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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z9J3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245578**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936670200**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY RESIDENCE AND REHABILITATION CENTER**
(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/04/2012**

6. DATE OF SURVEY **07/10/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 08/07/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/14/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245578
August 14, 2015

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

Dear Mr. Kallstrom:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 3, 2015 the above facility is certified for:

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

Your facility's Medicare approved area consists of all 66 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 2231

August 10, 2015

Ms. Laura Preheim, Administrator
Tuff Memorial Home
505 East 4th Street
Hills, Minnesota 56138

RE: Project Number S5548024

Dear Ms. Preheim:

On July 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 25, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 7, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 25, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 20, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 25, 2015, effective July 20, 2015 and therefore remedies outlined in our letter to you dated July 2, 2015, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245578	A. Building B. Wing	7/10/2015

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **07/10/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **07/10/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/10/2015**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/10/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **07/10/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/10/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/10/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/10/2015**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **07/10/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/10/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	08/07/2015	30923	07/10/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/28/2015			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245578	01 - BETHANY COVENANT HOME	8/4/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	08/03/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/kfd	08/07/2015	28120	08/4/2015
Reviewed By CMS RO				

Followup to Survey Completed on: 5/27/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Z9J3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00167

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(L1) **245578**
2.STATE VENDOR OR MEDICAID NO.
(L2) **936670200**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY RESIDENCE AND REHABILITATION CENTER**
(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/04/2012**

6. DATE OF SURVEY **05/28/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **66** (L18)

13.Total Certified Beds **66** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 06/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/07/2015 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
09/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 10, 2015

Mr. Jon Sondegaard, Administrator
Bethany Care Center
2309 Hayes Street Northeast
Minneapolis, Minnesota 55418

RE: Project Number S5578025

Dear Mr. Sondegaard:

On May 28, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 7, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 28, 2015 (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 November 28, 2015 (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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING _____ B. WING _____	05/28/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status;	F 272		6/29/15

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

Electronically Signed | 06/18/2015

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

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	245578	A. BUILDING _____ B. WING _____	05/28/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 1 Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurate for 1 of 3 residents (R40) reviewed for dental status and services. Findings include: R40 was observed on 5/26/15, at 5:14 p.m. seated on the edge of bed watching television and during the conversation it was noted she had several missing teeth on both back lower jaw sides and the front lower jaw. In addition the remaining teeth noted to have heavy tartar buildup around them. When asked if she had any chewing or eating problem R40 stated "I am missing several teeth I just gum the food." R40 was admitted to the facility on 5/10/14, with diagnoses including congestive heart failure (CHF), cataract and was currently enrolled to	F 272	4a) MDS corrected for the two resident¿s R2 and R40. Monitored by DNS b) Reviewed and updated policy and procedure. Monitored by DNS c) Nursing staff educated regarding how MDS/Careplan and overall assessments work together to help ensure the accuracy and coordination to ensure that the MDS and then the careplan reflect accurate information. Monitored by DNS d) Audits will be completed on 10% of all MDS¿s in regards to oral care assessments q week for 2 weeks and 10% of all MDS¿s completed in a 2 week period for 2 weeks. Then 10% of all MDS¿s completed in a month for 5	

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F 272	Continued From page 2 hospice obtained from Admission Record printed 5/28/15. R40's annual comprehensive MDS dated 5/6/15, indicated R40 was independent with personal hygiene, had no behaviors which included rejection of cares and had intact cognition. In addition the Oral/Dental section was left blank on the MDS. R40's annual MDS dated 5/6/15, indicated resident was still independent personal hygiene, no refusal of cares, and on the dental section "None of the above were present" which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. The MDS lacked evidence of a comprehensive assessment for the lack of teeth. R40's Care Area Assessment (CAA) dated 5/6/15, did not trigger a dental CAA for the lack of teeth and oral hygiene. The facility did not identify how the staff was to maintain or improve R40's oral functional status. R40's ADL care plan dated 5/12/15, did not address the assistance R40 required with oral hygiene and did not mention R40's missing teeth and/or her dental concerns. Review of documents revealed the following: -Apple Tree Dental MDS 3.0 Oral/Dental Assessment Form dated 5/30/14, indicated R40 had full upper dentures and partial lower dentures. The assessment indicated R40 required supervision with daily oral care. -Apple Tree Dental 3.0 Oral/Dental Assessment Form dated 4/20/15, indicated "unable to	F 272	months. Monitored by DNS/ADNS	

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examine patient [pt.] won't cooperate." Although the assessment had indicated R40 had refused the assessment at the time and did not attempt another assessment when completing the annual MDS dated 5/6/15.
-Nutritional Assessment dated 5/7/15, indicated R40 had no problems with chewing.

On 5/28/15, at 9:16 a.m. when asked about R40's care needs nursing assistant (NA)-F stated R40 required limited assistance and would only need set up with brushing her teeth. When asked about dental cares NA-F was not sure if R40 had dentures and if she had any missing teeth.

On 5/28/15, at 12:45 p.m. the director of nursing (DON) verified the annual MDS dated 5/6/15, was not accurate and verified a care plan had not been developed to reflect R40's dental status with missing teeth and dentures and the care neither addressed oral hygiene cares.
According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, directed the facility to assess the oral status of a resident as follows:
"Steps for Assessment
1. Ask the resident about the presence of chewing problems
or mouth or facial pain/discomfort.
2. Ask the resident, family, or significant other whether the
resident has or recently had dentures or partials. (If
resident or family/significant other reports that the resident
recently had dentures or partials, but they do not have
them at the facility, ask for a reason.)

