosure hazardous areas s as those construct	t 42 CFR, Subpart 483.70(a) is enced by: NFETY CODE STANDARD orridor openings in other than a sof vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least	K	018			8/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			(X3) DATE SURVEY COMPLETED	
		245434	B. WING			7/21/2016	6
NAME OF F	PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 120 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDÉR'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5 COMPLE DAT	OITE
K 018	in fully sprinklered required to resist the no impediment to to open devices that in pushed or pulled a provided with a medoor closed. Dutch permitted. Door framade of steel or ot with 8.2.3.2.1. Rollic CMS regulations in 19.3.6.3 This STANDARD Based on observate facility failed to made to resident room do (00) section 19.3.6 could affect the same and an undeterminiful smoke from a first access corridors in Findings include: On the facility tour on 07/21/2016 obstrevealed resident retightly in the frame. This deficient conditions are similar to the same access.	is not exceeding 1 inch. Doors smoke compartments are only the passage of smoke. There is the closing of the doors. Hold release when the door is the permitted. Doors shall be and suitable for keeping the doors meeting 19.3.6.3.6 are mes shall be labeled and ther materials in compliance for latches are prohibited by a fall health care facilities. The smoke resistance of the or according to NFPA 101 LSC and and staff interview, the sintain the smoke resistance of the or according to NFPA 101 LSC and and staff and visitors, are were allowed to enter the exit that in the smoke that in the exit that in the smoke that in the smoke resistance of the or according to NFPA 101 LSC and the smoke resistance of the or according to NFPA 101 LSC and the smoke that in the exit that in the exit that in the exit that in the smoke that in the exit that it is not that in the exit that it is not the exit that it is not t	K	018	Ecumen Bethany Home Matthew Fischer Executive Director 8/12/2016 Life Safety Code Survey Plan of Correction. Bethany Home Building 01 K018 Resident room 2124 has been correcte by facility maintenance to fit tightly to do frame to maintain the smoke resistance according to NFPA 101 LSC Date of completion is 8/2/2016 Weekly audits will be completed by faci Maintenance Staff to ensure continued compliance. Individuals responsible for correction ar assurance of compliance are as follows Facility Executive Director and Facility Maintenance Manger	ity	
K 025 SS=E	1	AFETY CODE STANDARD	K	025		8/10/	16
	least a one half ho	all be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - NURSING HOME		SURVEY PLETED
		245434	B. WING			07/2	21/2016
NAME OF F	PROVIDER OR SUPPLIER	I,, =		10	REET ADDRESS, CITY, STATE, ZIP CODE 20 LARK STREET LEXANDRIA, MN 56308	1 0111	1,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 025	atrium wall. Windou fire-rated glazing of steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD is Based on observate facility failed to main of several smoke be requirements of NF Sections 19-3.7.3 acould affect 31 of the facility tour on 07/21/2016 observealed penetration of located at the North one located in the labove the corridor. This deficient condition of Executive Director Manager. NFPA 101 LIFE SAD Door openings in second of the plates the from the bottom of Horizontal sliding of Doors are self-clost accordance with 15 and 15 an	ermitted to terminate at an ws shall be protected by r by wired glass panels and 7.5 s not met as evidenced by: tion and staff interview, the intain proper construction of 1 arrier walls according to the FPA 101 - 2000 edition, and 8.3. This deficient practice he 78 residents and an unt of staff and visitors by propagate from one smoke other. between 8:00 am to 3:00 pm ervations and staff interview ons in two smoke barriers, one in side of Latoka Landing and North side of the chapel lobby, doors. lition was verified by the and the Maintenance AFETY CODE STANDARD moke barriers have at least a ection rating or are at least a ection rating or are at least a do not exceed 48 inches the door are permitted. Hoors comply with 7.2.1.14. sing or automatic closing in 9.2.2.2.6. Swinging doors are ng with egress and positive	K	025	K025 Smoke barriers located on the no of Latoka Landing Hallway and the side of the Chapel lobby above the corridor doors has been sealed be maintenance per NFPA 101 LSC prevent smoke propagation betwee compartments. Date of completion is 8/10/2016 Weekly audits will be completed I Maintenance Staff to ensure contect compliance. Individuals responsible for correct assurance of compliance are as Facility Executive Director and Family Executive Director Di	e North ne y facility to een by facility tinued tion and follows;	8/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION D1 - NURSING HOME		SURVEY PLETED
		245434	B. WING			07/2	21/2016
NAME OF F	PROVIDER OR SUPPLIER Y HOME			10	TREET ADDRESS, CITY, STATE, ZIP CODE D20 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 027	19.3.7.7 This STANDARD is Based on observariacility has failed to smoke/fire barrier of 19.3.7.5. This deficit the 78 residents, as staff and visitors by from one smoke confirm on organization of the facility tour on 07/21/2016 observed and the smoke floor, south of the aproperly due to a bit This deficient conditions.	s not met as evidenced by: tions and staff interview, the maintain 1 of several doors in accordance with LSC ient practice could affect 20 of and an undtermined amount of allowing smoke to propagate empartment to another. Detween 8:00 am to 3:00 pm ervations and staff interview a barrier doors on the second admin suite did not close roken door coordinator. ition was verified by the and the Maintenance	K	027	K027 Smoke barrier doors located outsid the admin suite have been fitted wit new door coordinator by facility maintenance to allow for proper clo and smoke/fire barrier. Date of completion is 8/10/2016 Weekly audits will be completed by Maintenance Staff to ensure contincompliance. Individuals responsible for correction assurance of compliance are as fol Facility Executive Director and Facil Maintenance Manger	th a sure facility ued on and lows;	
K 062 SS=F	Required automatic continuously maint condition and are in periodically. 19.7 9.7.5 This STANDARD is Based on docume with staff, the facilit and maintain the anaccordance with NI Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire Indeficient practice deficient practice of Sprinkler System for the Inspection, water Based Fire Indeficient practice deficient practice deficient practice of the Inspection of Sprinkler System for the Inspection, water Based Fire Indeficient practice deficient practice	c sprinkler systems are ained in reliable operating aspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, s not met as evidenced by: ntation review and interview y has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), I 4.6.12, NFPA 13 Installation as (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is	K	062	K062 Quarterly sprinkler system tests of automatic sprinkler system in according with NFPA 101 LSC have been school to be completed each quarter by Startough Direct Supply has been set quarterly reminders. Date of completion is scheduled for 9/1/2016	rdance eduled ummit m t up for	8/30/16

OF LAIF	TO I OIT WILDIOMILE	: & MEDICAID SERVICES				TVID ITO.	0930-038
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - Nursing Home		SURVEY PLETED
		245434	B. WING			07/2	21/2016
	PROVIDER OR SUPPLIER			10	TREET ADDRESS, CITY, STATE, ZIP CODE 020 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 062	negatively affect, all undetermined amo Findings include: On the facility tour on 07/21/2016 reconstaff interview reveal. Quarterly sprink being conducted. The fluid color of kitchen freezer was This deficient conducted.	the event of a fire and could all of the 78 residents and an unt of staff and visitors. between 8:00 am to 3:00 pm ord review, observations and aled the following. ler system tests were not of the sprinkler head in the	K	062	Weekly audits will be completed be Maintenance Staff to ensure conticompliance. The sprinkler head located in the freezer has been replaced with a shead by NOVA. Date of completion is scheduled for 8/30/2016. Weekly audits will be completed be Maintenance Staff to ensure conticompliance. Individuals responsible for correct assurance of compliance are as for Facility Executive Director and Family Maintenance Manger	nued kitchen new or y facility nued ion and ollows;	

PRINTED: 08/15/2016 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - SUB ACUTE 245434 B. WING 07/21/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1020 LARK STREET **BETHANY HOME ALEXANDRIA, MN 56308** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey. Bethany Home Building 02 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:** HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL. MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

FORM CMS-2567(02-99) Previous Versions Obsolete

08/12/2016

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

Facility ID: 00108

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION 2 - SUB ACUTE		E SURVEY PLETED
		245434	B. WING			07/	21/2016
	PROVIDER OR SUPPLIER	1		102	REET ADDRESS, CITY, STATE, ZIP CODE 20 LARK STREET LEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of volto correct the deficited. 2. The actual, or proceedings of the second of	RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. or title of the person rection and monitoring to ence of the deficiency.		000			

Event ID: WIMT21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION ING 02 - SUB ACUTE		E SURVEY MPLETED
		245434	B. WING		07/	21/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 1020 LARK STREET ALEXANDRIA, MN 56308		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
K 000	basement that was (Heavy Timber) Building 04 - The 2 floor of the east side building 01 and two and dining area ad Building 02. This was a factor of the spring accordance with N Installation of Spring The facility has a fix smoke detection where the spring accordance with N Installed in accordance with N Installed in accordance of the facility has a fix smoke detection where the spring accordance with the spring accordance with N Installed in accordance of the facility has a limit of the spring with the Minnesotal edition). The facility has a limit of the spring sprin	age 2 2, is a 1-story building with no determined to be of Type IV 012 Renovation, is the 1st le of the Nursing Home of floors of the Main entrance jacent to the Sub Acute as a full renovation. cted throughout be an only of the system installed in FPA 13 Standard for the lakler Systems 1999 edition. The larm system with corridor in the smoke detectors in all despaces open to the corridor ance with NFPA 72 "The larm code" 1999 edition and is department notification. In average automatic fire detection larm system in accordance and State Fire Code (2007) censed capacity of 83 beds of 78 at the time of the survey.	K			
K 062 SS=F	NOT MET as evide NFPA 101 LIFE SA Required automatic continuously maint condition and are iperiodically. 19.79.7.5	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD c sprinkler systems are sained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25, is not met as evidenced by:		062		9/1/16

			E SURVEY PLETED			
		245434	B. WING		07/2	21/2016
	ANY HOME STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
K 062	staff, the facility has maintain the autom accordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire F deficient practice desprinkler system is fully operational in the negatively affect all undetermined amount on 07/21/2016 recorded quarterly sheing conducted.	eview and staff interview with a failed to properly inspect and atic sprinkler system in FPA 101 Life Safety Code (00), I 4.6.12, NFPA 13 Installation as (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This poes not ensure that the fire functioning properly and is the event of a fire and could 78 residents, and an unt of staff and visitors. Detween 8:00 am to 3:00 pm and review, and staff interview sprinkler system tests were not ation was verified by the and the Maintenance	K 06.	Bethany Home Building 02 K062 Quarterly sprinkler system tests of automatic sprinkler system in account NFPA 101 LSC have been so to be completed each quarter by Scompanies. Electronic TELS syst through Direct Supply has been so quarterly reminders. Date of completion is scheduled from 9/1/2016 Weekly audits will be completed by Maintenance Staff to ensure conticut compliance. Individuals responsible for correct assurance of compliance are as fracility Executive Director and Family Maintenance Manger	ordance cheduled Summit em et up for or by facility nued cion and ollows;	

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PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 03 - CHAPEL AREA 245434 B. WING 07/21/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1020 LARK STREET **BETHANY HOME** ALEXANDRIA, MN 56308 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRFFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey. Bethany Home Building 03 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:** HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL. MN 55101-5145. or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/12/2016

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

Facility ID: 00108

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDING 0	COMPLETED		
		245434	B. WING		07	/21/2016
	PROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	By e-mail to: Marian. Whitney@and Angela. Kappenma THE PLAN OF CODEFICIENCY MUFOLLOWING INF 1. A description of to correct the definition of the correct the correct the definition of the correct th	estate.mn.us an@state.mn.us ORRECTION FOR EACH IST INCLUDE ALL OF THE FORMATION: f what has been, or will be, done iciency. proposed, completion date. /or title of the person prection and monitoring to rrence of the deficiency.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00108

