#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		N AND TRANSMITTAL ID: ZHIN						
	PART	I - TO BE COM	PLETED BY T	HE STATI	E SURVEY	AGENCY	1	Facility ID: 00913
1. MEDICARE/MEDICAID PROVIDER NO	).	3. NAME AND ADI		ſΥ			4. TYPE OF ACTION	I: <u>7 (</u> L8)
(L1) <b>245295</b>		(L3) BETHEL CA (L4) 420 MARSHA					1. Initial	2. Recertification
2.STATE VENDOR OR MEDICAID NO. (L2) <b>493226900</b>		(L4) 420 MARSH2 (L5) SAINT PAUL			(	L6) 55102	3. Termination 5. Validation	4. CHOW 6. Complaint
							7. On-Site Visit	9. Other
5. EFFECTIVE DATE CHANGE OF OWN	ERSHIP	7. PROVIDER/SUP				(L7)	8. Full Survey After (	Complaint
(L9)	<b>2015</b> (201)	01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA		
6. DATE OF SURVEY 02/08/		02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF 11 ICF/IID	14 CORF 15 ASC		FISCAL YEAR ENDIN	G DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	(L10)	04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	15 ASC 16 HOSPIC	TE	12/31	
2 AOA 3 Other		04 514	00 01 1/51	12 kile	10 11051 10	, <b>L</b>		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:					
From (a):		X A. In Complian	nce With		And/Or Ap	pproved Waivers Of Th	e Following Requirements:	
To (b):		Program Rec Compliance	-		2.	Technical Personnel	6. Scope of Ser	vices Limit
		*				24 Hour RN	7. Medical Dire	
12. Total Facility Beds	141 (L18)	1. A	cceptable POC			7-Day RN (Rural SNF		1 Size
13. Total Certified Beds	141 (L17)	B. Not in Com	pliance with Program	ı	5.	Life Safety Code	9. Beds/Room	
		Requirements a	and/or Applied Waiv	ers:	* Code:	A*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN					15. FACILI	TY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1	1) or 1861 (j) (1):	(L15)	
141								
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	HOW LTC CANCELL						
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY AGENCY A	PPROVAL	Date:
Susanne Reuss, Uni	t Supervisor	[(	02/08/2017	(L19)	Kate J	lohnsTon, P	rogram Speciali	<u>st</u> 03/20/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE C	OR SINGLE STA	TE AGENCY	
19. DETERMINATION OF ELIGIBILITY		20. COM	PLIANCE WITH C	IVIL	21.	1. Statement of Finan	cial Solvency (HCFA-2572)	
X 1. Facility is Eligible to Part	cipate	RIGH	ITS ACT:			<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	Interest Disclosure Stmt (HC	FA-1513)
2. Facility is not Eligible						5. Dour of the Above		
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	NT	26. TERMI	INATION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE	Ξ	VOLUNTAR		<u>INVOLUN</u>	TARY
12/01/1985					01-Merger, C			Meet Health/Safety
(L24)	(L41)		(L25)			action W/ Reimbursem	ent 06-Fail to I	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS				voluntary Termination	OTHER	
	A. Suspension	of Admissions:	<i>a</i> . (1)		04-Other Rea	ison for withdrawar	07-Provide 00-Active	er Status Change
(L27)	B. Rescind Sus	pension Date	(L44)				00-Active	
	D. Resenta Sus	pendion Dure.	(L45)					
28. TERMINATION DATE:	29	INTERMEDIARY/C	ARRIER NO.		30. REMAR	KS		
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DAT	ΓE	Posted	03/21/2017 Co.		
	(L32)	02/02/2017		(L33)	DETERM	INATION APPRO	OVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245295 March 20, 2017

Ms. Kelly Ellis, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, MN 55102

Dear Ms. Ellis:

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

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

Effective January 31, 2017 the above facility is certified for or recommended for:

141 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 141 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.

Bethel Care Center March 20, 2017 Page 2

Sincerely,

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Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 17, 2017

Ms. Kelly Ellis, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, MN 55102

RE: Project Number S5295026 & H5295122

Dear Ms. Ellis:

On January 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 22, 2016 that included an investigation of complaint number H5295122.

This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 22, 2016, effective January 31, 2017 and therefore remedies outlined in our letter to you dated January 10, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Bethel Care Center March 17, 2017 Page 2

Sincerely,

Tomston atol X

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered March 17, 2017

Ms. Kelly Ellis, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, MN 55102

RE: Project Number F5295025

Dear Ms. Ellis:

On January 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 5, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 7, 2017, 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 January 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 5, 2017, effective January 31, 2017 and therefore remedies outlined in our letter to you dated January 10, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Bethel Care Center March 17, 2017 Page 2

Sincerely,

Tomston atol X

Kate JohnsTon, Program Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division 85 East Seventh Place, Suite 220 P.O. Box 64900 St. Paul, Minnesota 55164-0900 kate.johnston@state.mn.us Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /		MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER		A. Building			
245295	Y1	B. Wing	Y2	2/8/2017	Y3
NAME OF FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL CARE CENTER			420 MARSHALL AVENUE		
			SAINT PAUL, MN 55102		

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

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0166		Correction	ID Prefix	F0174		Correction	ID Prefix	F0225		Correction
Reg. #	483.10(j)(2)-(4)		Completed	Reg. #	483.10(	g)(6)(7)(i)	Completed	Reg. #	483.12(a)(3)(4)(c)(1	1)-(4)	Completed
LSC			01/31/2017	LSC			01/31/2017	LSC			01/31/2017
ID Prefix	F0226		Correction	ID Prefix	F0241		Correction	ID Prefix	F0253		Correction
Reg. #	483.12(b)(1)-(3), 483.95(c)(1)-(3)		Completed	Reg. #	483.10(	a)(1)	Completed	Reg. #	483.10(i)(2)		Completed
LSC			01/31/2017	LSC			01/31/2017	LSC			01/31/2017
ID Prefix	F0278		Correction	ID Prefix	F0282		Correction	ID Prefix	F0312		Correction
Reg. #	483.20(g)-(j)		Completed	Reg. #	483.21(	b)(3)(ii)	Completed	Reg. #	483.24(a)(2)		Completed
LSC			01/31/2017	LSC			01/31/2017	LSC			01/31/2017
ID Prefix	F0314		Correction	ID Prefix	F0318		Correction	ID Prefix	F0371		Correction
Reg. #	483.25(b)(1)		Completed	Reg. #	483.25(	c)(2)(3)	Completed	Reg. #	483.60(i)(1)-(3)		Completed
LSC			01/31/2017	LSC			01/31/2017	LSC			01/31/2017
ID Prefix	F0441		Correction	ID Prefix	F0465		Correction	ID Prefix			Correction
Reg. #	483.80(a)(1)(2)(4	)(e)(f)	Completed	Reg. #	483.90(	h)(5)	Completed	Reg. #			Completed
LSC			01/31/2017	LSC			01/31/2017	LSC			
REVIEWE STATE AG		REVIEWE (INITIALS		date 03/17/2	2017	SIGNATURE OF SI		6022		DATE	8/2017
REVIEWE CMS RO	D BY	REVIEWE (INITIALS	D BY	DATE		TITLE				DATE	0.2011
FOLLOW	<b>JP TO SURVEY C</b> 16	OMPLETED	ON			I ANY UNCORRECTE "ED DEFICIENCIES					6 🗌 NO

## **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01		DATE OF REVISIT	
245295	B. Wing	Y2	2/7/2017	Y3
	 -	12		15
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL CARE CENTER		420 MARSHALL AVENUE		
		SAINT PAUL, MN 55102		

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

ITE	Μ	DATE	ITEM	DATE	ITEM	DATE
Y4		Y5	Y4	Y5	Y4	Y5
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC	K0361	01/31/2017			LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC					LSC	
ID Prefix		Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #		Completed	Reg. #	Completed	Reg. #	Completed
LSC			LSC		LSC _	
REVIEWE STATE AG		REVIEWED BY (INITIALS) TL/KJ	date 03/17/2017	signature of surveyor 37	008	date 02/07/2017
REVIEWE CMS RO	D BY	REVIEWED BY (INITIALS)	DATE	TITLE		DATE
FOLLOWUP TO SURVEY COMPLETED ON 1/5/2017		CHECK FOR UNCORRECT				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