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F 272	Continued From page 4 3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment. 4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth. 5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present. 6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues."	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279		6/29/15

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F 279	Continued From page 5 needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive care plan that included monitoring the dialysis fistula for a positive bruit and thrill for 1 of 1 residents (R51) receiving hemodialysis. In addition the facility failed to develop a comprehensive care plan for 2 of 3 residents (R2, R16) reviewed for dental concerns, and 1 of 5 residents (R16) for repeated refusals of cares and showers. Findings include: R51 was admitted to the facility 1/16/15, with admission diagnoses of End Stage Renal Disease (ESRD) on hemodialysis. lower extremity limb amputation, and diabetes mellitus stage II. The Care Plan (CP) dated 1/16/15, indicated R51 required hemodialysis on Monday, Wednesday, and Friday, related to ESRD. The CP directed the staff to assist in transportation to and from dialysis, and directed the staff to assess the dialysis fistula access site to inspect for any signs	F 279	2 a) Changes made to careplan for R16 and R51 to reflect areas in non-compliance.Monitored by DNS b)Reviewed and updated policy and procedure for care planning. Monitored by DNS c) Nursing staff reeducated regarding initiating a new focus for a resident, updating, and making changes to careplans. LN¿s also reeducated regarding expectation for monitoring of all dialysis residents. Monitored by DNS d) Random audits of careplans 10% of census, 1x/wk for 1 month, then 2x/month for 1 month, then 1x/month for 4 months. Monitored by DNS/IDT	

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or symptoms of infection to access site: Redness, Swelling, Warmth, Drainage. Monitor and document for signs and symptoms of bleeding/hemorrhage. bacteremia, septic shock. observe for signs of infection at access site, observe for potential for bleeding. communicate with dialysis team as needed if complications occur. Access site is fistula in right arm. In case of bleeding, apply pressure and call 911. Explain and reinforce to the resident the importance of maintaining the diet ordered, encourage the resident to comply. explain risks and consequences of refusal/benefits of compliance. The care plan lacked direction to monitor the dialysis fistula for presence of positive bruit and thrill (A dialysis fistula must be monitored for ongoing function, a positive bruit (a roaring or whooshing sound indicated blood flow through the fistula, heard with a stethoscope) and thrill (a buzzing feeling of blood rushing past, palpation of pulse in dialysis fistula), if the bruit and thrill are not present, the physician should be notified immediately, and medical intervention could include, blood clot removal, or dialysis fistula revision (surgery).

The admission Care Area Assessment (CAA) dated 1/23/15, indicated R51 received a therapeutic renal diet due to her diagnosis of ESRD, had little interest or pleasure in doing things as expressed during interview. R51 also yelled and swore at staff when upset, that was resident's baseline. R51 spent much of the time with peers outside smoking or socializing. Also goes out for dialysis and clinic visits with family.

The Medication Administration Record (MAR) dated 5/1/15, directed staff to call for the dialysis reports on Tuesday, Thursday and Saturday, but

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lacked direction to check for a positive bruit and thrill.

The Treatment Administration Record (TAR) dated 5/1/15, lacked direction to check for a positive bruit and thrill.

Medical record review on 5/28/15, at 12:05 p.m. revealed the Order Summary Report dated 5/1/15, directed staff to provide Coumadin (a blood thinning medication) and to monitor the INR (a blood clotting test that monitors the effectiveness of Coumadin). But lacked direction to check for a positive bruit and thrill

The Medication Review Report dated 5/28/15, indicated renal diet, regular consistency. "Call dialysis and ask for run information and weights on Tuesday, Thursday and Saturday. That must be done and document weights in Weight section of the electronic medical record." But lacked direction to check for a positive bruit and thrill.

The quarterly Minimum Data Set (MDS) dated 4/22/15, indicated a moderate cognitive impairment, R51 rejected care four to six days in the review period, was independent with activities of daily living, was unsteady by able to stabilize without assistance from staff.

On 5/28/15, at 1:20 p.m. registered nurse (RN)-D verified the facility had failed to develop a comprehensive care plan, that included to check and document the bruit and thrill of the dialysis fistula. RN-D stated the fistula was in the right upper arm, but "we are not documenting it and we should be. I float all over the building and we do document for the bruit and thrill for the only other dialysis resident (living upstairs)." RN-D further

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F 279	Continued From page 8 stated, "Thank you for bringing that to our attention, we should be doing that because she has trouble with the shunt and takes the dressings off so it bleeds." RN-D verified she had not been documenting or checking for the bruit and thrill. -At 1:30 R51 had just showered, was willing to interview and allow fistula to be observed by not palpated by surveyor. -At 2:00 p.m. the director of nursing (DON), verified that the bruit and thrill monitoring and documentation were a standard of dialysis fistula care, and should have been included in a comprehensive care plan. The Dialysis Policy dated 11/95 and revised 6/14, directed the staff.... 5. Bethany Staff will communicate with dialysis any concerns regarding access site. The Shunt (fistula) will be checked every shift for bruit, this will be monitored and documented on the treatment sheets for each individual resident. The facility's MDS/Care Planning Policy dated 6/12, provided "an interdisciplinary pre-care conference is held monthly to assist in the coordination and accuracy of the plan of care and the other components in the clinical record." The policy further provided that the comprehensive plan of care "must list measurable objectives" to meet the resident's needs identified in the assessment. R16's Admission Record indicated R16 was admitted to facility on 1/31/14, with diagnoses including epilepsy with recurrent seizure, high cholesterol, vascular dementia, aphasia (difficulty with communication) due to stroke, and paralysis on one side of body.	F 279		

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The quarterly MDS dated 5/6/15, indicated R16 was cognitively intact but had problem with communication related to history of stroke. The MDS further indicated R16 had chronic pain and had episodes of rejecting cares and treatments.

On 5/27/15, at 12:56 p.m. R16 was observed in room with the activities director, who was inviting R16 to join residents' activity scheduled for the afternoon. The activities director stated R16 would sometimes refuse group activities because R16 preferred to do activities on his own like reading and watching television shows. R16 was calm, pleasant in mood and was heard stating willingness to join the afternoon group activity.

During interview on 5/28/15, at 9:17 a.m. R16 had difficulty answering when asked about shower refusals. However, R16 replied "yea" when asked if there had been medication refusal. When asked why medication was refused, R16 touched neck and stated it hurts. R16 answered "no" when asked if the medication he kept refusing was changed.