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		PEOTION IN TIPE INTERIOR NUMBER		TIPLE CONSTRUCTION ING 03 - CHAPEL AREA		(X3) DATE SURVEY COMPLETED	
		245434	B. WING		07/	21/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
K 000	constructed in 200 basement that was (Heavy Timber) Building 04 - The 2 floor of the east side building 01 and two and dining area acceptance.	age 2 2, is a 1-story building with no a determined to be of Type IV 2012 Renovation, is the 1st de of the Nursing Home of floors of the Main entrance lijacent to the Sub Acute was a full renovation.	K	000			
4	automatic fire spring accordance with North Installation of Spring The facility has a form of smoke detection where the fire Alarm monitored for fire alarm that is on the fire alarm to the fir	ected throughout be an inkler system installed in IFPA 13 Standard for the inkler Systems 1999 edition. Sire alarm system with corridor with smoke detectors in all individual dispaces open to the corridor ance with NFPA 72 "The in Code" 1999 edition and is department notification. The individual is alarm system in accordance a State Fire Code (2007)					
		icensed capacity of 83 beds of 78 at the time of the survey.					
K 062 SS=F	NOT MET as evid NFPA 101 LIFE SA Required automat continuously main condition and are	at 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD ic sprinkler systems are tained in reliable operating inspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,	К	062		9/1/16	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG 03 - CHAPEL AREA		(X3) DATE SURVEY COMPLETED	
		245434	B. WING		07/	21/2016	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOTH CORREST TO THE APPROPRIED OF THE APPROPRIED	ULD BE	(X5) COMPLETION DATE	
K 062	staff, the facility has maintain the autom accordance with NF Section 19.7.6, and of Sprinkler System for the Inspection, Water Based Fire F deficient practice disprinkler system is fully operational in the negatively affect all undetermined amore Findings include On the facility tour on 07/21/2016 recorded quarterly sheing conducted.	eview and staff interview with a failed to properly inspect and static sprinkler system in FPA 101 Life Safety Code (00), 4.6.12, NFPA 13 Installation as (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could 178 residents, and an unt of staff and visitors. between 8:00 am to 3:00 pm ord review, and staff interview sprinkler system tests were not lition was verified by the and the Maintenance	КО	Bethany Home Building 03 K062 Quarterly sprinkler system tests automatic sprinkler system in a with NFPA 101 LSC have been to be completed each quarter be Companies. Electronic TELS systhrough Direct Supply has been quarterly reminders. Date of completion is scheduled 9/1/2016 Weekly audits will be completed Maintenance Staff to ensure concompliance. Individuals responsible for corresponding to the completer of compliance are a facility Executive Director and Maintenance Manger	ccordance scheduled y Summit rstem set up for d for d by facility ntinued ection and s follows;		

Event ID: WIMT21

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 04 - 2012 RENOVATED AREA 245434 B. WING 07/21/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET **BETHANY HOME** ALEXANDRIA, MN 56308 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Bethany Home Building 04 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES TO:** HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Facility ID: 00108

Electronically Signed

08/12/2016

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

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 04 - 2012 RENOVATED AREA				(X3) DATE SURVEY COMPLETED	
		245434	B. WING			07/	21/2016	
NAME OF F	PROVIDER OR SUPPLIER	-S		102	REET ADDRESS, CITY, STATE, ZIP CODE 10 LARK STREET EXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
K 000	By e-mail to: Marian.Whitney@ and Angela.Kappenma THE PLAN OF CO DEFICIENCY MU FOLLOWING INF 1. A description of to correct the defice 2. The actual, or p 3. The name and/ responsible for co prevent a reoccur The Bethany Hombuildings as follow Building 01 - The in 1962 and 1977 and was determine construction. Building 02 - The constructed in 200 with full basement	state.mn.us an@state.mn.us DRRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rrection and monitoring to rence of the deficiency. le facility was surveyed as 4 //s: Nursing Home, was constructed is 1-story, with full basement ed to be of Type II(000) Sub Acute building, was 03, and is a 3-story structure that was determined to be of		000	DEFICIENCY)			
	Type II (111) cons building 02 is conseparated by a 2 Building 02 is also occupancy that wassisted living fac	truction. The Sub Acute nected to be of truction. The Sub Acute nected to building 01 and is hour fire barrier. the Sub Acute of connected to an assisted living as not surveyed because the ility is separated from the the g 02 by a 2-hour fire barrier.						
	Building 03 - The	Chapel Addition, was						

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L' IDENTIFICATION NUMBER		TIPLE CONSTRUCTION NG 04 - 2012 RENOVATED AREA		(X3) DATE SURVEY COMPLETED	
		245434	B. WING		07	/21/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1020 LARK STREET ALEXANDRIA, MN 56308			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
K 000	constructed in 2000 basement that was (Heavy Timber) Building 04 - The 2 floor of the east side building 01 and two and dining area ad Building 02. This was a final to the facility is proteautomatic fire spring accordance with N Installation of Spring The facility has a final smoke detection was common areas and installed in accordance of the facility has a final fire Alarm monitored for fire of Hazardous areas in that is on the fire a with the Minnesotal edition). The facility has a light facility has a l	age 2 2, is a 1-story building with no determined to be of Type IV 012 Renovation, is the 1st le of the Nursing Home of floors of the Main entrance jacent to the Sub Acute as a full renovation. cted throughout be an alkler system installed in FPA 13 Standard for the lakler Systems 1999 edition. The alarm system with corridor in the smoke detectors in all dispaces open to the corridor ance with NFPA 72 "The in Code" 1999 edition and is department notification. In average automatic fire detection larm system in accordance State Fire Code (2007) censed capacity of 83 beds of 78 at the time of the survey.	KO	00			
K 051 SS=D	NOT MET as evide NFPA 101 LIFE SA A fire alarm system components appro- accordance with N and NFPA 72, Nati	t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD in is installed with systems and eved for the purpose in FPA 70, National Electric Code onal Fire Alarm Code to earning of fire in any part of the	K	051		8/10/16	

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING 04 - 2012 RENOVATED AREA			(X3) DATE SURVEY COMPLETED	
	245434	B. WING		07	/21/2016	
PROVIDER OR SUPPLIER			10	REET ADDRESS, CITY, STATE, ZIP CODE 120 LARK STREET		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
transmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each r boxes in patient sie required at exits if located at all nurse notification is provisignals. In critical conficient. The fire alarm automatically the event of fire. The activates required records are maintal 18.3.4, 19.3.4, 9.6 This STANDARD Based on observation 18.3.4.2, 9 Fire Alarm Code (9) deficient practice of alarm system to so a fire event which commount of staff and Findings include: On the facility tour on 07/21/2016 observealed a smoke HVAC diffuser on the Pelican Bay entrantal This deficient condexecutive Director	are monitored for integrity. alarm system is by manual required sprinkler system evice, or detection system. It is are provided in the path of equired exit. Manual alarm evening areas shall not be manual alarm boxes are its stations. Occupant ded by audible and visual eare areas, visual alarms are alarm system transmits the yto notify emergency forces in the fire alarm automatically control functions. System eined and readily available. It is not met as evidenced by: tions and staff interview the east the smoke detection in FPA 101 Life Safety Code (00).6.1.4 and NFPA 72 National 199) section 2-3.6.6.2. This could affect the ability of the bound in a timely manner during could affect an undetermined divisitors. The between 8:00 am to 3:00 pm ervations and staff interview detector within 36 inches of an the second floor east of the ince.	K	951	of the 36 inch window by facility maintenance and in accordance with NFPA 101 LSC. Date of completion is 8/10/2016 Weekly audits will be completed by facilit Maintenance Staff to ensure continued compliance. Individuals responsible for correction and	у	
	AFETY CODE STANDARD	K	062		9/1/16	
	PROVIDER OR SUPPLIER Y HOME SUMMARY STA (EACH DEFICIENC' REGULATORY OR LE Continued From patransmission paths Initiation of the fire means and by any alarm, detection de Manual alarm boxe egress near each reported at exits if located at all nurse notification is provisignals. In critical contification is provided at all nurse alarm automatically the event of fire. The activates required for a continuous continuo	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 18.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect he ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 observations and staff interview revealed a smoke detector within 36 inches of an HVAC diffuser on the second floor east of the Pelican Bay entrance. This deficient condition was verified by the Executive Director and the Maintenance	PROVIDER OR SUPPLIER Y HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm automatically to activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 14.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. 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TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION 4 - 2012 RENOVATED AREA	(X3) DATE SURVEY COMPLETED	
		245434	B. WING			07/2	21/2016
NAME OF PROVIDER OR SUPPLIER BETHANY HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET ALEXANDRIA, MN 56308					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 062 SS=F	maintained in reliable inspected and tested 4.6.12, NFPA 13, NThis STANDARD is Based on docume with staff, the facility and maintain the attactordance with NI Section 18.7.6, and of Sprinkler System for the Inspection, Water Based Fire Indeficient practice disprinkler system is fully operational in negatively affect, a undetermined amount of 17/21/2016 reconstaff interview reversulted in the closet of This deficient conditions.	r systems are continuously ble operating condition and are ed periodically. 18.7.6, 19.7.6, IFPA 25, 9.7.5 is not met as evidenced by: intation review and interview by has failed to properly inspect utomatic sprinkler system in FPA 101 Life Safety Code (00), if 4.6.12, NFPA 13 Installation ins (99), and NFPA 25 Standard Testing and Maintenance of Protection Systems, (98). This oes not ensure that the fire functioning properly and is the event of a fire and could lift of the 78 residents and an unit of staff and visitors.	KO		K062 Quarterly sprinkler system tests of automatic sprinkler system in account NFPA 101 LSC have been so to be completed each quarter by Strough Direct Supply has been squarterly reminders. Date of completion is scheduled find 9/1/2016 Weekly audits will be completed to Maintenance Staff to ensure conticompliance. An Escutcheon was installed on the sprinkler head in the closet of rool by facility maintenance. Date of completion is 8/2/2016 Weekly audits will be completed to Maintenance Staff to ensure conticompliance. Individuals responsible for correct assurance of compliance are as find a facility executive Director and Maintenance Manger	ordance cheduled Summit em et up for or or py facility inued he m 123 by facility inued tion and	

Facility ID: 00108



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted September 7, 2016

Mr. Matthew Fischer, Administrator Bethany Home 1020 Lark Street Alexandria, MN 56308

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5434025

Dear Mr. Fischer:

The above facility was surveyed on July 18, 2016 through July 22, 2016 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

Bethany Home September 7, 2016 Page 2

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 Pam Kerssen at (218) 308-2129 or email: pam.kerssen@state.mn.us.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

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PRINTED: 08/22/2016 FORM APPROVED

(X6) DATE

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, §	STATE, ZIP CODE	<u> </u>	_,
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTENTION*****					
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of which is a schedule of the Minnesota Department of the Minnesota Departm	nether a violation has been compliance with all				
	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.					
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at state.mn.us/divs/fpc/profinfo/in ate licensing orders are				

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

08/12/16 **Electronically Signed**

TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		DATE SURVEY COMPLETED	
		00108		B. WING		07/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•		
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2 000	Department of Hea you electronically, is necessary for Sta enter the word "cortext. You must then State licensure procompletion date, the corrected prior to elements and the following corplease indicate in your and identify the date. Minnesota Department's sand the following correction that you and identify the date. Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned tag in column entitled "ID statute/rule out of computer the statement and replaces the "Torrection order. The findings which are in after the statement, evidence by." Follower the Suggested Time period for Conputer States DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. Lugh 7/22/2016, surveyors of taff, visited the above provider correction orders are issued. Four electronic plan of have reviewed these orders, e when they will be completed. Lent of Health is documenting correction Orders using an umbers have been note state statutes/rules for the prefix Tag." The state compliance is listed in the ent of Deficiencies" column to Comply" portion of the his column also includes the n violation of the state statute as wing the surveyors findings method of Correction and crection. LRD THE HEADING OF THE	2 000				