		ND TRANSMI			ID: ZHIN			
		I - TO BE COM			E SURVEY AG	ENCY		Facility ID: 00913
1. MEDICARE/MEDICAID PROVIDER N (L1) 245295	0.	3. NAME AND ADI (L3) BETHEL CA		Y			4. TYPE OF ACTION:	<u>2 (</u> L8)
2.STATE VENDOR OR MEDICAID NO.		(L4) <b>420 MARSH</b>					1. Initial	2. Recertification
(L2) <b>493226900</b>		(L5) SAINT PAUL			(L6)	55102	<ol> <li>Termination</li> <li>Validation</li> <li>On-Site Visit</li> </ol>	<ol> <li>CHOW</li> <li>Complaint</li> <li>Other</li> </ol>
5. EFFECTIVE DATE CHANGE OF OWN (L9)	VERSHIP	7. PROVIDER/SUF 01 Hospital	PPLIER CATEGORY 05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	) 22 CLIA	8. Full Survey After Co	
6. DATE OF SURVEY 12/22/	/ <b>2016</b> (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		FISCAL YEAR ENDING	DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		12/31	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS:				1	
From (a):		X A. In Compliar	nce With		And/Or Approv	ved Waivers Of The	Following Requirements:	
To (b) :		Program Red			2. Tech	nnical Personnel	6. Scope of Serv	ices Limit
		Compliance	Based On:		3. 24 H	Iour RN	7. Medical Direc	tor
12. Total Facility Beds	141 (L18)	<u>X</u> 1. A	cceptable POC		4. 7-Da	ay RN (Rural SNF)	8. Patient Room	Size
13. Total Certified Beds	141 (L17)	B Not in Com	pliance with Program		5. Life	Safety Code	9. Beds/Room	
15. Total Certified Deas	()		and/or Applied Waive	rs:	* Code:	A1*	(L12)	
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY N			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
141						0, ( )		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	S (IF APPLICABLE S	SHOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	VEY AGENCY API	PROVAL	Date:
Mary Beth Lacin	a, HFE NE l	[] (	01/23/2017	(L19)	Kate John	<u>nsTon, Pro</u>	gram Specialist	02/01/2017 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE OR S	SINGLE STAT	EAGENCY	
19. DETERMINATION OF ELIGIBILITY			IPLIANCE WITH CI	VIL			al Solvency (HCFA-2572)	
1. Facility is Eligible to Part	ticipate	RIGE	ITS ACT:			Ownership/Control Ii Both of the Above :	nterest Disclosure Stmt (HCFA	A-1513)
2. Facility is not Eligible								
	(L21)							
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEMEN	T	26. TERMINAT	FION ACTION:	(	L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DATE		VOLUNTARY	00	INVOLUNI	ARY
12/01/1985					01-Merger, Closu	ire	05-Fail to M	eet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction	n W/ Reimbursemen	t 06-Fail to M	eet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIV	E SANCTIONS			03-Risk of Involu	ntary Termination	OTHER	
	A. Suspension	of Admissions:			04-Other Reason	for Withdrawal	07-Provider	Status Change
			(L44)				00-Active	
(L27)	B. Rescind Sus	pension Date:						
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION C	OF APPROVAL DAT	E	Posted 02/	02/2017 Co.		
	(L32)			(L33)	DETERMINA	ATION APPROV	VAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 10, 2017

Ms. Kelly Ellis, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, MN 55102

RE: Project Number S5295026 and Complaint Number H5295122

Dear Ms. Ellis:

# Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.

On December 22, 2016, a standard survey was completed at your facility by the Minnesota Department of Health 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. In addition, at the time of the December 22, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5295122, which was found to be substantiated at F225, F226, F282 and F314.

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

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

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

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

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

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

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

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

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

#### DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 <u>susanne.reuss@state.mn.us</u> Telephone: (651) 201-3793 Fax: (651) 215-9697

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 31, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 31, 2017 the following remedy will be imposed:

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

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

#### Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

#### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

## Original deficiencies corrected but new deficiencies found during the revisit

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

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

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

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

		AND HUMAN SERVICES				FORM	APPROVED
	COF DEFICIENCIES						<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
							С
		245295	B. WING _			12/	22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
0(0)15		TEMENT OF DEFICIENCIES		3	PROVIDER'S PLAN OF CORRECTION	4	(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	00			
	signature is not req						
	revisit of your facilit validate that substa	acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with					
		vey was conducted and tion were also completed at dard survey.					
F 166 SS=D	completed. The cor Deficiencies issued	complaint H5295122 was nplaint was substantiated. at F225, F226, F282, F314 GHT TO PROMPT EFFORTS EVANCES	F 16	66			1/31/17
	must make prompt	has the right to and the facility efforts by the facility to resolve dent may have, in accordance					
		ust make information on how or complaint available to the					
	to ensure the prompregarding the resider paragraph. Upon re	ust establish a grievance policy pt resolution of all grievances ents' rights contained in this equest, the provider must give ance policy to the resident. The ust include:					
LABORATORY	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						01/20/2017

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

PRINTED: 01/23/2017

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING			( 12/2	22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	Continued From pa	ge 1	F 1	66			
	postings in promine facility of the right to (meaning spoken) of grievances anonym of the grievance off can be filed, that is, address (mailing ar number; a reasonal completing the revie to obtain a written of grievance; and the independent entities be filed, that is, the Quality Improvemen Agency and State L program or protection (ii) Identifying a Grie responsible for over receiving and trackin conclusions; leading by the facility; main information associa example, the identifi grievances submitted written grievance de coordinating with st necessary in light o (iii) As necessary, ta prevent further pote right while the alleg investigated; (iv) Consistent with	t individually or through ent locations throughout the o file grievances orally or in writing; the right to file iously; the contact information icial with whom a grievance his or her name, business ad email) and business phone ble expected time frame for ew of the grievance; the right lecision regarding his or her contact information of s with whom grievances may pertinent State agency, nt Organization, State Survey cong-Term Care Ombudsman on and advocacy system; evance Official who is rseeing the grievance process, ing grievances through to their g any necessary investigations taining the confidentiality of all ted with grievances, for ty of the resident for those ed anonymously, issuing ecisions to the resident; and ate and federal agencies as f specific allegations; aking immediate action to ential violations of any resident ed violation is being §483.12(c)(1), immediately i violations involving neglect,					

If continuation sheet Page 2 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 166	Continued From pa	-	F	66			
	and/or misappropria anyone furnishing s	uries of unknown source, ation of resident property, by ervices on behalf of the ninistrator of the provider; and e law;					
	include the date the summary statemen the steps taken to in summary of the per regarding the reside as to whether the g confirmed, any corr taken by the facility	written grievance decisions grievance was received, a t of the resident's grievance, nvestigate the grievance, a tinent findings or conclusions ent's concerns(s), a statement rievance was confirmed or not ective action taken or to be as a result of the grievance, itten decision was issued;					
	accordance with Sta of the residents' rig or if an outside entit the State Survey Ac Organization, or loc confirms a violation	ate corrective action in ate law if the alleged violation hts is confirmed by the facility ty having jurisdiction, such as gency, Quality Improvement al law enforcement agency for any of these residents' a of responsibility; and					
	result of all grievand 3 years from the iss decision. This REQUIREMEN by: Based on interview facility failed to ensu- made by the facility	dence demonstrating the ces for a period of no less than suance of the grievance NT is not met as evidenced and document review, the ure that prompt efforts were to resolve grievances for 1 of			Immediate Corrective Action: Social Services followed up with R 1.13.17 to set up a care conference		
	1 resident (R88) rev grievance to facility Findings include:	<i>r</i> iewed, who expressed a staff.			related to R88 plan of care. The care conference was held on	1/18/17.	