On 5/28/15, at 9:22 a.m. RN-D stated R16 had been refusing to take Lipitor (a medicine to treat high cholesterol level) many times. RN-D stated R16 associated the Lipitor with neck pain. RN-D further stated R16 started to complain of neck pain since Lipitor was started almost a month ago on 4/30/15. RN-D claimed she "just notified the nurse practitioner yesterday" on 5/27/15 about R16 refusing the Lipitor. RN-D also confirmed R16's shower refusals as documented in nurses' notes but RN-D was not sure why R16 kept refusing take showers. RN-D admitted that a care plan was not developed to address R16's refusals

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F 279	Continued From page 10 of medications and showers, despite R16 having been known to have so many rejections of cares and treatments. On 5/28/15, at 9:58 a.m. the director of nursing stated she expected R16's rejections of care to have been addressed in a care plan. The facility's MDS/Care Planning Policy dated 6/12, directed staff to develop a comprehensive care plan within seven days from the completion of a comprehensive assessment. R43 R43's Admission Record (AR) printed on 5/28/15, indicated R43 was admitted to facility on 3/20/2012. The AR listed R43's diagnoses including major depressive disorder and unspecified schizophrenia (mental disorder affecting a person's ability to think, feel and act). R43's MAR dated 5/15, indicated R43 had the following medications: Sertraline Hydrochloride 200 milligrams (mg) by mouth one time a day for depression; Trazodone Hydrochloride 100 mg by mouth one time a day for depression; Wellbutrin XL 150 mg by mouth one time a day for depression; and Geodon 60 mg by mouth one time a day for schizophrenia. The Analysis of Findings section of the CAA dated 2/6/15, indicated R43 was on anti-psychotic and antidepressants, but CAA did not specify what behaviors and mood symptoms R43 manifested. The CAA indicated R43 was at risk for falls related to the use of anti-psychotic and antidepressants.	F 279		

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The latest quarterly MDS dated 4/29/15, indicated R43 had no cognitive impairment. The MDS further indicated R43 had mild depression.

R43's care plan was first initiated on 10/4/12, and was last reviewed on 5/5/15. The care plan indicated R43's use of psychotropic medications. The care plan directed staff to monitor and record occurrence of target behaviors noted as the number of "times [R43] expresses feelings of psychosis" and number of "verbal outbursts" every shift. The care plan further directed staff to note changes in mood noted as "sleep pattern, fatigue, appetite, ability to concentrate, participate in activities, crying." However, the care plan did not elaborate R43's specific target behaviors and depressive symptoms to be monitored. The care plan also did not address gradual dose reduction for the psychotropic medications. The care plan indicated R43 was at risk for falls and directed staff to "observe for ADR [adverse drug reaction] related to [R43's] psychotropic med use" but did not specify how or ADRs in relation to falls will be monitored.

On 5/28/15, at 9:27 a.m. RN-D stated that for more than a year now, she had been mainly assigned to care for residents in the first floor of facility to include R43. RN-D stated she did not know why R43 was on anti-psychotic and anti-depressants. RN-D denied monitoring R43 for any symptoms, including resident-specific target behaviors or side effects related to the use of psychotropic medications. RN-D admitted she was not checking monthly orthostatic blood pressures to monitor for side effects of psychotropic medications.
-At 10:08 a.m., the director of nursing (DON)

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F 279	Continued From page 12 stated, "We are not very good in putting resident-specific target behaviors and would improve on that." DON confirmed the current interventions with regard to monitoring target behaviors and side effects in R43's care plan were not specific to R43. The facility's MDS/Care Planning Policy dated 6/12, provided "an interdisciplinary pre-care conference is held monthly to assist in the coordination and accuracy of the plan of care and the other components in the clinical record." The policy further provided that the comprehensive plan of care "must list measurable objectives" to meet the resident's needs identified in the assessment. R2 R2 on 5/26/15, at 2:06 p.m. during interview when asked if she had any chewing or eating problems R2 stated "I have four teeth and they are rotten I guess I will be wearing false teeth very soon a few weeks ago I went to the dentist very far out there and the dentist said he was too busy. They checked the teeth and sent me home with the tooth I wanted to be pulled ..." -At 3:00 p.m. during general observations R2 was observed to have multiple missing teeth, some of the teeth were discolored and had brown spots buildup around them. R2 was admitted to the facility on 1/16/15, with diagnoses including depressive disorder, anemia,	F 279		

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senile dementia, secondary Parkinsonism, diabetes, cataract, and schizophrenia obtained from the Admission Record dated 1/16/15.

R2's admission MDS dated 4/22/15, identified R2 was independent with personal hygiene, had no behaviors which included rejection of cares and had intact cognition. In addition the MDS indicated on the dental section "mouth or facial pain, discomfort or difficulty with chewing."

R2's ADL care plan dated 1/30/15, identified resident with an ADL self-care performance deficit and required supervision/set-up with bathing at times. The care plan indicated R2 was independent with toileting and was continent of bowel and bladder. The care plan directed staff to encourage resident to participate to the fullest extent possible with each interaction. The care did not address R2's dental concerns and oral hygiene.

R2's ADL CAA's dated 1/27/15, indicated resident required supervision and set-up at times with bathing and was independent with all other ADLs. The CAA's did not address R2's oral hygiene care and the oral concerns.

On 5/27/15, at 1:40 p.m. when asked what assistance R2 required nursing assistant (NA)-C stated R2 was independent with cares and at times when she needed assistance would use the call light. When asked how she knew what assistance R2 required NA-C reached out to her pocket and retrieved nursing assistant assignment sheet which indicated R2 was independent with grooming. The NA assignment sheet did not address R2's dental concerns and neither did not address oral hygiene cares.

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F 279	Continued From page 14 On 5/28/15, at 12:33 p.m. the DON verified R2's care plan did not address oral hygiene care. DON further stated she would have expected the MDS nurse to develop the care plan which would reflect the care needed.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 1 of 1 resident (R58) in the sample who was observed for activities of daily living (ADL's). Findings include: On 5/28/15, at 8:56 a.m. R58 was observed in her room lying down in her bed, head of bed down in a flat position. Nursing assistant (NA)-A was in room with R58. NA-A was observed to be offering orange juice with a straw to R58, head of bed was down. R58 took two sips with a straw and refused. NA-A then offered R58 water in a glass with a straw. R58 took two sips with a straw and refused. R58's head of bed was down throughout the offering of the fluids. R58 was admitted to the facility on 1/7/13. R58's diagnoses included dysphagia (difficult	F 282	5a) All staff updated with current plan of care for resident R 58 and reviewed importance of following assignment sheet/plan of care. Careplan updated on R51 to include the monitoring of fistula qd. Monitored by DNS b) Reviewed policy and procedures for updating careplans.Monitored by DNS c) All nursing staff re-educated with importance of following the plan of care and updating as needed. Monitored by DNS d) Audits completed on 10% of residents care plans in facility q week for 4 weeks and then 10% of residents in facility q 2 weeks for 4 weeks and then q 4 weeks for (12 weeks) 3 months. Monitored by DNS Audits will be completed on all dialysis	6/29/15