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	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET ORIA, MN 56	308		
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2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			8/9/16
		omprehensive plan of care personnel involved in the 				
	by: Based on observati review the facility fa care for 2 of 3 resid were dependent up cares and for 1 of 1	ent is not met as evidenced on, interview and document ailed to implement the plan of lents (R78, R28) reviewed who on staff for shaving and oral resident (R65) reviewed with actures and required range of		Corrected 8/9/2016 per Director of Nursing	f	
	Findings include:					
	7/1/16, identified Rimpaired, required areas of daily living assistance to walk	finimum Data Set (MDS) dated 78 was moderately cognitively extensive assistance for all (ADL)with exception of limited in corridor and diagnoses kinson's disease, dementia, mpairment.				
	care deficit related hypertension, diabe	e plan, identified R78 had a self to Parkinson's Disease, etes, and dementia as ring assist with ADI 's -The				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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2 565	Continued From pa	ge 3	2 565			
	resident requires expersonal hygiene.	tensive assist of 1 staff with				
		ent care sheet, indicated R78 ne staff with dressing and				
	shave because of n	a.m. R78 stated, "I can't ny Parkinson, that is one thing on." At this time R78 has I upper lip.				
	his room to the dini	a.m. R78 was propelled from ng room by nursing assistant acial hair stubble on the upper				
		p.m. R78 was seated in his chair in front of the television. naven.				
		a.m. R78 was seated in not had face shaved, d heavy stubble.				
	to shave independented needs help. NA-H	a.m. NA-H indicated R78 tries ently and will ask staff when he indicated R78 was new to the as unsure of whether R78 had d cares.				
	verified if he was at do it every day. R78 face each morning electric razor but so verified his facial ha	on 7/20/16, at 1:00 p.m. R78 ble to shave himself he would a stated staff will shave his when they get him up with an ome times they forget. R78 air had not been shaved off ble to recall when staff last				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BETHAN	Y HOME		K STREET	200			
		ALEXAND TEMENT OF DEFICIENCIES	RIA, MN 56	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE	
2 565	Continued From pa	ge 4	2 565				
	no behaviors and d a walk, however, it example if his wife pain in his hip.	p.m. NA-I identified R78 had id occasionally refuse to go for was usually for a reason, for was here or if he was having a.m. NA-E indicated R78 was					
	hands. NA-E verifie this a.m. NA-E indic	lependently due to shaky d he/she had not shaved R78 cated R78 refused the offer to I had a routine of shaving only					
	On 7/21/16, at 11:00 a.m. NA-F verified R78 had a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, "We would normally shave a person if they can't themselves."						
	shaved this morning isn't so hard to get of R78 further identified	4 a.m. R78 verified he was not g. R78 stated, " it (facial hair) off" if he is shaved every day. ed with a clean shaven face it clean as things get caught,					
		3 a.m. licensed practical nurse '8 had facial stubble and had					
	(RN)-A verified R78 ADL's due to has F although his abilities was not able to sha electric razor. RN-A	1:14 a.m. registered nurse required assistance with Parkinson's Disease and schange from day to day, R78 we independently with an identified staff were male residents daily and would					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	BETHANY HOME 1020 LA ALEXAN			308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 5	2 565			
	not expect residents assistance.	s to have to ask for the				
	director of nursing (that staff follow the require assistance)	on 7/22/16, at 11:25 a.m. the DON) verified the expectation care plan and residents who with ADL's be provided the ted to ask for assistance.				
	required extensive a with personal hygie plan indicated R28 Staff were to assist offer R28 mouth swand while getting re	ed 7/15/16, identified R28 assistance to total assistance ne and oral cares. The care had upper and lower dentures. with cleaning dentures and to rab and mouth was in the AM ady for bed, and staff were to spection with cares and as				
	did not wear the de	nt care sheet, indicated R28 ntures. The resident care rection regarding oral cares				
	from 8:23 a.m. to 8 assisted R28 with p washing her face, p During the observation offered the opportuncares. R28's oral c dry.	of morning cares on 7/20/16, 254 a.m. NA-A and NA-G personal cares which included perineal cares and dressing. tion, R28 was not assisted nor nity for completion of oral avity and lips appeared very				
	while R28 was posi wearing any denture breakfast food item consume the strawl -At 9:01 a.m. NA-A shut off the bedroor	assisted R28 with breakfast tioned in bed. R28 was not es, and R28 refused the s and juice offered. R28 did perry supplement. gathered the breakfast tray, in lights and stated some days and some days are not.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	2/2010
BETHAN	Y HOME		K STREET			
040.15	CLIMANA DV CTA		RIA, MN 56		ONI	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 6	2 565			
	tray to the kitchen,	A then delivered the breakfast R28 was not assisted nor nity for completion of oral				
	reported R28 no lor stated she was goir breakfast to provide	7/20/16, at 8:45 a.m. NA-A anger wears dentures, and ang to wait until after R28 at ear oral cares which included touth with a toothette.				
	with the breakfast r completed morning she did not comple included swabbing	confirmed R28 had finished neal and confirmed she had cares for R28. NA-A verified te nor offer oral cares which the mouth with a toothette or er, NA-A confirmed she did not with cares.				
	confirmed R28 no leverified staff are exwith morning cares will at times refuse. dry mouth and slee	7/21/16, at 10:35 a.m. RN-B onger wore dentures. RN-B pected to swab R28's mouth, or at least attempting as R28 RN-B confirmed R28 has a ps with the oral cavity open, must be attempted.				
	DON confirmed sta	7/22/16, at 10:08 a.m. the ff are expected to provide or all resident twice per day as re plan.				
	2010, directed staff plan for any special	Care Policy dated October to review the resident's care needs of the resident. and oment and supplies as needed.				
	(MDS) dated 4/27/1	arterly Minimum Data Set 6, identified R65 had severe nt and had diagnoses which				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016
	PROVIDER OR SUPPLIER	1020 LAR	DRESS, CITY, S K STREET DRIA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	included Parkinson' disease and cerebrhemiplegia. The M totally dependent or living (ADL's) and h contractures. Review Assessment (CAA) had severe cognitive Alzheimer's disease staff for ADL's and Review of R65's calidentified R65 had be upper and lower exidependent on staff range of motion with rolls in both hands and contractures. On 7/18/16, at 5:38 in space wheelchair station prior to the end hands were held in bent and hands rested near her heather left upper chest placed in her hands seated in a tilt in spanurses station follower mained without keep on 7/19/16, from 8 was lying in bed tilted against her back, be cover R65 to mid to fisted position, arm fisted hands rested have kerlix in her hands rested have hands rested have kerlix in her hands rested have hands rested have hands	Is disease, Alzheimer's avascular disease with DS further identified R65 was a staff for activities of daily ad bilateral upper extremity of R65's annual Care Area dated 8/19/15, identified R65 and to the impairment due to a was totally dependent on thad contractures. The plan print dated 2/25/16, bilateral contractures of the tremities, was totally for all ADL's, required gentle the daily care, required gauze 23/hrs/day: to be removed for ally for hygiene for bilateral p.m. R65 was seated in a tilt of a cross from the nurses evening meal. Both of R65's a fisted position, elbows were ted on her chest, right hand art and her left hand rested on a R65 did not have kerlix acce wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are wheelchair near the wing the evening meal. R65 are were observed to be a so were bent at the elbow, against her chest. R65 did not as were bent at the elbow, against her chest. R65 did not	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
			K STREET			
BETHAN	IY HOME		ORIA, MN 563	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 8	2 565			
	elbows, hands were were clenched fiste clenched hand was left clenched not have kerlix is care planned and was left care planned and was left were responsible for R65's kerlix were in contractures. RN-A were too contracted out, nor could R65 independently. RN contracted and had	r with both arms bent at the e resting on her chest and d position. R65's right resting over her heart and her was resting on her upper left s observed in R65's hands. on 7/21/16, at 5:09 p.m. anager (RN)-A confirmed R65 in her contracted hands as was unsure why the kerlix was ated the medication nurses or checking to make sure is both hands for bilateral hand stated she felt R65 hands if for the kerlix to have fallen remove the kerlix stated R65's hands were fully been for years. RN-A directed nurse (LPN)-D to apply kerlix.				
	open R65's right had contracted, fisted prapproximately an in roll into R65's hand was hurting her fing stopped opening R6 stated there were tineeded to be soaked the hands up. RN-AR65's to her room a her bathroom, while out of the faucet. Not held it under the was opened R65's hand the kerlix. NA-B the under the water while washed, dried and a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	YHOME		K STREET DRIA, MN 56	308		
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2 565	Continued From pa	ge 9	2 565			
	her wheelchair and station.	wheeled R65 back to nursing				
	supposed to have to at all times. NA-B so them in after R65's stated she felt about kerlix were not in he place the kerlix into hard time doing so. R65's hands were fould not fall out an unable to remove the she felt R65's hand last few years. On 7/22/16, at 10:2 required total assist stated on average a not have the cloth r	p.m. NA-B stated R65 was he kerlix in both of her hands tated the nurses usually put hands were washed. NA-B at 3-4 times a week R65's er hands and she would then R65's hands and often had a NA-B further stated she felt isted very tightly so the kerlix at she felt R65 would be he kerlix herself. NA-B stated is had not worsened over the 3 a.m. NA-C stated R65 tance with all ADL's, NA-C a few days a week R65 would olls, (kerlix) in her hands and				
	contracted hands.	ace the kerlix in R65's				
	not had a recent oc though had one a fe R65 had complete of RN-A confirmed R6 directed nursing state placed in both conting removed when was the licensed nurses R65 had the kerlix in the kerlix on the (TA) expected the kerlix staff could apply the fully contracted han	7 a.m. RN-A stated R65 had cupational therapy evaluation, ew years ago which identified contractures of both hands. 55's current physician orders aff to ensure R65 had kerlix racted hands and only to be hed twice daily. RN-A stated were responsible to ensure in place and would document AR.) RN-A stated she to be in place as any care exertix. RN-A stated R65 had add and fingers.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BETHAN	Y HOME		K STREET RIA, MN 56	308			
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2 565	be implemented as not feel that R65's k hand contractures to control. The DON ophysician orders in medical record ider was ordered for hand the facility policy the Assessment and Plindicated the care pof care from admission to the facility's Care F2010, indicated the enhance the optimal and/or aid in prevent resident's functional levels. SUGGESTED MET The director of nurs review and revise pto ensuring the care resident is followed designee could devand develop a monare providing care a of care.	expected resident care plans to directed. DON stated she did serlix treatment was for her out were more for moisture confirmed R65's current point click care electronic ntified R65's kerlix treatment and contractures. Eled Resident MDS 3.0 an of Care revised 03/12, plan was to provide continuity	2 565				
2 830	Proper Nursing Car	,	2 830			8/12/16	
		general. A resident must e and treatment, personal and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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2 830	custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			
	by: Based on observati review, the facility fa assess, ensure ade implement intervent further falls for 1 of who sustained mult injury while utilizing combination type de immediate jeopardy failed to investigate the resident's falls w to determine wheth have been implement ensure interventions	ent is not met as evidenced on, interview and document ailed to comprehensively equate supervision and tions, to decrease the risk of 3 residents (R87) reviewed iple falls. R87 experienced an a Merry walker (a walker/chair evice), resulting in an (IJ) situation. The facility and comprehensively assess while utilizing the Merry walker er new interventions should ented, and the facility failed to s currently in place were istently implemented to r further falls.		Corrected 8/12/2016 per Director Nursing	of	
	when R87 sustaine walking in the Merry administrator and d notified of the imme on 7/19/16, at 7:05	pardy (IJ) began on 10/24/15, d a fall with injury while walker. The facility's irector of nursing (DON) were ediate jeopardy (IJ) situation p.m. The IJ was removed on concompliance remained at a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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BETHAN	Y HOME		K STREET RIA, MN 56	308		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT!	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
		plated scope, with severity of not immediate jeopardy.				
	Findings include:					
	gait belt fastened a Merry walker made had been fastened the walker on three was attached to the attached to the fron located between R8 wandered about the Merry walker. Fa shuffling gait and abrasion near her r doorway to the dining the Merry walker for stationery in the donursing assistant (Naround in the Merry ambulate in the opp to move around the	on 7/18/16, at 5:31 p.m. with a round her waist, standing in a of PVC pipe. Cloth weights with zip ties to the bottom of sides and a cloth type strap a seat of the walker. The strap at of the walker and was 37's legs. R87 independently a Darling Springs unit utilizing R87 was observed to walk with was noted to have an ight eye. When she got to the ng room, R87 couldn't move rward. R87 remained orway to the dining room until NA)-D assisted R87 to turn a walker so R87 could posite direction. R87 continued a area of the Darling Springs bing into walls and doorways.				
	walking in the Merry hallway with a shuff bumping into walls, wheelchairs while w Merry walker device observed at that tim Merry walker to stra few minutes later, F walk/bump into the	erved on 7/18/16, at 6:48 p.m. y walker in the Darling Springs fled gait. R87 was observed doorways and residents in valking down the hallway in the e. The administrator was ne to grasp a corner of the aighten R87's navigation. A R87 was observed to right front corner of the Merry				
	walker, bounced bathe seat of the Meri buttock positioned	ry walker with half of her on the seat of the walker. R87 tinued to wander throughout				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY
ANDILAN	OF CONTILCTION	IDENTIFICATION NOWIDEN.	A. BUILDING:		COM	LLILD
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET			
			RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	the hallway while attempting to navigate the Merry walker.					
	guide R87, who was her room to the hall independently walk observed to walk w located in the short not within staff view the corner of the sh grasp the door hand labeled B-13 and jig turned her body to twalker, moved the out from the corner nurses' desk located the dining room. At move about in the Ngait. She navigated located near her roside of the nurses' sarea. At 10:47 a.m (technician) and two side of the nurses' sarea. At 10:47 a.m (technician) and two side of these three of R87 as they walk a.m. licensed practithe nurses' station amedication cart whi direction from R87. area where R87 cottime, R87 was observed to hat the Merry walker see On 7/19/16, at 10:5 observed in the hall	2 a.m. NA-E was observed to s in the Merry walker, out of way. NA-E then left R87 to in the Merry walker. R87 was ith a shuffled gait. She was hall outside of her room, but with the Merry walker in ort hall, R87 was able to determine the bathroom door to get the handle. R87 then the right side of the Merry walker in a sideways direction and moved toward the don the opposite side from 10:46 a.m. R87 continued to Merry walker with a shuffled to and from the short hallway on which was located on the station desk without staff in the a lab (laboratory) tech of facility staff walked near the station facing the dining room. As staff looked in the direction area and approached the chaced the opposite LPN-C did not move to an all does under the station face backwards, and the lifted her right knee onto eat.				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D WING			
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET			
	I		RIA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 14	2 830			
2 830	Neither NA looked is once again maneur corner of the hall ar forward. At 10:51 at the Merry walker. The Merry walker were walls in the short havicinity nor in view of At 10:55 a.m. R87 of the corner with the feet, one at a time, bar of the Merry waright knee onto the a.m. R87 shuffled the location of the nurse Merry walker bar, sforward with little should to resident rooms be direction. At 11:00 ambulate with small walker toward the nurses' R87 stood up in the caught against the noted on the dining. At 11:11 a.m. on 7/1 female resident seathe vicinity of the nupushed her Merry walker and shook it while R87 continued the resident located the resident l	n the direction of R87 as she rered the Merry walker into the and was unable to propel it im. R87 stood backwards in the front and one side of the ocated against the corner allway. No staff were in the of R87 to provide supervision. The mained unable to move from Merry walker. R87 raised her placing them onto the bottom liker. She then placed her seat of the walker. At 10:57 the Merry walker towards the est desk, leaned over the pit on the floor and continued auffled steps in the direction of the near the bathroom. NA-E was to be delivering water mugs ut did not walk in R87's a.m. R87 continued to a steps, navigating the Merry urses' station. R87 stopped to walker when it butted up station desk. At 11:08 a.m. Merry walker while it was nurses' station. Staff were room side of the desk. 19/16, R87 and another the direction of the desk. At 11:14 a.m. R87 walker into the other female air. When R87 could not grasped the top bar of the back and forth. At 11:17 a.m., of to shake the Merry walker, in the wheel chair grasped stated "go tell your mother".	2 830			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
			A. BUILDING:			
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET DRIA, MN 56	200		
	OLIMA AA DV OTA		-			0.60
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	the walker. At 11:1 through the area puronto the elevator, wof R87. At 11:19 a. in the Merry walker buttock seated on the Merry walker remains resident's wheel characteristic from the seat, and a walker. The resider you want me to spanwrist. At that time, the At 11:22 a.m. regist the two residents.	8 a.m. facility staff walked ushing a housekeeping cart vithout looking in the direction m. R87 finally seated herself with only the right side of her he Merry walker seat. The ned in contact with the other air. At 11:19 a.m. R87 stood again began shaking the nt in the wheelchair stated, "do ank you?" and grasped R87's he surveyor summoned staff. Hered nurse (RN)-A separated num Data Set (MDS) dated				
	5/11/16, identified F memory problems of to never understood assistance for all ad facility form, Order the physician 6/27/diagnoses included Parkinson's disease R87's Care Area As 5/11/16, included: "severe impairment CAA r/t [related to] with Lewy bodies, F ADL functional /Rel assist with ADL's ar Disease, Dementia [hypertension], ostefalls]. See CP [care interventions are in Noted to have 2 fall monitor and implem [as needed]. Reside times will wander in	R87 had long and short term with no recall ability, was rarely d, and required extensive ctivities of daily living (ADL). A Summary Report signed by 16, indicated R87's medical dementia with Lewy Bodies, and anxiety disorders. Seessment (CAA) dated Cognitive loss /Dementia: w(with)/cognition triggered dx [diagnosis] of dementia Parkinson's and depression abilitation Potential: Requires and mobilities r/t Parkinson's with Lewy Bodies, HTN coarthritis and Hx [history of plan] for details. Safety place to prevent falls/injuries. Is since previous MDS. Will ment safety interventions PRN ent does wander about unit. At to other resident's rooms.				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DETLIAN	VUONE	1020 LAR	K STREET			
BETHAN	IY HOME	ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
2 830	attempts to wander put across other res resident of entering times. Is at risk for I [related to] Dement Speech is mumbled right words. Responsense. Is sometime understands commat this time." Behave to have behaviors of others and wanderi with PRN pain med showing aggression ram into things with PRN pain meds have behaviors." R87's care plan reversident was "at risl Lewy Bodies, and Finterventions included appropriate footweam obilizing in wheel protocol. Physical the treat as ordered or information on past cause of falls. Reconstituted appropriate footweam obilizing in wheel protocol. Physical the treat as ordered or information on past cause of falls. Reconstituted in Merry walk activity doors in the Merry walker. Bathrow resident is not using on base of Merry walker in case one walker in case one	outside. Velcro sashes are sidents' doorways to detour room. Does help detour at impaired communication r/t ia and Parkinson's Disease. If and has difficulty finding the nee does not always make as understood and sometimes unication. No referral needed vioral Symptoms: "Observed of physical abuse towards ng. Staff will provide [R87] is [medications] when is not in her face. [R87] will also her Merry walker repetitively. We shown to redirect this rewed 7/13/16, indicated the fact for falls due to dementia with Parkinson's disease." ed: "Ensure [R87] is wearing ar when ambulating or chair. Follow facility fall nerapy eval [evaluation] and as needed. Review falls and attempt to determine ord possible root causes. Imily/caregivers/ IDT am] as to causes. Safety ow bed and safety mats when ar gripper slippers to be worn er. (3) Close dining room and evening when [R87] is in soom door to be closed when go the bathroom. (4) Weights alker to increase stability. (5) ip [SIK] slippers in Merry falls off. (6) 1:1 staff assist/	2 830			
	with PRN pain med showing aggression ram into things with PRN pain meds have behaviors." R87's care plan reversident was "at rist Lewy Bodies, and Finterventions includ appropriate footweamobilizing in wheel protocol. Physical threat as ordered or information on past cause of falls. Reconstituted appropriate footweamobilizing in wheel protocol. Physical threat as ordered or information on past cause of falls. Reconstituted interventions: (1) Lower behavior in the factivity doors in the factivity doors in the factivity doors in the factivity walker. Bathrow the factivity walker is not using on base of factivity walker walker in case one	s [medications] when is in her face. [R87] will also her Merry walker repetitively. We shown to redirect this liewed 7/13/16, indicated the k for falls due to dementia with Parkinson's disease." ed: "Ensure [R87] is wearing ar when ambulating or chair. Follow facility fall nerapy eval [evaluation] and as needed. Review falls and attempt to determine ord possible root causes. mily/caregivers/ IDT am] as to causes. Safety ow bed and safety mats when ar gripper slippers to be worn er. (3) Close dining room and evening when [R87] is in soom door to be closed when go the bathroom. (4) Weights alker to increase stability. (5) up [SIK] slippers in Merry				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMPI	
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
RETHAN	BETHANY HOME 1020 LAF					
ALEXANI			RIA, MN 56			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 17	2 830		ļ	
	she moves or gets up (has soft touch call light). (8) Staff will monitor whereabouts every 30 minutes and PRN. (9) Bring to bathroom before sitting in recliner."					
	regarding specific of identified safety into (1) to ensure to take assisting to the reclused, (3) clip call low bed and safety when not in bed), (5 (close to resident), when ambulating, of dining room, use be wanderguard worn, indicated in the configuration [see purple sheet in directed staff to "obthe NA care sheet of the Merry walker, no given even though monitor R87's when PRN. When interviewed of stated R87 was safe	et (a reference NAs used care for residents) undated, erventions for R87 to include: e R87 to the bathroom before iner, (2) keep bathroom door light on R87 at bed time, (4) mat (put mat against wall 5) keep gait belt on walker (6) Follow with wheel chair one to one assist when in ody pillow to position in bed, The NA care sheet also ment section: "Merry Walker NA book]." The purple sheet serve frequently." Although directed staff to observe R87 in o specific time frame was the care plan indicated staff to reabouts every 30 minutes and on 7/19/16, at 11:22 a.m. RN-A e to be unsupervised in the tated, "we check on her every				
	usual practice to all in the Merry walker "We try to keep her job of keeping her calthough she had n involving the Merry had stepped on the	p.m. NA-E indicated it was ow R87 to walk around while unsupervised. NA-E stated, safe, the nurses do a good close." NA-E verified that ot witnessed R87's falls walker, she'd heard that R87 bottom of the walker causing using a cut to R87's face. e temple area.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
7 IND I EAR	OF GOTHLEG FIGH	BENTH TO A PONTONIBER.	A. BUILDING:	A. BUILDING:		
		00108	B. WING		07/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET RIA, MN 56	308		
040.15	CLIMMA DV CTA		-	PROVIDER'S PLAN OF CORRECTION	DNI .	()(5)
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 18	2 830			
	following 27 docum involved the use of was admitted on Ma (1) 5/10/15- found of walker; No apparent Care plan and multibeing followed at tir member (F)-A. Disc the Merry walker, F walker continues to a greater risk of injumerry walker and so will continue with 30 continue with	on floor underneath Merry				
	walker; head up age bruising on RUE (ripprevious fall; No oth was crying but able Unwitnessed. Will pwhen not in bed to no mat or wheeling also continue Q (ev (3) 5/20/15- found to the floor with one le Merry walker aroun back into Merry wal (mechanical device of IDT (interdiscipling) (4) 5/30/15- found to with one leg around	on floor, had tipped over Merry ainst the wall on right side; ght upper extremity) from her noted injuries. Resident to voice if she was hurt. blace safety mat against wall prevent resident from tripping over it with Merry walker. Will ery) 30 minute checks. By a staff member laying on g still around the strap of d 4:00 p.m. Resident assisted ker with 2 staff and EZ hift. No further documentation hary team) review of fall.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING	-		
		00108			07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHANY HOME			K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 19	2 830			
	(5) 6/20/15- found sitting opposite direction in Merry walker. Sitting on floor. No apparent injuries.					
	staff removed Merry	on floor in Merry walker. When y walker to assist off the floor, oting on her butt on the floor. CP being followed.				
	and right leg crosse grabbed for medica this caused [R87] a left. Right hip pain a Lump on left side o Pupils sluggish. Gu	y walker, stumbled to the left ed over left leg and resident tion cart to catch herself and nd Merry walker to fall to the and right foot rotated inward. If head and above left eye. arded movement to the right lead abrasion and lump. Sent epartment (ED).				
	balance and fell to to over. Was sent to E returned with no fra	y walker when lost her the floor, tipping Merry walker ER (emergency room) and ctures or injuries. CP being eights added to base of merry ity.				
		n floor in Merry walker in room. of 2 staff. Resident was				
		on the floor of bedroom in juries noted from fall. CP was continue current				
	another resident's r head. Was wearing	on floor at 11:30 a.m. in com with no injuries or hitting slippers and in Merry walker ce. Action: Up off floor and er.				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
RETHANY HOME			K STREET ORIA, MN 56	308		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 20	2 830			
	station in Merry wal noted. Continue cu					
	appears to be more grimacing. Is not all pain with staff. No i being followed. Act	alls in one day. Resident e restless and has facial ways able to communicate njuries from either fall. CP was tion: Physician referral out to s to see if this helps with				
	Merry walker in her between legs; shirt in place; R87 agitat	sitting on floor backwards in room, leg strap still attached off at this time, gripper socks red at the time. Staff last shortly before, less than hour				
		on the floor, in Merry walker, ot tip over. No injuries noted followed.				
	room, was lying und Merry walker was in	ved on floor next to bed in der the Merry walker. The ntact, was assisted to the toilet walker at 2:20 p.m. No lumps noted to her head.				
	the time of fall. No if followed. Resident signs of pain and harmonic signs are the signs are the signs of pain and harmonic signs of pain and harmonic signs of pain are the signs of pain and harmonic signs of pain are the sign o	on floor, in Merry walker at injuries noted. CP being has been showing increased as been more anxious, likely stanyl patch was increased atinue with current				
		in room on the floor valker at 7:00 p.m. The strap				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET			
			ORIA, MN 56			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 21	2 830			
	was hooked around her back. A small q	I R87's foot and was lying on uarter sized bruise was found rought to the bathroom and				
	interview, [R87\ ass Received a small be the fall. Action: Fen was recently increa monitor pain and ef	on the floor in room per staff sisted just prior to fall. ruise to buttocks as a result of tanyl patch (pain medication) sed on 9/21. Will continue to fects of Fentanyl patch as o be more anxious and or falls.				
	sideways and was funable to move. [Rimouth bleeding from [sik] the incident so trying to do at the time from the floor whole where face in the floor whole with the floor with th	dent tipped merry walker over found face down on floor, 87] hit head/mouth on floor; m losing a tooth. No one seen don't know what resident was me. Action: resident was lifted assist of 3 and EZ lift. A ote dated 10/26/15 at 11:41 reviewed fall from 10/24/15. For merry walker and landed on a small abrasion under nose a result of the fall. Seroquel cation) was recently dnesday, [R87] more active ughter's request, she would ased to the previous dose, she in her mom have more added d like her mom to be more and falling. Referral filled out cory. Also, weights added to rry walker to balance it. (The ed weights to the base of the nitiated after R87 had 6/28/15). A nurses' note dated (1:39 p.m.) included:"Res.				