Facility ID: 00913

If continuation sheet Page 3 of 46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETE BUILDING         NAME OF PROVIDER OR SUPPLIER       245295       B. WING       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETE BUILDING         BETHEL CARE CENTER       SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102         Image: Complexity of the preceded by FULL PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102         Image: Complexity of the preceded by FULL PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCY (EACH ORRECTIVE ACTION MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102         Image: Complexity of the preceded by FULL PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCY (EACH ORRECTIVE ACTION MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       S (MONE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       S (MONE AND SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       S (MONE AND SHOULD BE CROSS-REFERENCED TO THE APP			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	): 01/23/2017 APPROVED ). 0938-0391
245295     B. WING     12/22/2016       NAME OF PROVIDER OR SUPPLIER       BETHEL CARE CENTER       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (X4) ID PREFIX TAG     PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     (X5) COMPLET DEFICIENCY)       F 166       PRESEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     F 166       F 166       PRESEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       F 166       PREVIDE CONTEX ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 166       Resident R88 was offered a shower on 1/18/17.       OTHER APPROPRIATE DEFICIENCY       DURING CONTEXT AND TO CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       DURING CONTEXT ASTACT AND AND ADD TO THE APPROPRIATE DEFICIENCY       DURING TO CONTEXT ASTACT AND ADD ADD ADD ADD ADD ADD ADD ADD ADD	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BETHEL CARE CENTER       SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       D         PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D         F 166       Continued From page 3       ID Resident R88 was offered a shower on 1/18/17.         F 166       Continued From page 3       F 166         When interviewed on 12/2/16, at 6:45 p.m. R88 expressed filing a grievance on 12/2/16, and the facility had not gotten back to R88 in regard to the resolution to the grievance on 12/20/16, at 9:05 a.m. family member (FM)-B was present and further expressed frustration that the facility had not resolved a grievance filed 12/2/16.       F 100         Document review of the quarterly Minimum Set (MDS) dated 11/4/16, indicated R88 was cognitively intact. Diagnoses from the MDS dated 11/4/16, indicated quadriplegia, decubitus ulcer,       A new grievance log was developed to track all resident grievances to ensure ongoing compliance with facility policy. Social services was educated on the log on 1/13/17.			245295	B. WING		12	
BETHEL CARE CENTER         SAINT PAUL, MN 55102           (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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         (X5) (EACH OERICITY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         (X5) (COMPLET DEFICIENCY)           F 166         Continued From page 3         F 166         Resident R88 was offered a shower on 1/18/17.         (X1)/18/17.           When interviewed on 12/19/16, at 6:45 p.m. R88 expressed filing a grievance on 12/2/16, and the facility had not gotten back to R88 in regard to the resolution to the grievance and that a care conference was supposed to have been scheduled and that had not happened yet either.         F 166         Resident R88 was offered a shower on 1/18/17.           During an interview with R88 on 12/20/16, at 9:05 a.m. family member (FM)-B was present and further expressed frustration that the facility had not resolved a grievance filed 12/2/16 and no family care conference had been set up as the facility had said they would do 12/2/16.         Policy and Procedure by 1/31/17. A new grievance log was developed to track all resident grievances to ensure ongoing compliance with facility policy. Social services was educated on the log on 1/13/17.           Document review of the quarterly Minimum Data Set (MDS) dated 11/4/16, indicated R88 was cognitively intact. Diagnoses from the MDS dated 11/4/16, indicated quadriplegia, decubitus ulcer,         The Grievance policy and procedure was	NAME OF	PROVIDER OR SUPPLIER			S		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLET DATE         F 166       Continued From page 3       F 166       Resident R88 was offered a shower on 1/18/17.       Continued From page 3       F 166         When interviewed on 12/19/16, at 6:45 p.m. R88 expressed filing a grievance on 12/2/16, and the facility had not gotten back to R88 in regard to the resolution to the grievance and that a care conference was supposed to have been scheduled and that had not happened yet either.       F 166       Resident R88 was offered a shower on 1/18/17.       Completing PREFIX During an interview with R88 on 12/20/16, at 9:05 a.m. family member (FM)-B was present and further expressed frustration that the facility had not resolved a grievance filed 12/2/16 and no family care conference had been set up as the facility had said they would do 12/2/16.       Policy and Procedure by 1/31/17. The Resident Grievance form by 1/31/17. A new grievance log was developed to track all resident grievances to ensure ongoing compliance with facility policy. Social services was educated on the log on 1/13/17.         Document review of the quarterly Minimum Data Set (MDS) dated 11/4/16, indicated R88 was cognitively intact. Diagnoses from the MDS dated 11/4/16, indicated quadriplegia, decubitus ulcer,       The Grievance policy and procedure was	BETHEL	CARE CENTER					
When interviewed on 12/19/16, at 6:45 p.m. R88 expressed filing a grievance on 12/2/16, and the facility had not gotten back to R88 in regard to the resolution to the grievance and that a care conference was supposed to have been scheduled and that had not happened yet either.Resident R88 was offered a shower on 1/18/17.During an interview with R88 on 12/20/16, at 9:05 a.m. family member (FM)-B was present and further expressed frustration that the facility had not resolved a grievance filed 12/2/16 and no family care conference had been set up as the facility had said they would do 12/2/16.Policy and Procedure by 1/31/17: The Resident Grievance form has been updated and the IDT will be educated on the new Grievance form by 1/31/17.Document review of the quarterly Minimum Data Set (MDS) dated 11/4/16, indicated R88 was cognitively intact. Diagnoses from the MDS dated 11/4/16, indicated quadriplegia, decubitus ulcer,A new grievance policy and procedure was	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
<ul> <li>expressed filing a grievance on 12/2/16, and the facility had not gotten back to R88 in regard to the resolution to the grievance and that a care conference was supposed to have been scheduled and that had not happened yet either.</li> <li>During an interview with R88 on 12/20/16, at 9:05 a.m. family member (FM)-B was present and further expressed frustration that the facility had not resolved a grievance filed 12/2/16 and no family care conference had been set up as the facility had said they would do 12/2/16.</li> <li>Document review of the quarterly Minimum Data Set (MDS) dated 11/4/16, indicated R88 was cognitively intact. Diagnoses from the MDS dated 11/4/16, indicated quadriplegia, decubitus ulcer,</li> <li>Actions as it Applies to Others: Staff will be re-educated related to the Grievance</li> <li>Policy and Procedure by 1/31/17: The Resident Grievance form has been updated and the IDT will be educated on the new Grievance form by 1/31/17.</li> <li>A new grievance log was developed to track all resident grievances to ensure ongoing compliance with facility policy. Social services was educated on the log on 1/13/17.</li> </ul>	F 166	p	-	Fi	166	Resident R88 was offered a shower on	
anxiety, asthma and depression.reviewed on 1/17/17 and remains current.Document review of the form titled; Grievance Form, dated 12/2/16, read, "Resident reported someone (nurse or nurse aide) left [R88] in [R88] wheelchair for a long time without transferring [R88] to [R88] bed. [R88] also reports they keep forgetting to give [R88] showers. Resident has stated [R88] either has or would like to call Welcov Corporate to voice [R88] concerns.Recurrence will be prevented by: Social services will review and discuss all resident grievances daily Mon-Fri during the IDT quality conference to ensure follow-up and resolution with resident concerns. Each grievance will be reviewed until resolution has been achieved and reviewed with the resident. This will be an ongoing facility practice.The section which reads; Action taken to address Grievance: read, Reported to MDH (Minnesota Department of Health) Investigation initiated. Care Plan meeting being set up by social services with resident and [R88] family.The responsible person signature on the form was the Director of Nursing (DON) and dated 12/5/16. The administrator signed the GrievanceThe original family.		expressed filing a g facility had not gotter resolution to the gri conference was sup scheduled and that During an interview a.m. family membe further expressed fin not resolved a griew family care confere facility had said the Document review o Set (MDS) dated 11 cognitively intact. D 11/4/16, indicated of anxiety, asthma and Document review o Form, dated 12/2/1 someone (nurse or wheelchair for a lon [R88] to [R88] bed. forgetting to give [R stated [R88] either Welcov Corporate t The section which r Grievance: read, Re Department of Hea Care Plan meeting services with reside The responsible pe was the Director of	rievance on 12/2/16, and the en back to R88 in regard to the evance and that a care oposed to have been had not happened yet either. with R88 on 12/20/16, at 9:05 r (FM)-B was present and rustration that the facility had vance filed 12/2/16 and no nce had been set up as the y would do 12/2/16. f the quarterly Minimum Data 1/4/16, indicated R88 was iagnoses from the MDS dated uadriplegia, decubitus ulcer, d depression. f the form titled; Grievance 6, read, "Resident reported nurse aide) left [R88] in [R88] ig time without transferring [R88] also reports they keep i88] showers. Resident has has or would like to call to voice [R88] concerns. reads; Action taken to address eported to MDH (Minnesota Ith) Investigation initiated. being set up by social ent and [R88] family. rson signature on the form Nursing (DON) and dated			<ul> <li>1/18/17.</li> <li>Actions as it Applies to Others: Staff will be re-educated related to the Grievance</li> <li>Policy and Procedure by 1/31/17: The Resident Grievance form has been updated and the IDT will be educated on the new Grievance form by 1/31/17.</li> <li>A new grievance log was developed to track all resident grievances to ensure ongoing compliance with facility policy. Social services was educated on the log on 1/13/17.</li> <li>The Grievance policy and procedure was reviewed on 1/17/17 and remains current.</li> <li>Recurrence will be prevented by: Social services will review and discuss all resident grievances daily Mon-Fri during the IDT quality conference to ensure follow-up and resolution with resident concerns. Each grievance will be reviewed until resolution has been achieved and reviewed with the resident. This will be an ongoing facility practice.</li> <li>The Correction will be monitored by:</li> </ul>	

If continuation sheet Page 4 of 46

		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	COM	E SURVEY PLETED C
		245295	B. WING				22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 166	Continued From pa form 12/5/16.	ge 4	F 1	66			
	indicated a written r recommended action returned to Adminis within 72 hours. A r resident/representa findings and actions be taken. If they are other actions will be During an interview Administrator on 12 they were not aware have any other doc	a, Revision date: July 2015, report of investigation and on will be completed and strator/Social Service Director neeting with the tive will occur to review the s taken and/or those that will e not satisfied with the results, e developed as needed. with the DON and 2/22/16, at 8:40 a.m. verified e of the follow up and did not umentation for investigation of					
F 174 SS=E	with the current soc been working as a f since 12/11/16, veri resident or family a discuss concerns. S a meeting with the Furthermore, SW-A Grievance/Concern informed of the follo the facility did not for conference for the care concerns but S immediately. 483.10(g)(6)(7)(i) R ACCESS WITH PR	r on 12/22/16, at 11:30 a.m. bial worker (SW)-A who had temporary fill in social worker ified no knowledge of the nticipating a meeting to SW-A was not aware to set up resident or family. A verified not seeing the of for R88 and not being bw up required. SW-A verified blow up with a care resident and family to discuss SW-A would follow up	F	174			1/31/17
		has the right to have to the use of a telephone,					

Facility ID: 00913

If continuation sheet Page 5 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 01/23/2017 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY IPLETED C
		245295	B. WING			22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 174	the facility where ca overheard. This incluse a cellular phone expense. (g)(7) The facility m resident's right to co and entities within a including reasonabl (i) A telephone, inclu This REQUIREMEN by: Based on documer interview, the facility residents (R82, R12 R167) on the 3rd flo privacy when using making/receiving per Findings include: Document review o Data Set (MDS), da cognitive impairmer During an observati R82 was being assi nurse (LPN)-B to m nursing desk. R82 o on the phone by the common area near not being aware of a to use. Document review o	TDD services, and a place in flD services, and a place in flls can be made without being ludes the right to retain and e at the resident's own ust protect and facilitate that ommunicate with individuals and external to the facility, e access to: uding TTY and TDD services; NT is not met as evidenced int review, observation and y failed to ensure 7 of 47 2, R55, R91, R43, R115 and oor had reasonable access to the telephone for ersonal phone calls. f R82's most recent Minimum ted 9/17/16, revealed severe	F	174	Immediate Corrective Action: "A grievance form was completed on behalf of residents R82, R12, R55, R 91, R43, R115, R167 regarding access to a private phone." Actions as it Applies to Others: All cordless phones will be examined to ensure the phones are in working condition. Cordless phones will be located behind the nurses' station and a sign-out log will be implemented. Nursing staff will be educated on the new sign-out sheet for the use of the phone and the need to provide residents with privacy while using the phone by January 31, 2017. Recurrence will be prevented by: Resident interviews will be conducted 3x weekly for 90 days on each unit to ensure residents are provided privacy while using the phone. The interview results will be	