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F 282	Continued From page 15 swallowing) and aphasia (difficult speaking). R58's Minimum Data Set (MDS) dated 4/8/15, indicated R58 needed extensive assistance with bed mobility, total assistance with transfers, dressing, toileting, eating and personal hygiene. R58's plan of care dated 4/14/15, indicated R58 should not use straws, must be sitting upright with all po intakes, encouraged chin tuck with swallowing, and needs supervision and assistance with feeding all po intakes. R58's Physician's Orders dated 5/7/15, indicated "no straws with liquids, sips from cup only; needs to be sitting upright with all po [oral] intake; encourage chin tuck with swallowing; needs supervision/assist with feeding with all po intake." Physician's Orders further indicated R58 was on regular diet with regular texture and consistency, often refused oral intake and was on tube feedings. The undated NA Care Sheet directed staff not to use straws with R58, R58 must be seated upright with all po intakes, encourage R58 to perform the chin tuck with swallowing and that R58 needs supervision and assistance with feeding all po intake. On 5/28/15, at 10:22 a.m. NA-A was interviewed. NA-A stated that she was not supposed to use a straw with R58 and that she was supposed to make sure R58 was sitting upright before providing any oral intake. NA-A stated, "I tried to give R58 juice without a straw and she would not take it, so decided to use a straw." NA-A further stated she tried to raise head of bed and bed would not go up.	F 282	residents on admission and q month for 6 months for documentation of fistula. Monitored by DNS/ADNS	

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F 282	Continued From page 16 On 5/28/15, at 10:49 a.m. director of nursing (DON) was interviewed. She did not expect her staff to offer fluids to R58 while lying down or use straw.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor and document the right forearm dialysis fistula for 1 of 1 resident (R51) who received hemodialysis. In addition the facility failed to develop a comprehensive care plan for 1 of 3 residents (R16) who had repeated refusals of cares and showering, Findings include: R51 was admitted to the facility 1/16/15, with admission diagnoses of End Stage Renal Disease (ESRD) on hemodialysis, lower extremity limb amputation, and diabetes mellitus stage II. The Care Plan (CP) dated 1/16/15, indicated R51 required hemodialysis on Monday, Wednesday, and Friday, related to ESRD. The CP directed the staff to assist in transportation to and from	F 309	6a) Careplan for R16 was changed and reflects resident¿s refusal of bathing and added interventions for staff to try to attempt to meet bathing needs of resident. Part 2 was not corrected for this resident as resident discharged herself AMA prior to facility being able to correct plan of care. However plan of care checked for other dialysis residents to make sure that LN is monitoring shunt/fistula. Monitored by DNS b) Reviewed policy and procedure. Monitored by DNS c) All nursing staff reeducated with how to make updates or changes on careplans and reviewed with NAR¿s what they should be doing when resident¿s refuse	6/29/15

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F 309	Continued From page 17 dialysis, and directed the staff to assess the dialysis fistula access site to inspect for any signs or symptoms of infection to access site: "Redness, Swelling, Warmth, Drainage. Monitor and document for signs and symptoms of bleeding/hemorrhage. bacteremia, septic shock. Observe for signs of infection at access site, observe for potential for bleeding. communicate with dialysis team as needed if complications occur. Access site was a fistula in right arm. In case of bleeding, apply pressure and call 911. Explain and reinforce to the resident the importance of maintaining the diet ordered, encourage the resident to comply. Explain risks and consequences of refusal/benefits of compliance." The care plan lacked direction to monitor the dialysis fistula for presence of postive bruit and thrill. The admission Care Area Assessment (CAA) dated 1/23/15, indicated R51 received a therapeutic renal diet due to her diagnosis of ESRD, had little interest or pleasure in doing things as expressed during interview. R51 also yelled and swore at staff when upset, this was resident's baseline. R51 spent much of the time with peers outside smoking or socializing. Also goes out for dialysis and clinic visits with family. The quarterly Minimum Data Set (MDS) dated 4/22/15, indicated a moderate cognitive impairment, R51 rejected care four to six days in the review period, was independent with activities of daily living, was unsteady by able to stabilize without assistance from staff. Medical record review on 5/28/15, at 12:05 p.m. revealed: The Order Summary Report dated 5/1/15,	F 309	cares. Monitored by DNS d) Audits to be done for 10% of residents in regards to changes in behavior and refusal of medications q week for 4 weeks then q 2 weeks for 1 month and q month for 4 months. Monitored by DNS Audits to be done on all new admissions with dialysis for 6 months to ensure that all areas are covered in the care plan and reflective in the NAR sheets/MAR/TAR as appropriate. Monitored by DNS	

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F 309	Continued From page 18 directed staff to provide Coumadin (a blood thinning medication) and to monitor the INR (a blood clotting test that monitors the effectiveness of Coumadin). But lacked direction to check for a positive bruit and thrill The Medication Administration Record (MAR) dated 5/1/15, directed staff to call for the dialysis reports on Tuesday, Thursday and Saturday, but lacked direction to check for a positive bruit and thrill. The Treatment Administration Record (TAR) dated 5/1/15, lacked direction to check for a positive bruit and thrill. Medication Review Report dated 5/28/15. indicated Renal diet, regular consistency. Call dialysis and ask for run information and weights on Tuesday, Thursday and Saturday. This must be done and document weights in Weight section of the electronic medical record. But lacked direction to check for a positive bruit and thrill. On 5/28/15 at 1:20 p.m. registered nurse (RN)-D verified that the facility had failed to document the bruit and thrill of the dialysis fistula. RN-D stated the fistula was in the right upper arm, "but we are not documenting it and we should be. I float all over the building and we do document for the bruit and thrill for the only other dialysis resident (living upstairs)." RN-D further stated, "Thank you for brining that to our attention, we should be doing that because she has trouble with the shunt and takes the dressings off so it bleeds." RN-D verified she had not been documenting or checking for the bruit and thrill. -At 1:30 R51 had just showered, was willing to interview and allow fistula to be observed by not	F 309		

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palpated by surveyor.
-At 2:00 p.m. the director of nursing (DON) verified the bruit and thrill monitoring and documentation were a standard of dialysis fistula care.