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RETHANY HOME			K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	xray to face. RN U coordinator] aware. after talking to CNF Subsequent nursing had ordered a head tomography X-ray] from 16:53 (4:53 p. scan results from the had presented with confusion than usu. Conclusion: 1. Nor anterior superior mease of the nose. A from 10:49 a.m. on resident required at Despite the number utilizing the Merry wassess R87's fall (21) 1/6/16- found of still in Merry-walker intact. Resident was wall in the bathroom Resident was assist (mechanical full booked. Then placed in further review of the (22) 1/8/16- found of Merry walker; Merry injuries from fall. Classisted to the bath to the fall, not attern the time of the fall. the bathroom door wanders into her room the control of the control of the still the bathroom door wanders into her room the control of the control of the fall.	ed to [MD] to inquire about C [registered nurse unit [MD's] nurse will call back c [certified nurse practitioner]. In ontes indicated the physician of CT scan [computed for that date. Documentation [m.) 10/26/15 indicated CT and date, indicated the resident facial pain and more al. The report further included: Indisplaced fracture through the lost maxilla (upper jaw) at the lost	2 830			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/:	22/2016	
NAME O	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
RETHANY HOME			RK STREET DRIA, MN 56	308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
2 83	(23) 2/2/16- on floor 7:30 a.m. in Merry of foot wear on at time (24) 4/16/16- found activity room close still in the Merry wa assisted back into the lift and 3 staff assisted continue to feel the and continues to be A physician visit for R87 was seen for a "Nursing has no combeen stable." (25) 5/13/16- found was tipped over on next to bed, feet still Was trying to get to Merry walker and flick Aide found resident Staff educated to me floor when [R87] not to remind staff to pict bed. (26) 6/26/16- found room in Merry Walk seat. No injuries no with family at all can this is her safest op gives her the freedd independent. Will conterventions. CP for (27) 6/27/16- found Merry walker outside.	r in front of nurses' station at walker. No injuries noted. Had a of occurrence. Continue CP. sitting on the floor in the to Turtle Beach (resident unit) lker; walker was still upright; he Merry walker with the EZ t. Continue with CP; Family Merry walker is safest option appropriate. In dated 4/18/16, identified a "regularly scheduled visit." Incerns with [R87], she has on right side, Merry walker the floor, laying on gray mat all inside tipped Merry walker. Herbergers, climbed on ipped Merry walker onto side. It on floor. No injuries from fall. In the same the mat is not on the out in bed. Sign placed on wall ck up the mat when not in on floor of other resident's the conferences and they feel oftion to avoid injury and also out to ambulate and be more ontinue with current	2 830				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00108	B. WING		07/2	2/2016
	PROVIDER OR SUPPLIER	1020 LAR	K STREET	STATE, ZIP CODE		
		ALEXAND	DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ae 24	2 830			
2 830	sleeping. No injuried continue with these When interviewed of director of nursing (reviewed resident fall, current interventions and positive line intervention received in the electronic received in the electronic received line intervention for line intervention	s. CP being followed;Will interventions. on 7/19/16, at 2:55 p.m. the (DON) identified an IDT alls to identify the cause of the ntions in place, previous ossible new interventions. This dot the nurse's progress notes ord and documented onto a sy form titled Resident or the dates of January 2016 to the following falls involving the 37: ne, interventions-Continue s-no injury. one, interventions-Continue s. one, interventions-Continue s. one, interventions-Will nt interventions.	2 830			
	maltreatment, care Resident has nume	one, interventions-No plan was being followed. Frous fall interventions in place. Theses interventions.				
	selected time frame documentation of a re-assessment of F	nat occurred during the e. The log also lacked comprehensive 187 and lacked documentation erventions implemented to				
	evidence of physica	d written records lacked any al (PT) or occupational therapy ad/or treatment. In addition,				