Facility ID: 00913

		& MEDICAID SERVICES					0938-039
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
			A. BOILDIN	·u_			C
		245295	B. WING _				22/2016
NAME OF	PROVIDER OR SUPPLIER	·		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
F 174	Continued From pa	age 6	F 17	74			
		ete all activities of daily living on and off the unit.			shared with the IDT at the monthly for recommendations on the need continue or discontinue audits.		
During an observation on 12/19/16, at 6:56 p.m., nursing assistant (NA)-E assisted R12 to make a phone call at the nursing desk. R12 was seated right next to R82, who was still using the phone. NA-E reported there was a cordless phone but that another resident might be using it.				The Correction will be monitored b Social Services and/or designee	y:		
	Document review of R55's most recent (MDS) dated 10/10/16, revealed R55 was cognitively intact and did not transfer from bed or other surfaces.						
Why repo but use calls [R55	reported there was but that it was ofter use by another resi calls and that peop	on 12/20/16 at 10:32 a.m., R55 a cordless phone on the unit, n not able to be located or in ident. R55 reported missed le were unable to contact ymore. R55 reported there m for phone use.					
		of R91's most recent MDS, realed moderate cognitive					
	R91 reported not b	on 12/20/16, at 11:53 a.m., eing able to make a private re was sometimes 3-4 people phone on the unit.					
		of R43's most recent MDS, ealed moderate cognitive					
	LPN-A informed R4	ion on 12/20/16, at 12:37 p.m., I3 about a phone call and then hone at the nursing desk. R43					

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		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		245295	B. WING				C 22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 174	stood at the nursing	desk to make the phone call. another, more private area, to	F 1	74			
	R115 made a phone During an observati R167 made a phone nursing desk. There other residents and R167 was observed not being used by th prefering to make a pointed to a cordles dining room and rep attempted to use it A policy on telephor not provided.	ion on 12/20/16, at 3:50 p.m. e call from the nursing desk. ion on 12/22/16, at 10:15 a.m. e call from the phone at the e was background noise as staff were in the area and d to use hand to cover the ear he phone. R167 reported a private phone call. R167 as phone on a table in the ported it did not work when on multiple occasions.					
F 225 SS=D	<ul> <li>483.12(a)(3)(4)(c)(1 ALLEGATIONS/INE</li> <li>(a) The facility must</li> <li>(3) Not employ or or who-</li> <li>(i) Have been found exploitation, misapp mistreatment by a c</li> <li>(ii) Have had a findi nurse aide registry or</li> </ul>	t- therwise engage individuals d guilty of abuse, neglect, propriation of property, or court of law; ing entered into the State concerning abuse, neglect, atment of residents or	F 2	225			1/31/17

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225	Continued From pa	ge 8	F 2	225			
	or her professional body as a result of a exploitation, mistrea misappropriation of (4) Report to the St licensing authorities actions by a court o which would indicat nurse aide or other	ate nurse aide registry or any knowledge it has of f law against an employee, e unfitness for service as a					
	<ul> <li>exploitation, or mist</li> <li>(1) Ensure that all a abuse, neglect, explicitly including injuries of misappropriation of reported immediate after the allegation cause the allegation cause the allegation serious bodily injury the events that cause abuse and do not reported immistrator of officials (including the administrator of officials (including to adult protective serior for jurisdiction in lor accordance with Staprocedures.</li> <li>(2) Have evidence to thoroughly investigation in the administrator of the administration in the administration in lor accordance with Staprocedures.</li> </ul>	reatment, the facility must: alleged violations involving aloitation or mistreatment, unknown source and resident property, are aly, but not later than 2 hours is made, if the events that n involve abuse or result in <i>t</i> , or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other the facility and to other the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established that all alleged violations are ated.					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 01/23/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CON	E SURVEY IPLETED
		245295	B. WING			/22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From pa investigation is in pi	-	F 2	25		
	administrator or his representative and with State law, inclu Agency, within 5 wo if the alleged violatic corrective action mu This REQUIREMEN by: Based on documen facility failed to ensu of mistreatment, ne thoroughly investiga administrator imme immediately to the s residents (R55) rev Findings include: R55 reported on 9/7 nurse threatened to the incident was no	to other officials in accordance uding to the State Survey orking days of the incident, and on is verified appropriate ust be taken. NT is not met as evidenced nt review and interview, the ure that all alleged violations glect and abuse are ated, reported to the diately and reported state agency for 1 of 3			Immediate Corrective Action: RN-I was counseled on 1/16/17 for failing to ensure the timely notification of alleged abuse per facility policy. Corrective Action as it Applies to Others: The policy and procedure "Abuse Prevention Plan" was reviewed and remains current. Nursing staff will be re-educated on the policy with respect to immediate reporting and the initiation of internal investigations for any allegation of abuse.	
	to the minimum dat 10/10/16, and diagr coronary artery dise hypertension. R55 had a physicial via nasal cannula (r obstructive pulmona According to the do written by registered	as cognitively intact according a set (MDS) annual review hoses from the MDS included ease, heart failure and n order for 3 liters of oxygen hc) continuously due to chronic ary disease. cument titled, Progress notes, d nurse (RN)-I dated 9/7/16, at ter notified of incident and			Recurrence will be prevented by: All Alleged incidents of abuse, mistreatment, neglect, or injuries of unknown origin and/or misappropriation of resident property will be audited to ensure timely reporting, immediate initiation of the internal investigation process and to ensure that witness interviews have been conducted per facility policy and procedure. Audits will be completed for 90 days, and audit results will be shared with the IDT during the monthly QAPI meeting for input on the need to continue or	•

Facility ID: 00913

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		245295	B. WING			( 12/2	) 22/2016
NAME OF PR	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL C	ARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
s c dd ia a [l e v [l c s v s [s ritt v n A w E [i p w () w n b A li n a e c	annot take away m loctors order". Pt w boud. Writer apologi and ensured pt that R55] room and we ensure [R55] is com- rerbalized that [R55 R55] room "ever ag- comfort pt and assu- tay out of [R55] roo rerbalized being col SOB [shortness of k saturation] 94% on poke with nurse ar emain out of the pa- he shift and we wo rerbalized understan- toted. According to the do written by RN-J date Behavior: Patient the nursing assistant re- patients room to ver- vas for another resi- threw a cup at me) words in the book. A pehavior. According to the do nurses working on t- pehavior.	ge 10 ent who verbalized, "the nurse hy oxygen, where is the vas upset and speaking very zed for any misunderstanding the oxygen would remain in will do anything we can to offortable and safe. Pt further 5] did not want the nurse in gain". Writer continued to ured pt that this nurse would om. Pt thanked writer and mfortable and without pain or oreath]. O2 [oxygen] sats 3 L [liters] O2 via nc. Writer nd ensured that [RN-J] would atients room the remainder of uld follow up tomorrow. Nurse anding. No further issues cument titled, Progress notes, ed 9/7/16, at 6:42 p.m. read, reatened writer and NAR egistered] after walking to rify the oxygen compressor ident. Patient was aggressive and abusive using all the Writer told the incident to other the unit. Will monitor residents cument titled, Internal on 9/12/16, at 12:00 p.m. the itioner reported to the irector of nursing that R55 ent on 9/7/16 where the ng finger in res face and O2 from the resident.	F 2	225	discontinue auditing. The Correction will be monitored by Administrator and/or designee.	/:	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
DETUE				4	20 MARSHALL AVENUE		
BEIHEL	CARE CENTER			S	SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 225	During an interview the administrator ar verified RN-I failed report abuse immediately start and failed to inform ther mental health pract 9/12/16, at 12:00 p. statement was obta from the NAR report Document review of dated, Nov 2016, and Plan, read; "The ad charge of the Abuse informed of all alleg of abuse, neglect, of In the case of the a the designee will be The State Agency in Furthermore, for Inv directed the facility incident report by a following the incident supervisor would im to keep the resident implementation revi are appropriate for resident. Under the directed; 1. All incid nature will be invest 2. Upon receipt of th designee on duty w situation by conduct the resident, speak situation and docum	on 12/22/16, at 8:40 a.m. with nd director of nursing (DON) to follow the facility policy to diately to the administrator and 9/7/16, at 8:00 p.m. failed to n internal investigation and n of the situation until the itioner reported the abuse on m. Furthermore, no written ined or interview conducted	F 2	225			

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		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
BETHEL	CARE CENTER				20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 225 F 226 SS=D	and location of susp and extent of the su other information be the suspected maltr accomplish this by o accident/Incident re form. Analyze the o changes are neede procedures to preve 483.12(b)(1)-(3), 48 DEVELOP/IMPLME POLICIES 483.12 (b) The facility must written policies and (1) Prohibit and pre- exploitation of resid resident property, (2) Establish policie investigate any such (3) Include training §483.95, (c) Abuse, neglect, the freedom from al requirements in § 4 provide training to the educates staff on- (c)(1) Activities that	pected maltreatment, Nature uspected maltreatment, Any elieved helpful in investigating reatment. Facility will completing the eport or issue and concern occurrences to determine what ed is any to policy and ent further occurrences. 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC t develop and implement procedures that: event abuse, neglect, and lents and misappropriation of es and procedures to h allegations, and as required at paragraph and exploitation. In addition to buse, neglect, and exploitation e83.12, facilities must also heir staff that at a minimum		225			1/31/17