The Dialysis Policy dated 11/95 and revised 6/14, directed the staff....
"5. Bethany Staff will communicate with dialysis any concerns regarding access site. The Shunt (fistula) will be checked every shift for bruit, this will be monitored and documented on the treatment sheets for each individual resident."

R16's Admission Record indicated R16 was admitted to facility on 1/31/14, with diagnoses including epilepsy with recurrent seizure, high cholesterol, vascular dementia, aphasia (difficulty with communication) due to cerebrovascular disease, and paralysis on one side of body.

A review of nurses' progress notes dated 4/7/15 to 5/27/15, reveal the following rejections of care and then refusal of medications related to neck pain:
- From 4/7/15 to 5/27/15 or for almost two months, R16 did not have any showers. R16 was noted either to have "refused" or "declined" shower on the scheduled bath days. The nurse's notes dated 5/26/15, also described R16 as "non-compliant."
-On 5/18/15 and 5/19/15, R16 complained of neck pain one time each day. R16 received Tylenol (which the doctor prescribed for fever) for each pain complaint.
-On 5/20/15, R16 complained of neck pain four times and had received Tylenol for each neck pain episode and also used warm blanket to wrap

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F 309	Continued From page 20 around neck. R16 started to refuse Lipitor, associating the neck pain to the Lipitor. The nurse practitioner (NP) was updated regarding R16's "frequent" neck pain complaints. -On 5/21/15, R16 again complained of neck pain and was given Tylenol. A care conference was also conducted where R16 "declined invitation to conference." R16 was noted to be "independent with ADLs [activities of daily living] and requires set up with bathing only." R16 was also noted to have complaints of neck pain pain related to sore muscles. The care conference did not address R16's many refusals for bathing and did not address R16's neck pain complaints in relation to Lipitor. -On 5/22/15, R16 complained of neck pain three times and received Tylenol for relief. R16 refused to take Lipitor. -On 5/23/15, R16 complained of neck pain and received Tylenol two times. -On 5/24/15, R16 complained of neck pain and received Tylenol one time -On 5/25/15, R16 complained of neck pain and received Tylenol two times. R16 refused to take Lipitor. -On 5/26/15, R16 continued to refuse Lipitor. R16 "refused to take Lipitor. [R16] this med caused [R16's] neck pain. The quarterly MDS dated 5/6/15, indicated R16 had was cognitively intact but had problem with communication related to history of stroke. The MDS further indicated R16 had episodes of rejecting cares and treatments. The care plan dated 5/8/15, did not address R16's history of rejecting cares and treatments and R16's potential for having pain.	F 309		

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The physician's current Order Summary Report (OSR) printed on 5/28/15, indicated R16 had a bath schedule every Tuesday. The OSR also directed staff to give Lipitor 20 milligrams (mg) by mouth one time a day for high cholesterol level and further directed staff to give Q-PAP (Tylenol) Liquid 160 mg/5 ml by mouth every 4 hours for fever.

On 5/28/15, at 9:17 a.m. R16 had a hard time finding words to answer when asked if R16 refused showers. However, R16 readily answered "yea" when asked if R16 refused Lipitor. R16 touched neck and voiced "hurts" when asked for reason of Lipitor refusal. When asked if the medication (Lipitor) had been changed, R16 answered, "no."

On 5/28/15, at 9:22 a.m. RN-D confirmed R16's shower refusals as documented in nurses' notes. RN-D stated she was not sure why R16 refused showers. RN-D also stated R16 had been refusing to take Lipitor many times. RN-D stated R16 associated the Lipitor with neck pain. RN-D confirmed R16 was still on Lipitor and there had been no changes made by the NP even with last visit on 5/27/15. RN-D stated she will call the NP again to ask if R16's order for Lipitor needed change.

On 5/28/15, at 9:58 a.m. the director of nursing stated R16's rejections of care should have been addressed in the care plan.

The facility's MDS/Care Planning Policy dated 6/12, directed staff to develop a comprehensive care plan within seven days from the completion of a comprehensive assessment. In addition the policy provided, "an interdisciplinary pre-care

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F 309	Continued From page 22 conference is held monthly to assist in the coordination and accuracy of the plan of care and other components in the clinical record." The policy further provided that a comprehensive plan of care must be reviewed and revised by an interdisciplinary team as determined by the resident's needs at least quarterly and within seven days of the revision of the comprehensive resident assessment.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance for 1 of 3 residents (R40) reviewed for dental status and services. Findings include: R40 was observed on 5/26/15, at 5:14 p.m. seated on the edge of bed watching television and during the conversation it was noted she had several missing teeth on both back lower jaw sides and the front lower jaw. In addition, the remaining teeth noted to have heavy tartar buildup around them. When asked if she had any chewing or eating problem R40 stated "I am missing several teeth I just gum the food." R40 was admitted to the facility on 5/10/14, with diagnoses including congestive heart failure	F 311	11 a) Care plan updated for R40. Monitored by DNS b) Oral care Policy and Procedure reviewed and updated. Monitored by DNS c) Staff educated regarding updating of care plan and importance of accuracy of information. Monitored by DNS d) Audits will be completed on 10% of all careplans in regards to oral care assessments q week for 2 weeks and 10% of all careplans completed in a 2 week period for 2 weeks. Then 10% of all careplans completed in a month for 5 months. Monitored by DNS/ADNS	6/29/15

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(CHF), cataract and was currently enrolled to hospice obtained from Admission Record printed 5/28/15.

R40's annual comprehensive MDS dated 5/6/15, indicated R40 was independent with personal hygiene, had no behaviors which included rejection of cares and had intact cognition. In addition the Oral/Dental section was left blank on the MDS. R40's annual MDS dated 5/6/15, indicated resident was still independent personal hygiene, no refusal of cares, and on the dental section "None of the above were present" which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing. The MDS lacked evidence of a comprehensive assessment for the lack of teeth.

R40's Care Area Assessment (CAA) dated 5/6/15, did not trigger a dental CAA for the lack of teeth and oral hygiene. The facility did not identify how the staff was to maintain or improve R40's oral functional status.