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A. BUILDING: O0108 B. WING O7/22/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE)16
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE)16
4000 LARK CERET	
BETHANY HOME 1020 LARK STREET	
ALEXANDRIA, MN 56308	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) MPLETE DATE
2 830 Continued From page 25 2 830	
Morse Fall Scale documents completed on 8/28/15, 10/26/15, 11/20/15, 11/22/15 and 5/9/16, each identified R87's risk for falling, the use of a walker, and identified the resident as having a weak gait, stooped posture and described gait with, "steps are short, resident may shuffle." Each of these Morse Fall Scale documents indicated the resident had a score of 80 with anything above 45 indicating a high risk for falls. None of the documents identified any other specific assessment information. On 7/19/16, at 4:19 p.m. registered nurse (RN)-A reviewed the progress notes and verified R87's falls involved the Merry walker and that assessments and new interventions were not consistently completed and/or implemented. RN-A identified the usual process after a fall as follows: (1) review the nurse's progress notes, (2) interview staff to see what [R87] was trying to do, (3) if interviewable, ask the resident, (4) reassess fall risk and whether planned interventions are effective. RN-A indicated these assessment findings would have been documented as a follow-up note after each fall. RN-A verified that R87 was cognitively impaired and that it was difficult to identify a cause for each fall because R87 could not express her needs or actions. RN-A further identified there were so many planned interventions! twas difficult to identify any new ones, and RN-A also stated fall assessment serves owner and all seconds of the service of t	

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RETHAN	IY HOME		K STREET			
DETITION		ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	admitted. RN-A alsincluded all of the confirmed it was an the care plan. RN-A responsible to chect and to document stands walker currently util obtained from storal facility, and stated swritten copy of the instructions/recomments and have to coobtain the instruction obtain the instruction of 7/19/16, at 4:57 nurse manager was assessment for resident in the Nassafe. The DON an actual written as of an observation to walker was appropriated. The DON and family were aw remained at risk for walker. The DON content of the family wishes single Merry walker, she was of chair (a reclinity also indicated impleater a fall would be problems with the Nassafe.	o stated the current CP urrent interventions and expectation that staff follow also stated the nurse was k on R87 every 30 minutes uch. RN-A explained the Merry ized by R87 had been ge in the basement of the she did not believe they had a manufacturer's nendations. RN-A indicated implete a "Google" search to	2 830	DEFICIENCY)		
	it properly. The DO expectation for care walker included free when walking by. T	N further indicated the e of a resident utilizing a Merry quent observations by all staff he DON said if a resident were of the Merry walker, staff may				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016
	PROVIDER OR SUPPLIER	1020 LAR	DRESS, CITY, S K STREET DRIA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	lay the resident in be next to the bed. The expected to follow they had tried nume follow family wishes of the Merry walker manufacturer's recommerced manuf	ge 27 ed with a safety mat placed by DON reiterated staff were he CP. The DON indicated by the CP. The DON indicated by the CP. The DON stated the continued use of the DON stated the commendations for use of the by the coated in the storage area. p.m. RN-A provided commendations for use of a cout from the Internet. These endations included: "The end of metal and weighted at the one should be individually the the height of the top frame gight of the pelvis to promote wever, the Merry walker R87 is constructed of PVC pipe to the weights with zip ties were on bar of the walker. In the end the height of the top frame R87 utilized was not at the but above the pelvis. 33 a.m. physical therapist wed. PT-A confirmed therapy bening and treatment of transfers, balance, walking of the most appropriate lifts for a PT-A stated, "[Merry walker] to be with a walker or cane." PT-A onsiderations for use of a include: look safe, maintain the theorem of the top device the pelvis were able to tip of that when R87 was admitted by screen to evaluate if	2 830			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00108	B. WING		07/2	22/2016
	PROVIDER OR SUPPLIER	1020 LAR	DRESS, CITY, S K STREET DRIA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	therapy services we PT-A indicated that been determined to order for treatment confirmed R87 had services any time s and confirmed R87 for the use of the M The facility policy tit revised September Recognition identific will evaluate and do the individual is in the and where they hap events, ect. Treatm on the preceding as physician will identific to prevent subseque of serious consequent The immediate jeons and identified on 7/removed on 7/20/16 be verified by observinterviews, the the interventions included incontinuing the uniterventions included as a physician will implement appropriate assess and a new safety plus the consultant phase medications and a proposition of the consultant phase in the consultant phase	ere required was conducted. at that time services had not be needed so no physician had been requested. PT-A not been provided therapy ince admission (March 2015) had not been evaluated by PT lerry walker. Ided, Falls- Clinical Protocol 2012, Assessment and ed the following: #5 The staff ocument falls that occur while he facility: for example, when open, and observations of the ent/Management: #1- Based sessment, the staff and fy pertinent interventions to try ent falls and to address risks ences of falling. Dardy that began on 10/24/15, 19/16, at 7:05 p.m, was 6, at 3:30 p.m. when it could rvation, record review and staff facility had implemented ing: use of the Merry walker for R87 mented for R87 until ments could be completed an initiated armacist reviewed R87's was conducted and a chair/walker with 18" wheels ered e-assessment of the new to determine appropriateness				