		& MEDICAID SERVICES			MB NO.	APPROVEI 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	`́сом	E SURVEY PLETED	
		245295	B. WING _			C 22/2016	
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CODE			
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 226	<ul> <li>(c) (2) Procedures for neglect, exploitation resident property</li> <li>(c) (3) Dementia map prevention.</li> <li>This REQUIREMEN by:</li> <li>Based on document facility failed to following alleged violations in origin, or alleged violations in origin, or</li></ul>	ange 13 or reporting incidents of abuse, n, or the misappropriation of anagement and resident abuse NT is not met as evidenced nt review and interview, the ow the policy to ensure that all nvolving injuries of unknown olations of mistreatment, were reported to the state ghly investigated for 1 of 3 riewed for incidents. of the facility policy revision nd titled, Abuse Prevention ministrator is ultimately in e Prohibition Plan and must be ged or substantiated incidents or maltreatment immediately. dministrator being unavailable, e notified in this timeframe. nust be notified immediately". vestigation the document staff would complete an licensed staff immediately nt. The unit manager/night nplement immediate changes t safe, with follow up iewed to make sure that they the resident and condition of Internal Reporting the policy lents that are suspicious in tigated by the internal process. he report, the DNS or	F 22	<ul> <li>Immediate Corrective Action: RN-I was counseled on 1/16/17 fo to ensure the timely notification of abuse per facility policy.</li> <li>Corrective Action as it Applies to C The policy and procedure "Abuse Prevention Plan" was reviewed an remains current.</li> <li>Nursing staff will be re-educated o policy with respect to immediate re and the initiation of internal investi for any allegation of abuse.</li> <li>Recurrence will be prevented by: All Alleged incidents of abuse, mistreatment, neglect, or injuries of unknown origin and/or misappropri resident property will be audited to timely reporting, immediate initiation internal investigation process and ensure that witness interviews hav conducted per facility policy and procedure. Audits will be completed days, and audit results will be shart the IDT during the monthly QAPI in for input on the need to continue of discontinue auditing.</li> <li>The Correction will be monitored be</li> </ul>	alleged Others: d n the eporting, gations of iation of ensure on of the to re been ed for 90 red with neeting r		

Facility ID: 00913

		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	situation by conduct the resident, speak situation and docum documentation will the resident, identified and location of sussion and extent of the su- other information by the suspected malti- accomplish this by A\accident/Incident form. Analyze the o- changes are needed procedures to preve- R55 reported on 9/7 nurse threatened to the incident was no or state agency unt R55 was assessed to the minimum dat 10/10/16, and diagr coronary artery dise hypertension. R55 had a physicia via nasal cannula (r obstructive pulmona According to the do written by registered 8:11 p.m. read; Wri spoke with the patie cannot take away m doctors order". Pt w loud. Writer apologi	ill begin investigating the ting a physical assessment of ing to all staff involved in the nent such findings. 3. That include the following; Identify y the caregiver, Time, date bected maltreatment, Nature uspected maltreatment, Nature uspected maltreatment, Any elieved helpful in investigating reatment. Facility will completing the report or issue and concern occurrences to determine what d is any to policy and ent further occurrences. 7/16, at 8:11 p.m. that the b take away the oxygen and t reported to the administrator il 9/12/16, at 12:00 p.m. as cognitively intact according a set (MDS) annual review noses from the MDS included ease, heart failure and n order for 3 liters of oxygen nc) continuously due to chronic	F 2	226	Administrator and/or designee.		

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		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE		
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 226	<ul> <li>[R55] room and we ensure [R55] is com verbalized that [R55] is com verbalized that [R55] room "ever ag comfort pt and assustay out of [R55] room verbalized being co SOB [shortness of I [saturation] 94% on spoke with nurse ar remain out of the pathe shift and we wo verbalized understanded.</li> <li>According to the dowritten by RN-J date Behavior: Patient th [nursing assistant repatients room to verwas for another ress (threw a cup at me) words in the book. Investigation Form, mental health pract administrator and dexpressed the incid charge nurse pointi threatening to take</li> <li>During an interview the administrator ar verified RN-1 failed report abuse immediates and the set of the s</li></ul>	ge 15 will do anything we can to nfortable and safe. Pt further 5] did not want the nurse in gain". Writer continued to ured pt that this nurse would om. Pt thanked writer and mfortable and without pain or breath]. O2 [oxygen] sats 0.3 L [liters] O2 via nc. Writer nd ensured that [RN-J] would atients room the remainder of uld follow up tomorrow. Nurse anding. No further issues ocument titled, Progress notes, ed 9/7/16, at 6:42 p.m. read, meatened writer and NAR egistered] after walking to rify the oxygen compressor ident. Patient was aggressive and abusive using all the Writer told the incident to other the unit. Will monitor residents ocument titled, Internal on 9/12/16, at 12:00 p.m. the itioner reported to the lifector of nursing that R55 lent on 9/7/16 where the ng finger in res face and O2 from the resident.	F 22				

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		
		245295	B. WING _			C 22/2016
NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 226	immediately start a failed to inform ther	n internal investigation and m of the situation until the itioner reported the abuse on	F 22	26		
F 241 SS=D	483.10(a)(1) DIGNI INDIVIDUALITY	TY AND RESPECT OF	F 24	1		1/31/17
	promotes maintena her quality of life re- individuality. The fa promote the rights of This REQUIREMEN by: Based on document	NT is not met as evidenced nt review, observation, and		Immediate Corrective Action:		
	environment for 2 c reviewed for dignity accommodate resid	y failed to ensure a dignified of 4 residents (R140, R160) of by not providing furniture to dents of all sizes, and by not rivacy from the window view in		A grievance form was completed to residents R140 and R160 about accommodating seating and privat Corrective Action as it applies to co Blinds were provided for all showed and installed on January 31, 2017	cy. others: er rooms	
	(eMR) revealed R1 on 7/21/2016. R140 intact during the qu (MDS) assessment pounds on 12/21/16 electronic medical n During an observat	of the electronic medical record 40 was admitted to the facility 0 was assessed as cognitively arterly minimum data set 11/10/16. R140 weighed 486 6, as documented in the record. ion on 12/20/16, at 10:05 a.m. bed. R140's room furnishings		A chair will be ordered for R140 by January 31, 2017. Other residents will be interviewed determine if additional concerns e regarding the availability of accommodating seating based on resident weight/size. Additional fu will be obtained by January 31, 20 accommodate other residents with concerns.	d to xist irniture 17 to	
	lacked seating othe wheelchair. R140 s	aid the facility did not have a and did not think a wheelchair		The policy and procedure for Resi Rights and Dignity for all Nursing Procedures was reviewed and rer		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245295	B. WING			( 12/2	; 22/2016
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				0 MARSHALL AVENUE		
				3/	AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 241	Continued From pa	ge 17	F 2	41			
	counted as a norma	al chair. Since being admitted ot feel able to get in and out of			current.		
	the wheelchair safe legs underneath me	ly, explaining "I can't get my e to get out of the wheelchair			Nursing staff will be re-educated on t policy by January 31, 2017.	the	
	tried to assist with t	said that the last time two staff he transfer out of the ell back down onto the			Recurrence will be prevented by: Resident interviews will be conducted	d on	
		side of body on the chair, and			each unit 3x a week for 90 days to er residents needs are met in a manner	nsure	
	wheelchair. R140 s get R140 back up a	aid it took six facility staff to gain.			promotes dignity about accommodat seating and privacy. Audit results will	lbe	
		on on 12/21/16, at 8:24 a.m. eakfast in bed. When asked			shared with the IDT during the month QAPI meeting for recommendations the need to continue or discontinue a	on	
	whether R140 prefe	erred eating in bed, R140					
	area on the unit did				The Correction will be monitored by: Administrator and/or designee		
	R140 was intereste	ht/size. When asked whether d in spending time in the					
	there! But they aren	0 stated, "I want to get out I't even bothering to get me a					
	wheelchair, but I do	They tell me I can sit in my n't want the wheelchair! I want					
		3 p.m. R140 described nting a bigger chair to "anyone					
	and everyone," but couldn't find one.	that eventually staff said they					
		on 12/21/16, at 2:39 p.m. the ist (OT) explained the facility					
	was unable to find a R140 that was cove	a wheelchair to accommodate					
	did not have a chair accommodate R14	that was wide enough to 0.					
		60 was not provided dignity of f the window to the outside					

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED C 12/22/2016			
		245295	B. WING						
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE				
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 241	Continued From pa	ge 18	F 2	241					
	Document review of the quarterly MDS, dated 12/6/16, indicated R160 was cognitively intact. During an interview on 12/20/2016, at 11:57 a.m. R160 described a courtyard outside that residents used as a smoking area. R160 said from this courtyard, you can look up at the window in the fourth floor shower room and see the silhouette of the person in the shower room. R160 said it was possible to tell if the person in the shower room was male or female, and mentioned asking staff for curtains multiple times. R160 said staff tried to reassure that it was not possible to see anything from the courtyard outside, even though R160 insisted on seeing the body outlines from the courtyard.								
	the fourth floor show have two shower st The shower stall fa against the outside had a large window overlooked the cou started approximate was approximately	ion on 12/21/16, at 1:39 p.m. wer room was observed to alls separated by a curtain. rthest from the doorway was wall of the building. This wall with frosted glass that rtyard below. The window ed 1.5 feet up from the floor, 4 feet wide, and approximately low lacked a curtain.							
	12/21/2016, at 2:34 room window was w below. From the co (RN-A) looked up a stood in the showed person in the showed verified it was poss person while lookin	ion from the courtyard on p.m. the fourth floor shower visible from the courtyard urtyard, a registered nurse t the window while someone r room. The figure of the er room was visible. RN-A ible to see the outline of the g up from the courtyard. RN-A ild contact maintenance to							