R40's ADL care plan dated 5/12/15, did not address the assistance R40 required with oral hygiene and did not mention R40's missing teeth and/or her dental concerns. The plan of care laced evidence of interventions put into place to minimize the tartar build-up, assistance needed for set up if any, and how the facility was to maintain R40's highest practicable outcome for the oral status.

Review of documents revealed the following:
-Apple Tree Dental MDS 3.0 Oral/Dental

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F 311	Continued From page 24 Assessment Form dated 5/30/14, indicated R40 had full upper dentures and partial lower dentures. The assessment indicated R40 required supervision with daily oral care. -Apple Tree Dental 3.0 Oral/Dental Assessment Form dated 4/20/15, indicated "unable to examine patient [pt.] won't cooperate." Although the assessment had indicated R40 had refused the assessment at the time and did not attempt another assessment when completing the annual MDS dated 5/6/15. -Nutritional Assessment dated 5/7/15, indicated R40 had no problems with chewing. On 5/28/15, at 9:16 a.m. when asked about R40's care needs nursing assistant (NA)-F stated R40 required limited assistance and would only need set up with brushing her teeth. When asked about dental cares NA-F was not sure if R40 had dentures and if she had any missing teeth. On 5/28/15, at 12:45 p.m. the director of nursing (DON) verified the annual MDS dated 5/6/15, was not accurate and verified a care plan had not been developed to reflect R40's dental status with missing teeth and dentures and the care neither addressed oral hygiene cares.	F 311		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		6/29/15

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F 329	Continued From page 25 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility did not ensure specific target behaviors were monitored, adequate side-effects monitoring was in place, and gradual dose reduction was attempted for 1 of 5 residents (R43) reviewed for psychotropic medications. Findings include: R43 The Analysis of Findings section of the Care Area Assessment (CAA) dated 2/6/15, indicated R43 was on anti-psychotic and antidepressants, but CAA did not specify what behaviors and mood symptoms R43 manifested. The CAA indicated R43 was at risk for falls related to the use of anti-psychotic and antidepressants. The latest quarterly Minimum Data Set (MDS)	F 329	10a) Target behaviors changed and request sent to physician for a dose reduction in R-43 medication. (Antipsychotic) Changes made to care plan to reflect non-pharmacological interventions for R62 and R46. Monitored by DNS b) Policy and Procedure reviewed.Monitored by DNS c) Staff educated on changes specifically related to these residents and on the process for ensuring specific target behaviors related to each resident, gradual dose. Reeducation and making sure that each resident on antipsychotic medications has non-pharmacological interventions specific to the individual	

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	245578	A. BUILDING _____ B. WING _____	05/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 329	Continued From page 26 dated 4/29/15, indicated R43 had no cognitive impairment. The MDS further indicated R43 had mild depression. R43's care plan last reviewed on 5/5/15, indicated R43's care plan for the use of psychotropic medications was first initiated on 10/4/12. The care plan directed staff to monitor and record occurrence of target behaviors noted as the number of "times [R43] expresses feelings of psychosis" and number of "verbal outbursts" every shift. The care plan further directed staff to note changes in mood noted as "sleep pattern, fatigue, appetite, ability to concentrate, participate in activities, crying." However, the care plan did not elaborate R43's specific target behaviors and depressive symptoms to be monitored. The care plan also did not address gradual dose reduction for the psychotropic medications. The care plan identified R43's risk for falls and directed staff to "observe for ADR [adverse drug reaction] related to [R43's] psychotropic med use" but did not specify how ADRs will be monitored. R43's Admission Record (AR) printed on 5/28/15, indicated R43 was admitted to facility on 3/20/2012. The AR listed R43's diagnoses including major depressive disorder and unspecified schizophrenia (mental disorder affecting a person's ability to think, feel and act). R43's Medication Admission Record (MAR) dated 5/15, indicated R43 had the following medications: Sertraline Hydrochloride 200 milligrams (mg) by mouth one time a day for depression; Trazodone Hydrochloride 100 mg by mouth one time a day for depression; Wellbutrin XL 150 mg by mouth one time a day for depression; and Geodon 60 mg by mouth one	F 329	resident. Monitored by DNS d) Facility will audit 5 current plus all new admissions residents q week until whole facility audit is complete on antipsychotics for proper target behaviors (appropriate for dx and individualized for resident), gradual dose reduction was attempted and when. Date the MD was notified and the response. Also that resident¿s plan of care has appropriate/individualized interventions. Monitored by DNS/ADNS	

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F 329	Continued From page 27 time a day for schizophrenia. On 5/28/15, at 7:34 a.m. R43 was interviewed and verbalized awareness of being on an anti-psychotic and antidepressant medications. However, R43 was not able to state any symptom being treated by the prescribed medications. -At 9:27 a.m. registered nurse (RN)-D stated that for more than a year now, she had been mainly assigned to care for residents in the first floor of facility to include R43. RN-D described R43 as "pretty stable." RN-D stated she did not know why R43 was on anti-psychotic and anti-depressants. RN-D denied monitoring R43 for any symptoms, including resident-specific target behaviors or side effects related to the use of psychotropic medications. RN-D admitted not checking monthly orthostatic blood pressures to monitor for side effects of psychotropic medications. -At 10:08 a.m., the director of nursing (DON) stated, "We are not very good in putting resident-specific target behaviors and would improve on that." DON confirmed the current interventions with regard to monitoring target behaviors in R43's care plan were not specific to R43. DON stated side effects of psychotropic medications should have been adequately monitored and recorded. DON further stated R43 had "not been to a Psych doctor lately" and so the primary doctor was supposed to be managing psych medications. DON stated a gradual dose reduction should have been attempted. The facility's Policy No. N-4 or Monitoring Psychoactive Medications dated 6/12, provided all psychoactive medications will be monitored on a "routine basis" to ensure compliance with regulatory guidelines. The policy directed staff to monitor target behaviors every shift and to	F 329		