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	22/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BETHAN	YHOME		K STREET DRIA, MN 56	308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	- a comprehensive developed and staff appropriately; a pos required progress nelectronic chart to toplan to include modinterventions; all staverbally, via e-mail nurses' stations; NALPNs, activity staff, to confirm impleme Although numerous noncompliance remseverity of a G, isolactual harm that is because the facility assessment and stainterventions to mail support of the second of the fall incide conducted to ensure assessed for safety. The results of the aquality assurance contents of the second of	fall assessment was f were educated to implement st fall assessment, including note, was created in the rigger a review of the care lifications and review of aff were educated either and/or by written postings at as, RNs, case managers, and PT staff were interviewed ntation of the plan. s interventions were initiated, nained at the lower scope and ated scope with severity of not immediate jeopardy, had failed to ensure ongoing aff compliance with identified intain resident safety. THOD OF CORRECTION: ses' could inservice staff to ments are conducted after care could be implemented to lents. Audits could be te that equipment is used after and that falls are assessed. udits could be reported to	2 830				
2 895	MN Rule 4658.0525 Motion	5 Subp. 2.B Rehab - Range of	2 895			8/12/16	
		motion. A supportive program ard prevention of deformities					

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NAME OF PROVIDER OR SUPPLIER BETHANY HOME 1020 LARK STREET ALEXANDRIA, MN 56308 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 895 Continued From page 30 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	
BETHANY HOME 1020 LARK STREET ALEXANDRIA, MN 56308 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 895 Continued From page 30 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to			00108	B. WING		07/2	2/2016
ALEXANDRIA, MN 56308 X4 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 895 Continued From page 30 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to	BETHAN	NY HOME			308		
through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions for identified contractures for 1 of 1 resident (R65) reviewed for range of motion (ROM.) Findings include: Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which included Parkinson's disease, Alzheimer's disease and cerebrovascular disease with hemiplegia. The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures. Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures. Review of R65's care plan print dated 2/25/16,	2 895	through positioning implemented and momprehensive resion nursing services development of a missing service that: B. a resident with receives appropriate increase range of modecrease in range of the decrease in range of	and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which the a limited range of motion the treatment and services to notion and to prevent further of motion. The is not met as evidenced on, interview and document alled to implement entified contractures for 1 of 1 the ewed for range of motion arterly Minimum Data Set 6, identified R65 had severe not and had diagnoses which is disease, Alzheimer's ovascular disease with DS further identified R65 was no staff for activities of daily and bilateral upper extremity nual Care Area Assessment 5, identified R65 had severe not due to Alzheimer's disease, ent on staff for ADL's and had	2 895	Corrected 8/12/2016 per Director	of	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/	22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
BETHAN	NY HOME		RK STREET DRIA, MN 563	308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
2 895	identified R65 had a upper and lower ex dependent on staff range of motion wit rolls in both hands and some state of R65's cu 7/19/16, revealed a 10/21/2015, directe kerlix roll in bilatera shift, should have k additional gauze be and gauze when so for contractures. The staff to wash R65's instruction sheet. Review of R65's pro 5/27/16, revealed Froutine visit in which contractures which and hands. Review of R65's motherapy (OT) assess revealed R65 had be which were in a fixed evaluation directed exercises and in har contractures. - R65's medical receivaluations for hand Review of R65's treated recomark for R65's treated recomark f	bilateral contractures of the tremities, was totally for all ADL's, required gentle h daily care, required gauze 23/hrs/day: to be removed for aily for hygiene for bilateral rrent physician orders signed n order with a start date of d nursing staff to check R65's I hands for placement every erlix in hands at all times and tween thumb, change kerlix siled and as needed every shift he orders also directed nursing hands twice daily per by					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BETHAN	IY HOME		RK STREET DRIA, MN 56	308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 895	chart code legend with the treatment was in Review of R65's ca 5/17/16, revealed Ricontractures of her note further reveale apply gauze to R65 indicated that was to Review of R65's pro 7/13/16, revealed the -1/24/16, revealed the bilateral hands and and gauze rolls place to keep R65's hand -2/5/16, revealed Rimotion (PROM) to be extremities due to capply gauze rolls in -3/5/16, revealed a identified R65 had be and required total and ADL's. -4/6/16, revealed a identified R65 had be and required total and ADL's. -4/23/16, revealed a identified R65 had be and required total and R65 required total and ADL's.	which a check mark indicated in place on all days. The conference note dated a continued to have thands and extremities. The side staff were to continue to the continue. The properties of the continue to the contractures to the contractures of the contractures and lower contractures, staff continued to the contractures, staff continued to the contractures to the contractures to the contractures to the contractures and lower contractures, staff continued to the contractures to the contractures and contractures are seistance from staff for all the contractures are contractures and contractures are contractures and contractures are contractures are contractures and contractures are contractured and contractures are contractures are contractured and contractures are contractured are contractured and contractures are contractured are contractured and contractures are contractured and contractures are contractured and contractures are contractured and contractured are cont	2 895	DELIGIENCY)			
	which identified R65						

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00108 B. WING 07/22/20	2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BETHANY HOME 1020 LARK STREET ALEXANDRIA, MN 56308	
	(X5) COMPLETE DATE
2 895 Continued From page 33 both hands to help her contractures and maintain skin integrity. -5/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -5/28/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands. -5/29/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands. -6/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -6/27/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -7/13/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was	

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STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	nurses station follow remained without known 7/19/16, from 8 was lying in bed tiltured against her back, but cover R65 to mid to fisted position, arm fisted hands rested have kerlix in her hand was left clenched hand was licensed practical out, nor could R65 independently. RN contracted and had a licensed practical on 7/21/16, at 5:13 open R65's right had contracted, fisted papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her fing stopped opening R65's right had contracted and papproximately an in roll into R65's hand was hurting her f	wing the evening meal. R65 erlix/gauze in both hands. 1:45 a.m. to 10:55 a.m. R65 ed to her right side with pillows lankets were observed to orso. R65's hands were in a as were bent at the elbow, against her chest. R65 did not ands. p.m. R65 was seated in a tilt or with both arms bent at the extering on her chest and doposition. R65's right oresting over her heart and her was resting on her upper left observed in R65's hands. p. m. R65 was seated in a tilt or with both arms bent at the exterior on her chest and doposition. R65's right oresting over her heart and her was resting on her upper left observed in R65's hands. p. m. 7/21/16, at 5:09 p.m. anager (RN)-A confirmed R65 on her contracted hands as was unsure why the kerlix was extend the medication nurses or checking to make sure of both hands for bilateral hand of stated she felt R65 hands of for the kerlix to have fallen or the kerlix stated R65's hands were fully been for years. RN-A directed nurse (LPN)-D to apply kerlix.	2 895			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00108	B. WING		07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 895	needed to be soaked the hands up. RN-A R65's to her room a her bathroom, while out of the faucet. Notheld it under the ward opened R65's hand the kerlix. NA-B the under the water who washed, dried and NA-B assisted R65 her wheelchair and station. On 7/21/16, at 5:12 supposed to have the at all times. NA-B steed the herlix into hard time doing so. R65's hands were frould not fall out and unable to remove the she felt R65's hand last few years. On 7/22/16, at 10:2 required total assist stated on average and have the cloth in NA-C would then ple contracted hands. On 7/22/16, at 10:3 not had a recent oc though had one a fe R65 had complete of R65 had complete	ge 35 ed in warm water to help open and NA-B then wheeled and NA-B wheeled R65 into a RN-A started to run the water A-B took R65's right hand, arm water while RN-A slowly I, washed, dried and applied on took R65's left hand, held it ile RN-A opened R65's hand, applied another roll of kerlix. back out of the bathroom in wheeled R65 back to nursing p.m. NA-B stated R65 was the kerlix in both of her hands tated the nurses usually put hands were washed. NA-B at 3-4 times a week R65's for hands and often had a NA-B further stated she felt isted very tightly so the kerlix and she felt R65 would be the kerlix herself. NA-B stated as had not worsened over the standard and and ace the kerlix in R65's 7 a.m. RN-A stated R65 had cupational therapy evaluation, and we years ago which identified contractures of both hands. So's current physician orders	2 895			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•		
BETHAN	Y HOME		K STREET DRIA, MN 56	308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 895	directed nursing staplaced in both continuous the licensed nurses R65 had the kerlix in the kerlix on the (Trexpected the kerlix staff could apply the fully contracted ham.) On 07/22/16, at 11: (DON) stated she eresident care plans stated she did not five was for her hand composture control. To the current physician of electronic medical intreatment was order the thighest practicable. A policy was request physician orders, the care plan to inform the care plan to inform as directed, compliance. The repart of the overall of plan.	aff to ensure R65 had kerlix racted hands and only to be shed twice daily. RN-A stated were responsible to ensure in place and would document AR.) RN-A stated she to be in place as any care exertive. RN-A stated R65 had ads and fingers. 13 a.m. the director of nursing expected physician orders and to be implemented. DON eel that R65's kerlix treatment entractures but were more for the DON confirmed R65's record identified R65's kerlix tred for hand contractures. policy titled, Restorative eviewed 5/2011, revealed a promote each residents well being.	2 895				
	(21) days.	TOOTHILOTION. TWEITLY-OHE					

6899

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
	00108	B. WING		07/22/2	2016
NAME OF PROVIDER OR SUPI			STATE, ZIP CODE		
BETHANY HOME		RK STREET DRIA, MN 50	6308		
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE ((X5) COMPLETE DATE
Subp. 6. Active comprehensive home must en B. a resident activities of data services to material and personal at a services to material and personal and personal hygical at a service at a service and personal hygical at a service and personal at a se	t who is unable to carry out illy living receives the necessary aintain good nutrition, grooming, and oral hygiene. Illiement is not met as evidenced ervation, interview and document illity failed to provide oral care and cial hair for 2 of 3 residents (R78, I who were dependent upon staff and personal cares. Ide: On Minimum Data Set (MDS) dateded R78 was moderately cognitively iired extensive assistance for all living (ADL) with exception of limited walk in corridor and diagnoses of Parkinson's disease, dementia, sion impairment. I care plan, identified R78 had a self ated to Parkinson's Disease, diabetes, and dementia as requiring assist with ADL's -The res extensive assist of 1 staff with		Corrected 8/9/2016 per Director of Nursing		/9/16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	Y HOME		K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From particles of nother area a little lax of stubble on chin and on 7/20/16, at 7:57 his room to the dinin (NA)-H. R78 had falip and chin area. On 7/20/16, at 1:00 room in a stationary R87 remained unshord on 7/21/16, at 9:26 room dressed, has mustache and bear on 7/20/16, at 8:51 to shave independented help. NA-H if facility and NA-H was behaviors or refuse when interviewed overified if he was also it every day. R78 face each morning electric razor but so verified his facial has today and was unall shaved him.	ge 38 B a.m. R78 stated, "I can't hy Parkinson, that is one thing on." At this time R78 has upper lip. a.m. R78 was propelled from any room by nursing assistant acial hair stubble on the upper p.m. R78 was seated in his chair in front of the television. aven. a.m. R78 was seated in his chair in front of the television. aven. a.m. R78 was seated in not had face shaved, dheavy stubble. a.m. NA-H indicated R78 tries only and will ask staff when he as unsure of whether R78 had dicares. and 7/20/16, at 1:00 p.m. R78 alle to shave himself he would a stated staff will shave his when they get him up with an ame times they forget. R78 air had not been shaved off ole to recall when staff last	2 920			
	no behaviors and di a walk, however, it	p.m. NA-I identified R78 had id occasionally refuse to go for was usually for a reason, for was here or if he was having				
	On 7/21/16, at 9:54	a.m. NA-E indicated R78 was				