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		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION 		Сом	(X3) DATE SURVEY COMPLETED C	
245295			B. WING			12/22/2016		
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COD	•		
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 241	Continued From page 19		F 2	241				
F 253 SS=E				253			1/31/17	
	<ul> <li>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>Based on document review, interview, and observation, the facility failed to provide a comfortable odor free room environment for resident (R55) and failed to ensure the environment was maintained in a safe and comfortable manner for 9 of 10 residents (R160, R140, R91, R166, R103, R50, R157, R155, R159) reviewed for environmental concerns.</li> <li>Findings include:</li> <li>R55's most recent Minimum Data Set (MDS), dated 10/10/16, revealed R55 was cognitively intact and did not transfer from bed or other surfaces. On 12/20/2016, at 9:41 a.m., R55 reported the urine smell in the room gave R55 headaches. R55 reported was unable to leave the room and the condition of the room made R55</li> <li>"very depressed", adding "I got no choice.</li> <li>Anyone else can come in and leave." R55's room was noted to have a strong foul urine odor. R55 also expressed concern as was vulnerable to infection and did not feel the condition of the room was sanitary, based on observations of odors. On 12/22/16, at 9:53 a.m., R55's room again had a strong foul urine odor.</li> </ul>			Har and repl The stat edg Fan plac 1/3/ Wh resi Mis repl Duc was Acti The was	mediate corrective action: hdrails in 300 hallway will b l endcap by the laundry roc laced on 12/7/16. e edges to the countertop n ion will be replaced with a le guard. hs and Vents were all clean ced on a regular cleaning s (17. eelchair armrests will be re- dents 4, 7, 40 and 41 by 1, sing tile in laundry room will laced by 1/3/17. et work in laundry room loo s removed on 12/7/16. ion as it applies to others: e Preventative Maintenances s reviewed and remains cu- ninistrator will follow the sci-	om was hear nurses' cleanable hed and schedule on eplaced for /3/17. ill be ose insulation e Program rrent.		
	tour with the mainte	5 a.m. during environmental enance director (MD) and ctor (ED), the following		belo	ow to assure Program is fo lity is kept in clean order a	llowed and		

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT OF DE AND PLAN OF COR	FICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF PROVID	DER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL CARE	E CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
R55 urine head now work R10 that strip day. staff On 1 tour envii cond On 1 tobse R16 pillov the I on th obse wall had On 1 tobse insid from was	e odor. R55 sta daches from the . Registered nu king with staff to 5 will pull cathe contributed to t bed and clean ED confirmed cleaning it thre 2/22/16, at 9:3 with the mainter ronmental direct cerns were note 2/20/16, at 12: erved to have tw 0's pillow. R160 w cases becaus inens. The pillo ne inside pillowo 2/20/16, at 10: ave a stain on a low covering to 2/20/16, at 1:1 erved with smal near the bed. In several chips ir 2/19/16, at 4:4 erved with seve le edge. The win the bottom sid next to the wino	<ul> <li>ad.</li> <li>served to have a strong foul ted can't you smell it, gets a smell, but had no headache rse (RN)-F indicated had been to clean the room. RN-F stated ter out, staff can't help it, and he smell. RN-F stated staff will the room three to four times a the room was a concern with the to four times a day.</li> <li>5 a.m. during environmental enance director (MD) and tetor (ED), the following and verified:</li> <li>31 p.m. R160's room was yoo pillowcases covering there often were stains on wcase had light brown stains case.</li> <li>57 a.m. R140 was observed a sheet being used for a keep the breeze out.</li> <li>0 p.m. R91's room was a concern with the transmitter of the wood molding the model of the wood molding the top case the staff top case the ter out.</li> </ul>	F2	253	All resident wheelchairs arms were inspected and will be replaced if ner Recurrence will be prevented by: Walking rounds by the Maintenance Director and Administrator or design be completed 3x weekly x 90 days to review facility cleanliness and maintenance needs. Administrator report results to facility QAPI comm for input on the need to increase, decrease or discontinue the frequer rounds. The correction will be monitored by Administrator/Maintenance Director	e nee will to will ittee ncy of	

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		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245295	B. WING				C <b>22/2016</b>
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BETHEL	CARE CENTER				420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	On 12/19/16, at 5:4 blinds were observe approximately 4 ind and left sides of ear with a bin of clothes stated they needed the wash. On 12/19 his room was cold. On 12/20/16, at 11: observed to not clo loose and there we the hallway wall near On 12/20/16, at 11: observed to have a placed a towel on the it, a towel on the flo allow her body to to On 12/20/16, at 8:4 cold next to the win a draft. On 12/20/16, at 12: the room was cold leaked a bit. On 12/19/16, at 4:3	Formica had jagged edges. 7 p.m. R103's room window ed with holes measuring thes by 4 inches on the right ch. The room was cluttered s near the window and R103 name labels and should go to b/16, at 5:08 p.m. R103 stated 45 a.m. R50's room door was se, the inside handle was re several holes midway up	F 2	253			
	stated would go into checks when it was	on 12/22/16, at 10:58 a.m. MD o a room for maintenance o vacant and checked blinds, things. MD stated every nurse					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 01/23/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245295	B. WING _			C 22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 253 F 278 SS=D	staff entered mainter maintenance staff of daily at 1:00 p.m. Document review of Room Readiness C check list directed: and foot boards, main mop floor checking the door Record a Document reivew of directed: "Directions environmental to en- sanitary, orderly, an No maintenance po- preventative mainter During an interview family member of R floor near the windor reported the floor has was admitted, and R satisfactory condition 483.20(g)-(j) ASSES ACCURACY/COOF (g) Accuracy of Ass must accurately refl (h) Coordination A registered nurse r each assessment w participation of heal (i) Certification	enance request book where enance requests. Additional hecked the request books f an undated policy titled, heck List Housekeeping 'wipe down bed frame, head attress, side rails Sweep and corners, edges, and behind any maintenance issues. f Audit Tool - Environmental s: Random weekly audits for usure facility maintains a d comfortable interior" licy was provided for mance routines. on 12/22/16, at 1:49 p.m, a 159 (F)-Q, noted cracks in the w and marks on the floor. F-Q ad been that way since R159 F-Q did not think it was in m. SSMENT RDINATION/CERTIFIED essments. The assessment ect the resident's status. must conduct or coordinate <i>i</i> th the appropriate th professionals.	F 25			1/31/17

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		E & MEDICAID SERVICES				0938-039
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COM	E SURVEY PLETED
		245295	B. WING			C 22/2016
NAME OF F	PROVIDER OR SUPPLIEF	1	ę	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
BETHEI	CARE CENTER			420 MARSHALL AVENUE		
				SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 278	(2) Each individua	I who completes a portion of the sign and certify the accuracy of	F 278			
	(j) Penalty for Fals (1) Under Medicar who willfully and k	e and Medicaid, an individual				
	resident assessm	erial and false statement in a ent is subject to a civil money e than \$1,000 for each				
	and false stateme	er individual to certify a material nt in a resident assessment is noney penalty or not more than assessment.				
	material and false	eement does not constitute a statement. ENT is not met as evidenced				
	interview, the facil	ent review, observation, and ity failed to accurately assess 1 40) reviewed for activities of		Immediate Corrective Actic The MDS dated 11/10/16 fo R140 was amended on Jan	or resident	
	Findings include:			Corrective Action as it appli MDS staff will be educated and verification of supportin	on the review	
	assessment, date	of the minimum data set (MDS) d 11/10/16, revealed that the 0 as needing limited assistance		documentation prior to codi January 31, 2017.		
	while eating. Acco assistance" is defi involved in the act maneuvering of lir	rding to the MDS, "limited ned as the resident being highly ivity, but staff providing guided nbs, or other non-weight e. This was a decline compared		Recurrence will be prevente MDS audit reviews will be c randomly 3x/week for ADL a Audits will continue for 90 d reviewed with the IDT, mon QAPI meeting to determine	onducted accuracy. lays and be thly, during the	

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	). 0938-039 TE SURVEY MPLETED
		245295	A. BUILDIN B. WING	IG		С
	PROVIDER OR SUPPLIER	245295	B. WING _	STREET ADDRESS, CITY, STATE, ZIP C		/22/2016
	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE
F 278	10/27/16, when sta supervision to eat. "supervision" is def encouraging, or cu Document review of 11/6/16-11/12/16, a 11/10/16 assessme documentation abo capability to feed s Document rview of plan, created 8/17/ able to eat indeper Document review of notes from 11/15/1 regular diet and ab During observation at 8:24 a.m. R140 When asked about confirmed no help able to eat indeper During an interview nursing assistant (I care said R140 did explained that staff room and left them need help setting u eating utensils. During an interview registered nurse (F R140 as needing li have helped in son	off assessed R140 to need only According to the MDS, fined as staff oversight, eing. of progress notes dated around the timeframe of the ent, did not reveal any but a change in R140's elf. R140's current nutrition care 16, revealed that R140 was idently after set-up. of Weekly Medicare meeting 6, revealed R140 was on a le to feed self independently. and interview on 12/21/2016, ate breakfast alone in bed. i needing help to eat, R140 was needed, as R140 was	F 27	continue or discontinue aud The Correction will be moni DON and/or Designee	0	

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		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 01/23/2017 RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		245295	B. WING			C 12/22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278 F 282 SS=D	support in the media progress notes, but associated with cha According to RN-E, was stable with no of During an interview RN-D was unable to staff were doing wh assistance during m was an example of was no documentat record. RN-D called to ask for anyone fa Over the phone, sta need help eating. 483.21 (b)(3)(ii) SEF PERSONS/PER CA (b)(3) Comprehensi The services provid as outlined by the c must- (ii) Be provided by the care. This REQUIREMEN by: Based on interview observation, the fac restorative nursing physician and as din 1 of 1 resident (R88 passive range of me extremities and for	cal record, RN-E reviewed was unable to find any notes inges or declines in eating. notes showed only that R140 changes. on 12/22/16, at 11:45 a.m. o find documentation of what en they provided limited heals. RN-D said guiding limbs limited assistance, but there ion of such in the medical I nursing staff on R140's floor uniliar with the resident's care. off confirmed R140 did not RVICES BY QUALIFIED ARE PLAN ve Care Plans ed or arranged by the facility, omprehensive care plan,	F 2		Immediate Corrective Action: Resident R88 was reassessed by thera on 12/22/16 and PROM recommendation were re-implemented. (RN)-B and (NA)-A were counseled for failing to provide resident R88 with PRC in accordance with the written plan of care.	ons