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F 329	Continued From page 28 monitor side effects and document in nurses' notes. The policy also directed staff to "update physician and request dose reductions q [every] 6 months or per Pharmacist [sic] review."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the consultant pharmacist failed to identify irregularity for facility not monitoring resident-specific target behaviors and not having adequate side effects monitoring for 1 of 5 residents (R43) reviewed for psychotropic medications. Findings include: The Analysis of Findings section of the Care Area Assessment (CAA) dated 2/6/15, indicated R43 was on anti-psychotic and antidepressants. The CAA did not specify what behaviors and mood symptoms R43 manifested. The CAA also indicated R43 was at risk for falls related to the use of anti-psychotic and antidepressants.	F 428	3a) Fax sent/received to primary physician for R-62, with a copy of her medications and requesting him to look at all the medications for potential unnecessary medications or irregularities. Send changes back to facility or note that he reviewed the meds and the benefits outweigh the risks. Monitored by DNS b) Reviewed and updated policy and procedure for pharmacy medication review. Monitored by DNS c) Nursing staff educated with changes of procedure.Monitored by DNS d) Audits will be done for 10% of	6/29/15

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F 428	Continued From page 29 R43's care plan last reviewed on 5/5/15, indicated R43's care plan for the use of psychotropic medications was first initiated on 10/4/12. The care plan directed staff to monitor and record occurrence of target behaviors noted as the number of "times [R43] expresses feelings of psychosis" and number of "verbal outbursts" every shift. The care plan further directed staff to note changes in mood noted as "sleep pattern, fatigue, appetite, ability to concentrate, participate in activities, crying." However, the care plan did not elaborate R43's specific target behaviors and depressive symptoms to be monitored. The care plan identified R43's risk for falls and directed staff to "observe for ADR [adverse drug reaction] related to [R43's] psychotropic med use." R43's Admission Record (AR) printed on 5/28/15, indicated R43 was admitted to facility on 3/20/2012. The AR listed R43's diagnoses including major depressive disorder and unspecified schizophrenia (mental disorder affecting a person's ability to think, feel and act). R43's Medication Admission Record (MAR) dated 5/15, indicated R43 had the following medications: Sertraline Hydrochloride 200 milligrams (mg) by mouth one time a day for depression; Trazodone Hydrochloride 100 mg by mouth one time a day for depression; Wellbutrin XL 150 mg by mouth one time a day for depression; and Geodon 60 mg by mouth one time a day for schizophrenia. On 5/28/15, at 7:34 a.m. was interviewed and R43 verbalized awareness of being on an anti-psychotic and antidepressant medications. However, R43 was not able to state any symptom being treated by the prescribed medications.	F 428	pharmacy reviews per month for 6 months. Monitored by DNS/ADNS	

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F 428	Continued From page 30 -At 9:27 a.m. registered nurse (RN)-D stated that for more than a year now, she had been mainly assigned to care for residents in the first floor of facility to include R43. RN-D described R43 as "pretty stable." RN-D stated she did not know why R43 was on anti-psychotic and anti-depressants. RN-D denied monitoring R43 for any symptoms, including resident-specific target behaviors or side effects related to the use of psychotropic medications. RN-D admitted not checking monthly orthostatic blood pressures to monitor for side effects of psychotropic medications. -At 10:08 a.m., the director of nursing (DON) stated, "We are not very good in putting resident-specific target behaviors and would improve on that." DON confirmed the current interventions with regard to monitoring target behaviors in R43's care plan were not specific to R43. DON stated side effects of psychotropic medications should have been adequately monitored and recorded. DON further stated R43 had "not been to a Psych (psychologist, psychiatrist) doctor lately" and so the primary doctor was supposed to be managing psych medications. The Consultant Pharmacist (CP) stated during interview on 5/28/15, at 1:20 p.m. that she expected resident-specific target behaviors and side effects to be adequately monitored. The facility's Policy No. N-4 or Monitoring Psychoactive Medications dated 6/12, provided all psychoactive medications will be monitored on a "routine basis" to ensure compliance with regulatory guidelines. The policy directed staff to monitor target behaviors every shift and to monitor side effects and document in nurses' notes.	F 428		

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F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	7a) LN involved reeducated regarding	6/29/15

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F 431	Continued From page 32 review, the facility did not ensure medications were stored appropriately for 1 of 7 residents (R43), observed with medications at the bedside. Findings include: R43's Admission Record (AR) printed on 5/28/15, indicated R43 was admitted to facility on 3/20/2012. The AR listed R43's diagnoses to include major depressive disorder; unspecified schizophrenia (mental disorder affecting a person's ability to think, feel and act); and chronic obstructive pulmonary disease (COPD). R43's Medication Administration Record (MAR) dated 5/15, indicated R43 was on Dulera Aerosol 2 puffs inhale by mouth two times a day for COPD; Ventolin one puff inhale orally four times a day for COPD; and Spiriva inhale one time a day for COPD. The care plan dated 5/5/15, indicated R43 "declines to self-medicate pills and would like to self-admin [self-administer] nebs [nebulizers] after set-up by nurse" and nursing to store and document all medications. On 5/27/15, at 9:16 a.m., R43 was in room making cigarettes with the use of a small cigarette-making machine which was on R43's night stand. There were also three inhalers on top of the night stand, identified as Ventolin, Dulera and Spiriva. These inhalers were medications used to treat pulmonary diseases (breathing problems). R43 stated ability to use the inhalers by herself. -At 4:32 p.m. R43 was in room. The three inhalers remain on R43's night stand. R43 could not state when the inhalers were in the room but	F 431	regulation in regards to storage of medications. Monitored by DNS b)Review of policy and procedure for medication storage. Monitored by DNS c) Re-education of LN staff on medication pass/storage, need to remain with resident while they are taking medication and removing medication from room unless determined by IDT that resident is appropriate to self administer and store medications in room.Monitored by DNS d) Audits of 3 random staff on 3 random shifts per wk for 4 weeks, then q 2 weeks for 4 weeks and then q 4 weeks 12 weeks. Monitored by DNS/ADNS	