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AND BLAN OF CORRECTION \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BETHAN	IY HOME		RK STREET DRIA, MN 56:	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 920	unable to shave inchands. NA-E verified this a.m. NA-E indices shave this a.m. and "every so often." On 7/21/16, at 11:0 a good memory and NA-F indicated he/s R78 often, however clean shaven. NA-F assisted R78 with consisted R78 further identified was easier to keep stating "I drool." On 7/21/16, at 11:1 (LPN)-E verified R7 not been shaved. On 7/21/2016, at 1 (RN)-A verified R78 ADL's due to has Falthough his abilitied was not able to shave expected to shave a shave to shave the shave the shave to shave the shave the shave to shave the shav	lependently due to shaky d he/she had not shaved R78 cated R78 refused the offer to I had a routine of shaving only 0 a.m. NA-F verified R78 had d what he says is accurate. She did not provide cares for r, did believe R78 was usually indicated staff usually oral care and shaving. NA-F normally shave a person if				
	director of nursing (that staff follow the	on 7/22/16, at 11:25 a.m. the DON) verified the expectation care plan and residents who with ADL's be provided the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/	22/2016
	PROVIDER OR SUPPLIER	1020 LAR	DRESS, CITY, S K STREET DRIA, MN 563	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 920	care and not expect The requested facil was not provided. R28's quarterly Min 6/15/16, identified F cognitively impaired included: Alzheimer arthritis. The MDS extensive assistant hygiene tasks. R28's care plan dat required extensive with personal hygie plan indicated R28 Staff were to assist offer R28 mouth sw and while getting re complete an oral in needed. The undated reside did not wear the de sheet lacked any di for R28. The nursing oral as indicated R28 had i fragments, and indi dentures. The asse chewing and swalld pureed diet. During observation from 8:23 a.m. to 8 assisted R28 with p washing her face, p	ge 40 ted to ask for assistance. ity personal hygiene policy imum Data Set (MDS) dated R28 was moderately and diagnoses which r's, psychotic disorder and indicated R28 required refor completion of personal red 7/15/16, identified R28 reassistance to total assistance ne and oral cares. The care had upper and lower dentures with cleaning dentures and to rab and mouth was in the AM rady for bed, and staff were to rection with cares and as ant care sheet, indicated R28 rection regarding oral cares sessment dated 6/13/16, no natural teeth or tooth cated R28 chose not to wear resident care rection regarding oral cares of morning cares on 7/20/16, resonal cares which included region, R28 was not assisted nor R28 was not assisted nor	2 920			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	00108		B. WING		07/2	2/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
BETHANY HOME			K STREET RIA, MN 56	308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 920	offered the opportucares. R28's oral of dryAt 8:57 a.m. NA-A while R28 was posi wearing any dentur breakfast food item consume the straw -At 9:01 a.m. NA-A shut off the bedroor are good with feedijust like today. NAtray to the kitchen, offered the opportucares. During interview on reported R28 no lor stated she was goir breakfast to provide swabbing out the material of the did not completed morning she did not completed morning she did not complete included swabbing mouthwash. Further inspect her mouth word in the material of the morning cares will at times refuse. In the did not state of the mouth word in the morning cares will at times refuse. In the did not complete the mouth word in the morning cares will at times refuse. In the did not complete the mouth and slee therefore, oral care.	nity for completion of oral avity and lips appeared very assisted R28 with breakfast tioned in bed. R28 was not es, and R28 refused the s and juice offered. R28 did berry supplement. gathered the breakfast tray, m lights and stated some days ng, and some days are not, A then delivered the breakfast R28 was not assisted nor nity for completion of oral 7/20/16, at 8:45 a.m. NA-A nger wears dentures, and ng to wait until after R28 ate e oral cares which included touth with a toothette. confirmed R28 had finished neal and confirmed she had cares for R28. NA-A verified the nor offer oral cares which the mouth with a toothette or er, NA-A confirmed she did not	2 920				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COM			SURVEY LETED	
		00108	B. WING		07/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	YHOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 920	Continued From page 42		2 920			
	offer oral cares to all resident twice per day as indicated on the care plan.					
	2010, directed staff plan for any special assemble the equip The purpose is to k tissues moist, to cle	Care Policy dated October to review the resident's care needs of the resident. and ment and supplies as needed. eep the resident's lips and oral canse and freshen the nd to prevent infections of the				
	The director of nursidevelop and implementated to the implementated to the provision shaving of facial has could provide training to providing the ser and assurance compandits to ensure control TIME PERIOD FOR	CHOD OF CORRECTION: sing (DON) or designee, could nent policies and procedures mentation of the care plan sion of oral hygiene and ir. The DON or designee, ng for all nursing staff related vices. The quality assessment mittee could perform random mpliance.				
21015	Subp. 7. Sanitary procedures and cor	O Subp. 7 Dietary Staff nitary conditi conditions. Sanitary nditions must be maintained in dietary department at all	21015			8/11/16
	by:	ent is not met as evidenced on, interview and document illed to maintain the		Corrected 8/11/2016 per Certified Manager	Dietary	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56:	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21015	cleanliness of the w sanitation and food This practice had the received food from Findings include: During the initial kite 7/18/16, at 1:14 p.n. the walk-in refrigerate door to the refrigerate frost and the stainled dark brown substant strong sour odor and inside the unit. Alone there was a significe shaped areas of blate between the second vegetables (leaf lett tomatoes) were sto tomatoes and leaf I without any coverin Throughout the ent and chipped paint we interior walls of the	valk-in cooler to promote safety in the main kitchen. ne potential to affect all 80 who	21015			
	was evident as the interior walls. Loca stored vegetables vapples. These fruit of the dark colored On 7/21/16, at 1:55 stated she had a deaid (DA)-A who clead Monday which included completed, the coorefrigerator. DD sta	paint was peeling from the ted adjacent to the shelves of were stored fresh oranges and items were next to the areas				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	· Í IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
	00108		B. WING		07/2	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DETHAN	VIIONE	1020 LAR	K STREET			
BETHAN	YHOME	ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 44	21015			
	would be entered into the computer. The DD confirmed the most recent work order entered had been related to a storage pallet sent last week.					
	was placing groceri the walk-in cooler/re the surveyor re-enter presence of the morand DD indicated the in the walk-in coole could not keep up version of the morand between the could not keep up version of the walk-in coole could not keep up version of the walk-in coole could not keep up version of the walk-in coole could not keep up version of the walk-in coole could not keep up version of the walk-in coole could not keep up version of the walk-in coole could not working properly. The version of the stated the walk-in coole coo	7/21/16, at 2:05 p.m. that C-A es onto the shelves located in efrigerator when the DD and ered the unit to confirm the Id identified on 7/18/16. C-A he humidity level was so high at that the refrigerator unit with the excessive humidity. Seen discussed with the eger (MM) approximately a get the door seal was not the MM had confirmed the ed separated from the door, operly to maintain the electronic color. The MM stated he cleaning the door seals and discussed with the excessive humidity. The MM stated he cleaning the door seals and discussed with the except the color. The MM stated he cleaning the door seals and discussed with the except the confirmed to the except the shall be consequently, moisture the broken seal and the extended from above the shelf down to the floor. There extended from above the shelf down to the floor. There has shaped black colored mold so on the wall with several, up and or long. DD wiped a large black substance with her due remained on her fingers. On firmed a strong odor was				

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have baking soda in the cooler anymore, but

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016
-	PROVIDER OR SUPPLIER	1020 LAR	DRESS, CITY, S K STREET DRIA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	used to use it to corconfirmed there washelf where a pork cardboard box. He had leaked liquid or C-A indicated both onto the floor. C-A floor in the walk-in cand had rusted. He significant rust local thawing rack which from the rack. On 7/21/16, at 2:10 vegetables from the top of a stainless stilt was observed that cooler on his knees bucket containing brag. C-A indicated hinside the cooler, and it had been washed substance was presilevel in the cooler. On oticed the black substance off bleach solution, grawall as it was washed substance off bleach solution, grawall as it was washed substance off bleach solution, grawall as it was washed substance off bleach solution, grawall as it was washed substance off bleach solution, grawall as it was washed substance off bleach solution, grawall as it was washed substance off bleach solution, grawall as it was washed substance off bleach solution, grawall as it was washed inside the walk-in coher scheduled hour wash the wall and washed been washe	ntrol the odor. C-A also is standing liquid in front of the roast was thawing in a confirmed the frozen roast into the floor during thawing. The pork and fish tend to leak stated they have a galvanized cooler, which was damaged a confirmed the floor had ted in front of the meat extended approximately 6 in. p.m. C-A removed the walk-in and had a small white plastic leach solution and a cleaning in had never washed the walls and was unsure of the last time. He stated the black sent due to the high humidity C-A indicated he had never ubstance substance until the maware. As C-A wiped the the wall of the cooler with the cycolored water ran down the ed. p.m. DA-A stated she was on Mondays from 9-11:30 she had not washed the walls cooler this past Monday during its been in washed. She was unsure	21015			
	inside the walk-in content scheduled hour wash the wall and wash they had been who was assigned indicated only recer	ooler this past Monday during s. DA-A verified she doesn't vas unsure how long it's been				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHANY HOME			K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	Continued From page 46		21015			
	had too many other noticed the black su past but was unsure bleach kills it.	he cooler cleanliness as she tasks. DA-A stated she had ubstance on the racks in the e how the mold returned as				
	When interviewed on 7/21/16, at 5:30 p.m. the MM and the administrator (A) confirmed they were unaware of the black substance in the walk-in cooler and agreed they needed to develop a system, procedure and cleaning schedule for the walk-in cooler. The administrator stated staff need to remove all of the food items and wash/clean the unit, including the shelves prior to returning the stored food items.					
	Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule.					
		ry cleaning schedule , dated gerators would be cleaned				
	dietary manager (D procedures regarding could include a syst of equipment in a till educate all appropri The DM could develope ensure ongoing corquality assurance c	THOD OF CORRECTION: The M) could develop policies and ng safe storage of foods. This tem for notification and repair mely manner. The DM could iate staff on these policies. Plop monitoring systems to impliance and report to the ommittee the audits e ongoing compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	2/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BETHAN	Y HOME		K STREET RIA, MN 56	308			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21685	Continued From pa	ge 47	21685				
21685	Subp. 2. Physical p	5 Subp. 2 Plant eration, & Maintenance plant. The physical plant, rs, ceilings, all furnishings,	21685			8/11/16	
	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, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen.			Corrected 8/11/2016 per Certified Manager	Dietary		
	tour with cook (C)-A covering underneat steamer and oven I area had an area of which measured ap 18 in. The area wadust and dirt particle another irregular shateamer and next to a dark brown, sticky measured approxim	4 p.m. during the initial kitchen a it was noted that the floor h and surrounding the affixed ocated in the food preparation f missing maroon floor tile, proximately 18 inches (in) by s filled with dark and light gray es. In addition, there was apped area directly under the othe missing tile area that was y, sludge material which nately 6 in by 4 in. The entire paration area was soiled with lirty.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING	WING		07/22/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	2/2010	
	IY HOME		K STREET	,			
ALEXANL			RIA, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE	
21685	Continued From page 48		21685				
	confirmed the dama. She indicated the fl this past year. DD a needed to be replace purchased another around and had protected the steamer which estated the brown stibut was compacted. She confirmed the cleanable surface, housekeeping staff week, otherwise die washing the floor.	p.m. the dining director (DD) age and dirty kitchen floor. oor had steadily gotten worse also stated the floor is old and ced. DD indicated they had oven, moved equipment oblems with water leaking from caused the floor damage. DD icky substance was not grease food material, dirt and grime. floor was no longer a thus dirty. She stated scrubbed the floor every other etary was responsible for					
	On 7/21/16, at 5:30 the maintenance manager (MM) and the administrator (A) confirmed the condition of the damaged floor tile and the dirty floor. MM knelt to the floor, wiped his hand across the area and visible gray dust was evident on his hand. MM and A confirmed the floor surface need to be repaired and/or replaced and agreed the damaged tile surface was unclean. MM and A confirmed a dark brown sticky material was evident on the floor behind steamer and stated it would be cleaned.						
	the Food Service D service staff shall m	ted facility policy, Sanitation of epartment identified the food naintain the sanitation of the ment through compliance with ule.					
	The administrator of identified kitchen er corrected and moni good repair and res	THOD FOR CORRECTION: or designee could ensure all nvironmental concerns are tored on an ongoing basis for ident satisfaction. The quality surance committee could					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00108	B. WING		07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 49	21685			
	perform random au	dits to ensure compliance.				
	TIME PERIOD FOR days.	R CORRECTION: Twenty (21)				
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults		21980			8/9/16
	reporter who has revulnerable adult is to or who has knowled has sustained a phyreasonably explained information to the condividual is a vulne the individual is adreporter is not required.	of report. (a) A mandated eason to believe that a peing or has been maltreated, dge that a vulnerable adult ysical injury which is not ed shall immediately report the ommon entry point. If an erable adult solely because mitted to a facility, a mandated ired to report suspected individual that occurred prior s:				
	another facility and believe the vulneral previous facility; or (2) the reporter k that the individual is in section 626.5572 (b) A person not provisions of this s as described above (c) Nothing in this known or suspected knows or has reason been made to the county of	s section requires a report of d maltreatment, if the reporter on to know that a report has				