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ΓIPL	E CONSTRUCTION	(X3) DATE	0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG _		COMPLETED C 12/22/2016	
		245295	B. WING				
NAME OF I	PROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	/-	
BETHEL	CARE CENTER		420 MARSHALL AVENUE SAINT PAUL, MN 55102				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ige 26	F 28	82			
	Findings include:				Nursing assistants (NA) - C and (Na were counseled for failing to provide in accordance with the written plan	cares	
L L L L L L L L L L L L L L L L L L L		PROM to upper extremities, the physician and as directed			for resident R64. The care plan and care card for res R64 were reviewed and updated or 12/22/16.	ident	
	expressed serious quadriplegic and ur body or extremities the head, staff were passive range of m as ordered by the p process of "stretchi occurring daily even staff the PROM to t	on 12/19/16, at 6:45 p.m. R88 concern due to being a nable to move any part of the except for slight movement of e not consistently providing otion to the upper extremities physician. R88 referred to the ing me out" that was not n when R88 would remind the the upper extremities was to			Corrective Action as it applies to oth Other residents with therapy recommendations for restorative nu services will be reviewed to ensure recommendations remain current a being provided in accordance with individualized care plans. Residents at risk for pressure ulcer	ursing the nd are	
	initiated of 10/20/16 read, Restorative: F bilateral shoulders, up to 10 reps. (repe PROM (passive rar	of the plan of care with a date 5, and Revision on 12/13/16, Passive Range of Motion to elbows, wrists, fingers, daily etitions) (Gently stretch before nge of motion) Resident is very nicating [R88] needs.			development, per their current skin assessment, will have care plan rev completed to ensure interventions a implemented to prevent or heal curr pressure ulcers. The resident care will be updated to reflect current ca planned interventions. Residents who are dependent with	are rent guides re	
	Nursing Program, of Occupational Thera right and left upper one time a day for nurse (RN) signed	of the form titled; Restorative dated 10/13/16, by the apist directed PROM to the extremities to be completed 10 repetitions. The registered the form on 10/26/16, and four (NA) signed the form on			toileting will have care plan reviews completed to ensure interventions a implemented to meet the resident's based on the current bladder asses The resident care guides will be up to reflect current care planned interventions.	are needs sment.	
	11/7/16, indicating t Document review o Planning, dated rev				Policy and Procedure titled "Care Planning" was reviewed and remain current. Staff will be re-educated on the poli January 31, 2017.		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
RETHEI	CARE CENTER			4:	20 MARSHALL AVENUE		
DETTEL	CARL CENTER			S	AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa initiated upon admis interdisciplinary tea stay to promote opt residence. When interviewed of occupational therap titled, Restorative N communicate with t transfer the restoral department effective education was com R88's upper extrem Document review of Sheet, and indicate PROM was not doc 12/16/16, 12/17/16, 12/20/16. No other were documented. When interviewed of stated the PROM d When interviewed of RN-B verified the P R88 on 12/22/16 ar was responsible for would need to chec to complete the PR When interviewed of NA-A who worked w PROA was not com NA-A verified the PI with the nurse which	ge 27 ssion and maintained by the m throughout the resident's imal quality of life while in on 12/22/16, at 12:41 p.m. the bist (OT) verified the form lursing Program, was used to he nursing department to tive care to the nursing pleted regarding PROM to tites. f the form titled Treatment d 12/1/16 - 12/31/16, revealed umented as occurred until 12/18/16 12/19/16 and dates for December 2016 on 12/22/16, at 9:45 a.m. R88 id not occur on 12/21/16. on 12/22/16, at 10:00 a.m. ROM was not completed for a RN-B was not sure who completing the PROM and k if therapies or nursing were OM. on 12/22/16, at 12:55 p.m. with R88 on 12/21/16, verified apleted on 12/21/16 for R88. ROM was to be coordinated h had not occurred 12/21/16.	F 2			week stent an of will ed	
	When interviewed of	n nad not occurred 12/21/16. on 12/22/16, at 10:20 a.m., ursing staff were to complete					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COM	E SURVEY PLETED
		245295	B. WING			C 22/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	Continued From pa and document the r R88 daily. Furtherm not document daily on the December tr R64's hygiene, skin plan, last revised 8/ 2 to turn and reposi wheelchair. Staff er maintain position w sheet to prevent frid repositioning." R64's care plan, las staff "I am total ass needs. Staff will trai my brief, and provid clothing as needed. The care guide, und [every 1 hour] reposition The care guide, und "Incontinent of B&B and Change q [ever During continuous of 7:32 a.m. to 12:44 p sitting in R64's whe	ge 28 restorative nursing PROM for hore, RN-A verified nursing did services for PROM for [R88] eatment record. and activity of daily living care 24/16, directed staff " Staff of tion every 2 hours in bed and hsure comfort and assist to ith pillows in bed. Use draw ction/shearing with at revised 8/24/16, directed istance with 2 staff for toileting nsfer me to bed, and change de pericares and adjust " dated, directed staff "Q1 hr sition." dated, further directed staff [Bowel and Bladder] Check ry] 2 hours." observation on 12/21/16 from o.m., R64 was noted to be eelchair for 4 continuous hours	F 282	DEFICIENCY)		
	for incontinence. At assistants, (NA)-C change R64's incor perineal area as the cares and then tran	itioned, offloaded or checked 7:32 a.m., two nursing and (NA)-D were observed to thinence brief and clean her by provided R64 with morning sferred R64 from a bed into a 0 a.m., R64 was wheeled to				

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMI	E SURVEY PLETED
		245295	B. WING _				( 12/2	22/2016
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE	, ZIP CODE		
BETHEL	CARE CENTER				0 MARSHALL AVENUE AINT PAUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD O THE APPROPF	BE	(X5) COMPLETION DATE
F 282	provided care to R6 the dining room. At with assistance from finished eating brea table. At 9:54 a.m., wheeled R64 onto the room for a church s dining room until 10 R64 back onto the of 10:45 a.m. RN-G pr medication cart until her wheelchair near 12:13 p.m. when NA table to her room. N had repositioned, or incontinence since cares at 7:32 a.m. used a mechanical wheelchair to a bed adjusted R64's pan incontinence brief, of applied cream to R6 brief and adjusted F back to the dining ro When interviewed of RN-G reported she repositioning, offloa incontinence that da be repositioned or of incontinence every nurse manager, RN reposition R64 ever incontinence every	8:48 a.m., the nurse (RN)-G, 64 briefly in the hallway near 9:04 a.m. R64 ate breakfast n staff. At 9:32 a.m. R64 was ukfast, yet remained at the the activity assistant, (AA)-A, he elevator and to the dining service. R64 remained in the 0:42 a.m. when AA-A wheeled elevator and to the unit. At rovided cares near the ii 10:47 a.m. R64 then sat in r the dining room table until A-C wheeled R64 from the IA-C and NA-D reported they ffloaded or checked R64 for they assisted her with morning At 12:19 p.m. NA-C and NA-D lift to transfer R64 from a l. NA-C and NA-D then ts, removed R64's used cleaned the perineal area and 64's bottom, applied a new R64's pants. R64 was wheeled	F 28	82				
F 312	-	ARE PROVIDED FOR	F 3 <sup>-</sup>	12				1/31/17

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	D: 01/23/2017 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DA	TE SURVEY MPLETED
		245295	B. WING		12	C 2/ <b>22/2016</b>
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312 SS=D	DEPENDENT RES (a)(2) A resident whactivities of daily livis services to maintain personal and oral h This REQUIREMEN by: Based on documen observation, the fac personal hygiene w daily living preferen residents reviewed R64. Findings include: Document review o Data Set [MDS], da short term memory impaired cognitive s The MDS, dated 11 extensive assistant	IDENTS no is unable to carry out ing receives the necessary in good nutrition, grooming, and ygiene. NT is not met as evidenced nt review, interview and cility failed to ensure necessary as maintained and activities of ces were provided for 1 of 3 for activities of daily living, f R64's most recent Minimum ted 11/23/16, had long and problems and severely skills for daily decision making. /23/16, revealed R64 required ce from 2 or more staff for	F	312	Immediate Corrective Action: Nursing assistants (NA) - C and (NA) - D were counseled for failing to provide care in accordance with the written plan of care for resident R64. Corrective Action as it applies to others: The policy and procedure for Nursing Care Standards was reviewed on 1/17/17 and remains current. Nursing staff will be re-educated on the policy by January 31, 2017. Residents who are dependent with toileting will have care plan reviews completed to ensure interventions are	e ,
	dependent on assis toileting and transfe When interviewed of	on 12/20/16 at 10:40 a.m., a			implemented to meet the resident's needs based on their current bladder assessment. The resident care guides will be updated to reflect current care planned interventions.	3
	R64 was not provid hygiene cares beca "poop" when F-A vis facility several times 12/22/16 at 11:32 a recently and R64 ha movement/urine an occurrence.	R64's (F)-A, reported concerns ed with the help needed with suse R64 had smelled of sited and F-A had spoke to the s about those concerns. On .m., F-A, reported visiting ad an odor of bowel d that was a frequent			Recurrence will be prevented by: Visual audits will be conducted 3x/week on each unit to ensure staff remain complaint with providing care consistent with the resident's individualized plan of care for toileting. Audits will continue for 90 days and be reviewed during the monthly QAPI meeting to determine the need to continue or discontinue auditing	