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F 431	Continued From page 33 stated nurses leave them for R43 to use. -At 4:40 p.m. registered nurse (RN)-D stated the inhalers in R43's room "were left by the night people." RN-D stated it was an error to keep the inhalers in R43's room. On 5/28/15, at 1:11 p.m. the director of nursing (DON) stated medications such as inhalers should not be kept in residents' rooms. The facility was unable to state if the resident had used the medications more than ordered by the physician. The facility's Storage of Medication policy dated 6/14, indicated "medications are not to be kept in the resident's room unless specifically ordered in writing by the attending physician." In addition, the policy provided that when medications are to be stored in a resident's room, medications will have a separate location that is locked and only the resident and licensed nurse to have a key, "to make sure other residents and visitors are kept safe."	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light was maintained in proper functioning order for 1 of 3 residents (R25) who was identified as being at	F 463	9a) Call light replaced with a functioning call light. All call lights checked in facility for proper functioning. Monitored by DNS	6/29/15

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F 463	Continued From page 34 risk for falls. Findings include: On 5/26/15, at 3:44 p.m. during R25's room observation, the call light was observed wrapped to the side rail when activated four times it was noted to be not light up outside the room and did not make a noise as other lights did when activated. When the white button was pushed inward, it just clicked. On 5/26/15, at 3:47 p.m. registered nurse (RN)-C came to room stated she was looking for R25 as she had R25's medications. At that time RN-C tried to activate the call light but was not able to. RN-C was observed take the call light off the wall the light outside the room lit up. Then plugged it to the wall and switched the call light in the empty bed to R25's side. When asked if R25 used the call light RN-C stated "Yes, she uses it." On 5/26/15, at 3:50 p.m. RN-C and maintenance staff returned both verified the call light R25's call light was not functioning. Maintenance staff left indicated she was going to get another one. -At 3:57 p.m. maintenance staff returned to the room with a single unit call light cord. When asked what was the problem with the other one she stated "When we have 2 splitters it shorts out the other one and we replaced it. -At 4:00 p.m. when asked if she used her call light R25 stated "I do I told someone it was not working" as R25 pointed to outside the room as she thought the light outside was not lighting up. R25 clapped and told surveyor "thank you." R25's fall Care Area Assessment (CAA) dated 9/16/14, indicated R25's primary diagnosis was	F 463	b)Policy and Procedure reviewed and updated. Monitored by DNS c)All staff reeducated regarding how and what to do if they discover broken equipment and which equipment needs immediate attention and which does not. Monitored by DNS/Administrator d) Staff will test 10 random call lights q week for 4 weeks then 10 random audits q 2 weeks and then 10 random audits q month. Monitored by DNS/Administrator/Maintenance	

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F 463	Continued From page 35 cerebral palsy and had chronic degenerative joint disease (DJD) pain and osteoporosis. The CAA indicated R25 required assist of one staff with all transfers and was able to stand but needs staff assistance to complete transfers safely. R25's fall care plan dated 9/24/14, identified R25 was at risk for falls related to cerebral palsy and history of falls. The care plan directed staff to "encourage to use the call light and wait for assistance with activities of daily living and to ensure the call light was within reach." Call light maintenance policy dated 6/5/13, directed "Maintenance staff will test call lights monthly and replace bulbs or cords as needed. Nursing staff will notify maintenance as necessary."	F 463		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure sanitary environment in 2 of 2 shared/common bathrooms reviewed for environmental concerns. This had the potential to affect 31 residents residing in the second floor. Findings include:	F 465	8a) Toilets cleaned and sanitized. Monitored by Housekeeper b) Policy and Procedure reviewed and updated. Monitored by DNS c) All staff educated with policy and procedure/education regarding cleaning of and disinfecting of toilets. Monitored by	6/29/15

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F 465	Continued From page 36 On 5/26/15, at 3:04 p.m. when asked if the building was clean, R76 stated "the bathroom on the floor needs to be cleaned more, there has been bowel movement [BM] on the toilet seat." R76's quarterly Minimum Data Set (MDS) dated 3/18/15, indicated R76 had intact cognition and was independent with toileting. On 5/28/15, at 7:53 a.m. to 8:05 a.m. the toilet seat on the shared bathroom located on the long hallway of 2 South by the nursing office was noted to have brown matter. R3 was observed going into the bathroom and came out briefly pants not zipped up and asked a staff to assist him. -At the same time the other bathroom located on the short hallway of the unit by the dining room was observed to have brown matter on the seat and several pieces of toilet paper on the floor around the toilet with brown/yellow matter cluttering the floor. -At 8:05 a.m. R30 was observed go into the toilet shut the door and was heard flush the toilet and came out. -At 8:06 a.m. the administrator verified both the seats and floor were not clean. When asked who was responsible for cleaning the shared bathrooms he stated housekeeping was at the facility daily until 3:00 p.m. and after nursing was supposed to make sure the common/shared toilets were kept clean as they were used by the residents in the unit who did not have toilets in their room. On 5/28/15, at 8:15 a.m. when asked who used the bathrooms/toilets in the room, NA-E stated any resident who was able to independently take them themselves to the toilet, did not have a toilet	F 465	DNS. d)Random audits of all public toilets in facility 3 times a wk for 4 wks, then 2 times a wk for 4 wks then wkly for 12wks. Monitored by DNS/Administrator/Housekeeping	

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F 465	Continued From page 37 in their room and at times the staff used the toilets to check and change residents who required assistance. When asked if residents from 2 North used the toilet NA-E stated "yes if they are in the dining room area." On 5/28/15, at 10:20 a.m. the housekeeping policy was requested but instead a Undated 2 South Weekly Cleaning Schedule was provided which directed "Everyday all bathrooms, public and private" were to be cleaned. The schedule did not indicate who was responsible for cleaning the common/shared toilets when housekeeping was not in the facility.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING **01 - BETHANY COVENANT HOME** B. WING _____	**05/27/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	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. At the time of this survey, Bethany Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/17/2015

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethany Care Center is a 2-story building with no basement. The building was constructed in 1960 and was determined to be of Type II(222) construction. The building is has a full fire sprinkler system in accordance with NFPA 13, 1999 Ed.. The facility has a fire alarm system with smoke detection in the corridors, by the smoke barrier doors, resident rooms and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 66 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029		8/3/15

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K 029	Continued From page 2 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect the residents. Findings include: During facility tour between 9:45 AM and 11:15 AM on 05/27/2015, observation revealed that one of the kitchen fire doors is missing the fire rated label. This deficient practice was verified by the administrator at the time of the inspection.	K 029	New door with appropriate fire rating label was ordered by Administrator on 6/2/2015. New door will be installed in place of current door. Date of Completion: 8/3/2015	