6899

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
	PROVIDER OR SUPPLIER	1020 LAR	DRESS, CITY, S K STREET DRIA, MN 56	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	reason to believe the 626.5572, subdivision. If the reported error with the criteria under set 17, paragraph (c), confacility may provided directly to the lead a how the event mee 626.5572, subdivision (5). The lead agent information when method the criteria under set 17, paragraph (c), confacility may provided directly to the lead a how the event mee 626.5572, subdivision (5). The lead agent information when method the criteria under sufficient the conformation when method t	nat an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any n investigation by a lead ne or should determine that was not neglect according to ection 626.5572, subdivision clause (5), the reporter or to the common entry point or agency information explaining its the criteria under section on 17, paragraph (c), clause making an initial disposition of	21980			
	by: Based on interview facility failed to ensi- were reported to the residents (R87) rev Findings include: R87's annual Minim 5/11/16, identified to problems with no re- understood and rec- all areas of daily livi titled Order Summa physician dated 6/2 diagnoses to includ Parkinson's disease R87's care plan rev resident is depende	and document review the ure injuries of unknown origine State agency (SA) for 1 of 3		Corrected per Director of Nursing		

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00108	B. WING		07/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
	Continued From par/t [related to] Lewy The care plan further physically abusive to Lewy Bodies, unspectively Bodie	ge 51 Bodies, Physical Limitations" or indicated "The resident has behaviors r/t dementia with ecified psychosis". Jursing progress notes ing: Sident tipped merry walker was found face down on floor, sident hit head/mouth on with was bleeding from loosing in [sik] the incident so we don't was trying to do at the time. If the incident so we don't was trying to do at the time. If the incident so we don't was trying to do at the time. If the incident in the floor work on her face. Received a small of the incident in the incident	21980			
	(DON) verified a rep the SA when R87 h 10/24/15. The DON considered it a major	8 a.m. the director of nursing port had not been submitted to ad an unwitnessed fall on indicated she had not or injury at the time because it R87 had a fractured jaw until a				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DETHAN	IY HOME	1020 LAR	K STREET			
DETHAN	IT HOWE	ALEXAND	PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21980	Continued From pa	ae 52	21980			
21980	day or two after the verified she had no state agency when had a fractured jaw typically report an ir fall when the reside. When interviewed of social services dire responsibility of over and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for allest neglect, exploitation the facility vulnerab given the scenario cognitively impaired fracture, SSD state guidelines." When it computer and the in observation, reside resulting injury; SSI so" regarding R87's unwitnessed fall. So had discussed the ibe a reportable inciprocedure for reportation or given by reading alinjury is considered and must be report	fall occurred. The DON to considered to report to the it became known that R87 from the fall; however, would nigury related to an unwitnessed ent is not cognitively intact. On 7/22/16, at 1:10 p.m. the ctor (SSD) verified the ersight for abuse prevention a SA. SSD indicated training d for many staff to submit VA office of Health Facility C (Minnesota Adult Abuse including nurse managers, nurses who worked the floor. Initial report was to be made eged or suspected abuse, and all things that fall under le adult (VA) policy. When of an unwitnessed fall of a diresident resulting in a direct	21980			
	injury was not obse source of the injury	rved by any person or the could not be explained by the				
		ne injury is suspicious because injury or the location of the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
	00108	B. WING		07/2	2/2016
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
BETHANY HOME		RIA, MN 56	308		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
electronic record beinguestions. On 7/22/16, at 1:56 had been reviewed with the continuous procedures for the facility policy title prevention Plan For Facilities updated 7/considered an injury be reported when be are present (1) The source of the any person or the sexplained by the (2) The injury is suspof the injury or the leinjury is located in any ulnerable to traumations observed at one par incidence of injuries. SUGGESTED METITHE The director of nursidevelop, review, and procedures to ensur are reported to the simmediately. The director of injuries inmediately. The director of the simmediately.	more time to review the fore answering any more p.m. SSD identified R87's fall with the interdisciplinary team edidn't think it was a serious explained the fractured jaw ospitalization or affect R87's ore it was not a serious injury. n 7/22/16, at 1:56 p.m. the ted the report would be try Assurance meeting to or reporting. ded Ecumen's Abuse Minnesota Skilled Nursing (2015, identified "An injury is of unknown source and must oth of the following conditions to the following conditions on the injury was not observed by ource of the injury could not resident; and picious because of the extent ocation of the injury (e.g., the narea not generally a) or the number of injuries ticular point in time or the over time." HOD OF CORRECTION: ing (DON) or designee could do or revise policies and re injuries of unknown origin state agency (SA) irector of nursing (DON) or cate all appropriate staff on	21980			

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00108	B. WING		07/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	Y HOME		K STREET DRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21980	Continued From pa	ge 54	21980			
		ing (DON) or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-one				
21995	MN St. Statute 626 Maltreatment of Vul	557 Subd. 4a Reporting - nerable Adults	21995			8/9/16
	(a) Each facility sha ongoing written pro applicable licensing of suspected maltre facility has an interr mandated reporter requirements of this internally. However	reporting of maltreatment. all establish and enforce an ocedure in compliance with rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting section by reporting r, the facility remains uplying with the immediate ents of this section.				
	by: Based on interview facility failed to impl procedures to inclure reporting of injuries	and document review the ement abuse policies and de consistent, immediate of unknown origin to the State of 3 residents (R87) reviewed.		Corrected per Director of Nursing		
	Findings include:					
	Prevention Plan For Facilities updated 7 considered an injury be reported when be are present: (1) The	led Ecumen's Abuse r Minnesota Skilled Nursing /2015, identified " An injury is y of unknown source and must oth of the following conditions e source of the injury was not rson or the source of the				

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	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
BETHAI	NY HOME		K STREET DRIA, MN 56:	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21995	injury could not be (2) The injury is sus of the injury or the I injury is located in a vulnerable to traum observed at one paincidence of injuries R87's annual Minim 5/11/16, identified to problems with no reunderstood and recall areas of daily livititled Order Summa physician dated 6/2 diagnoses to includ Parkinson's disease R87's care plan revresident is dependentional, intellectur/t [related to] Lewy The care plan furthe physically abusive to Lewy Bodies, unspectively Bodies, unspec	explained by the resident; and spicious because of the extent ocation of the injury (e.g., the an area not generally a) or the number of injuries rticular point in time or the sover time." num Data Set (MDS) dated ong and short term memory ecall ability, was rarely to never juried extensive assistance for ing (ADL). The facility form ary Report signed by the 7/16, identified R87's medical e dementia with Lewy Bodies, e, and anxiety disorders. Tiewed 7/13/16, indicated, "The ent upon staff etc. for ual, physical and social needs Bodies, Physical Limitations" er indicated "The resident has behaviors r/t dementia with ecified psychosis". Tursing progress notes ing: sident tipped merry walker was found face down on floor, esident hit head/mouth on ath was bleeding from loosing in [sik] the incident so we don't was trying to do at the time. In the silfed up from the floor we was silfted up from the floor we was found face down on floor, we silfted up from the floor we was silfted up from the floor we was found face down on floor, we silfted up from the floor we was found face down on floor, we silfted up from the floor we was found face down on floor, we silfted up from the floor we was found face down on floor, we silfted up from the floor we was found face down on floor, we silfted up from the floor we was found face down on floor, we silfted up from the floor we was found face down on floor, we	21995			

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		00108	B. WING		07/	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
BETHANY HOME ALEXAND			RK STREET DRIA, MN 563	808		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21995	result of the fall." Sof R87's brain date following Clinical inta fall, initial encount with more confusion Nondisplaced fractus superior most maxithe nose. Review of the facility Adult Incident Log, reports to the SA, ir submitted related to unwitnessed fall on On 7/22/16, at 11:24 (DON) verified a report the SA when R87 h 10/24/15. The DON considered it a maje was unknown that F day or two after the verified she had not state agency when had a fractured jaw typically report an ir fall when the reside When interviewed a social services directly responsibility of over and reporting to the had been complete reports to OHFC (Complaints)/MAAR Reporting Center) social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and SSD indicated the immediately for alleging the social services and social services and SSD indicated the immediately for alleging the social services and social s	tudy results of an x-ray (CT) and 10/26/15, identified the formation: [R87] presents with ter. Nurse states -facial pain in than usual. Conclusion: ure thorough the anterior lla (upper jaw) at the base of my form titled 2015 Vulnerable which logged the facility indicated a report had not been to R87's fractured jaw from an				

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	IT OF PERIODENCIES		(VO) MULTIPL	E CONSTRUCTION	(V2) DATE	CLIDVEY
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	LETED
			A. DOILDING.			
		00108	B. WING		07/2	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DETHAN	IY HOME	1020 LAR	K STREET			
BETHAN	IT HOME	ALEXAND	RIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21995	Continued From pa	ge 57	21995			
	given the scenario of cognitively impaired fracture, SSD states guidelines." When recomputer and the irrobservation, resider resulting injury; SSI so" regarding R87's unwitnessed fall. So had discussed the ibe a reportable inciprocedure for reportaging by reading ald injury is considered and must be reported and must be re	le adult (VA) policy. When of an unwitnessed fall of a diresident resulting in a diresident resulting in a diresident resulting in a diresident resulting in a directed on SSD's lap top noident included no not unable to explain and the Diresponded, "I would think a fractured jaw due to an SD indicated the facility staff noident and had not found it to dent. SSD verified the usual ting an injury of unknown bout the facility policy: An an injury of unknown source ed when both of the following ent: (1) The source of the rived by any person or the could not be explained by the ne injury is suspicious because injury or the location of the effore answering any more				
	had been reviewed (IDT) and stated,"w injury." SSD further did not result in a he	p.m. SSD identified R87's fall with the interdisciplinary team re didn't think it was a serious explained the fractured jaw ospitalization or affect R87's fore it was not a serious injury.				
	administrator indica	on 7/22/16, at 1:56 p.m. the steed the report would be ity Assurance meeting to for reporting.				
	The director of nurs	THOD OF CORRECTION: sing (DON) or designee could d/or revise policies and				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00108	B. WING		07/2	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHAN	IY HOME		K STREET PRIA, MN 56	308		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21995	procedures to ensurare reported to the immediately. The codesignee could edut the policies and proof The director of nurs develop monitoring compliance.	re injuries of unknown origin state agency (SA) lirector of nursing (DON) or cate all appropriate staff on	21995			

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