Facility ID: 00913

If continuation sheet Page 31 of 46

TATEMEN	T OF DEFICIENCIES DF CORRECTION	A MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
		245295	B. WING _		12	C 2/ <b>22/2016</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC 420 MARSHALL AVENUE SAINT PAUL, MN 55102	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 312	sitting in a wheelch without being check or bladder or provid a.m., two nursing a were observed to of brief and clean the R64 with morning of wheeled to the dinin nurse (RN)-G, provi- hallway near the dinin ate breakfast with a a.m. R64 was finis remained at the tail assistant, (AA)-A, wand to the dining ro- remained at the tail assistant, (AA)-A, wand to the dining ro- remained in the dir when AA-A wheele and to the unit. At cares near the mea R64 then sat in the room table until 12 R64 from the table NA-D reported the incontinence or pro- since they assisted 7:32 a.m. At 12:19 mechanical lift to the to the bed. NA-C a pants, removed R6 cleaned R64's peri R64's pants. R64 with incontinence brief	p.m., R64 was noted to be hair for 4 continuous hours keed for incontinence of bowel ded perineal cares. At 7:32 assistants, (NA)-C and (NA)-D change R64's incontinence perineal area as they provided cares. At 8:19 a.m., R64 was ing room. At 8:48 a.m., the vided care to R64 briefly in the ining room. At 9:04 a.m. R64 assistance from staff. At 9:32 hed eating breakfast, yet ble. At 9:54 a.m., the activity wheeled R64 onto the elevator for a church service. R64 hing room until 10:42 a.m. ed R64 back onto the elevator 10:45 a.m. RN-G provided dication cart until 10:47 a.m. e wheelchair near the dining 13 p.m. when NA-C wheeled to R64's room. NA-C and y had not checked R64 for by ided perineal cares for R64 d R64 with morning cares at p.m. NA-C and NA-D used a ransfer R64 from a wheelchair and NA-D then adjusted R64's 54's used incontinence brief, ineal area and applied cream to lied a new brief and adjusted was wheeled back to the dining	F 31	The Correction will be monitor DON and/or Designee	ored by:		

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION G	0	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING	i				C 22/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C	ODE		
BETHEL	CARE CENTER				420 MARSHALL AVENUE SAINT PAUL, MN 55102			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 312	and apply cream to bowel movement. A manager, RN-F, ve every 2 hours and o brief as needed. The care area asset " Resident triggered always incontinent of all toileting needs. F of bladder. She has no pattern of incont assistance of 2 staf change brief, provid after each incontine two hours and char applied after each i R64's care plan, la staff " Bowel & Blad of bowel and bladde and need total assis have a bowel move the bathroom. I am to] limited mobility." am total assistance Staff will transfer m and provide pericar needed." The hygie living care plan, las staff " My routine is the dayroom and per music or activity for between meals. I lik get tired from sitting	ange R64's incontinence brief R64's bottom if there was a At this time, the nurse rified staff should check R64 change R64's incontinence assment, dated 3/15/16, noted d for urinary CAA related to of B & B and total assist with Resident is always incontinent a no control present and has inence. She receives total if for toileting needs. Staff will de pericare and adjust clothing ence. Staff will check her every age as needed. EPC cream is ncontinent episode." st revised 8/24/16, directed der Function: I am incontinent er. I do wear incontinent briefs st with pericares. I usually ment everyday. I do not use at risk for constipation d/t [due The interventions included "I with 2 staff for toileting needs. e to bed, and change my brief, es and adjust clothing as ne, skin and activity of daily t revised 8/24/16, directed to get up for meals and sit in eople-watch or enjoy the a while before I lay down se to nap between meals as I g too long in my wheelchair."	F	312				
	get tired from sitting The care guide, und							

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	-	AND HUMAN SERVICES			FORM	): 01/23/2017 / APPROVED ). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED C
		245295	B. WING		12	/ <b>22/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From pa and Change q [eve	-	FS	312		
F 314 SS=D	483.25(b)(1) TREA		F٥	314		1/31/17
	(b) Skin Integrity -					
	(1) Pressure ulcers comprehensive ass facility must ensure	essment of a resident, the				
	professional standa pressure ulcers and ulcers unless the in	es care, consistent with ards of practice, to prevent d does not develop pressure dividual's clinical condition they were unavoidable; and				
	necessary treatmer professional standa healing, prevent inf from developing. This REQUIREMEN	oressure ulcers receives nt and services, consistent with ards of practice, to promote ection and prevent new ulcers NT is not met as evidenced				
	interview, the facilit was provided to pre	nt review, observation, and y failed to ensure repositioning event pressure ulcer of 3 residents, R64, reviewed			Immediate Corrective Action: Nursing assistants (NA) - C and (NA) - D were counseled for failing to provide care in accordance with the written plan of care for resident R64.	
	Findings include:				The care plan and care card for resident R64 were reviewed and updated on	
	Data Set [MDS], da short term memory impaired cognitive s The MDS, dated 11 extensive assistant	f R64's most recent Minimum ted 11/23/16, had long and problems and severely skills for daily decision making. /23/16, revealed R64 required ce from 2 or more staff for nd bed mobility and was totally			12/22/16. Corrective Action as it applies to others: Residents at risk for pressure ulcer development, per their current skin assessment, will have care plan reviews completed to ensure interventions are	

Facility ID: 00913

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	0938-039 SURVEY PLETED	
		245295	B. WING				C 22/2016	
	PROVIDER OR SUPPLIER			4	TREET ADDRESS, CITY, STATE, ZIP CODE 20 MARSHALL AVENUE SAINT PAUL, MN 55102	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 314	dependent on assis toileting and transfe During continuous of 7:32 a.m. to 12:44 p sitting in R64's whe without being repose a.m., two nursing a were observed to p transferred R64 into R64 was wheeled to a.m., the nurse (RN briefly in the hallwa a.m. R64 ate break At 9:32 a.m. R64 w yet remained at the activity assistant, ( <i>A</i> elevator and to the service. R64 remain 10:42 a.m. when A/ the elevator and to provided cares nea 10:47 a.m. R64 the the dining room tab wheeled R64 from and NA-D reported offloaded R64 since morning cares at 7: and NA-D used a m from R64's wheelc back to the dining r When interviewed of RN-G verified did n repositioning or offl reported R64 shoul every 2 hours. The	stance from 2 or more staff for ers. observation on 12/21/16, from p.m., R64 was noted to be belchair for 4 continuous hours sitioned or offloaded. At 7:32 ssistants, (NA)-C and (NA)-D rovide morning cares and then p a wheelchair. At 8:19 a.m., o the dining room. At 8:48 J)-G, provided care to R64 y near the dining room. At 9:04 fast with assistance from staff. as finished eating breakfast, table. At 9:54 a.m., the AA)-A, wheeled R64 onto the dining room for a church ned in the dining room until A-A wheeled R64 back onto the unit. At 10:45 a.m. RN-G r the medication cart until n sat in R64's wheelchair near ble until 12:13 p.m. when NA-C the table to R64's room. NA-C they had repositioned or e they assisted R64 with c32 a.m. At 12:19 p.m. NA-C nechanical lift to transfer R64 hair to bed. R64 was wheeled oom at 12:44 p.m. on 12/21/16, at 1:49 p.m. ot assist R64 with oading that day. RN-G d be repositioned or offloaded e nurse manager, RN-F, l reposition R64 every 1 hours	F 3	314	implemented to prevent or heal cur pressure ulcers. The resident care will be updated to reflect current ca planned interventions. The Skin Program policy and proce was reviewed and remains current. Nursing staff will be educated on the policy by January 31, 2017. Recurrence will be prevented by: Visual audits will be conducted 3x/o on each unit to ensure staff remain complaint with providing care consis with the resident's individualized pla care for repositioning and pressure prevention. Audits will continue for days and be reviewed during the m QAPI meeting to determine the need continue or discontinue auditing. The Correction will be monitored by DON and/or designee	guides re edure week stent an of ulcer 90 onthly ed to		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 01/23/2017 APPROVED . 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		245295	B. WING	i			C <b>22/2016</b>
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BETHEL	CARE CENTER				420 MARSHALL AVENUE		
	I				SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 35	F:	314			
	(CAA), dated 3/15/7 triggered for pressu of stage II, total ass incontinence of B & stages of dementia include decreased decreased sensation diabetes, B&B [bow The interventions in repositioning q2hrs cream to buttocks a reduction mattress, knees, palm protec intact at this time." Document review of activity of daily living 8/24/16, directed st stage 2 coccyx ulce buttocks which hav right heel ulcer and hand. Per Braden A completed, I am at pressure ulcers d/t friction and shearin mobility and activity bladder, and dx [dia have pressure ulce fingers (3rd,4th, 5th contracture. Interve- turn and reposition wheelchair. Staff er maintain position w sheet to prevent frio repositioning."	B. Resident dx include end , DB, HTN. Some risk factors activity and mobility, on d/t dx [due to diagnosis] of rel and bladder] incontinence. Include turning and [every in bed and w/c, barrier and periarea, pressure abductor pillow between tors, foam boots. [R64] skin is f R64's hygiene, skin and g care plan, last revised aff " I was admitted with a er and pink areas on my e resolved. I also have a hx of blisters on my left arm and assessment recently a high risk for developing [due to] these risk factors; g, contractures, decreased r, incontinent of bowel and agnosis of diabetes. I recently r wound stage II on my left b) possibly from friction d/t entions included: "Staff of 2 to every 2 hours in bed and asure comfort and assist to ith pillows in bed. Use draw					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/23/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
		245295	B. WING			_ 22/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	
BETHEL	CARE CENTER			420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 314	Document review o	ge 36 r [every 1 hour] reposition." f the Skin Program policy, last ected staff "To provide care	F 3	14		
F 318 SS=D	and services to pre- development, to pro-	vent pressure ulcer omote the healing of pressure are present, and prevent ditional pressure REASE/PREVENT	F 3	18		1/31/17
	receives appropriat increase range of m decrease in range of (3) A resident with li appropriate service	imited range of motion e treatment and services to notion and/or to prevent further of motion. imited mobility receives s, equipment, and assistance ove mobility with the maximum				
	practicable indepen mobility is demonst This REQUIREMEN by: Based on interview facility failed to prov service as physician the plan of care, for sample identified fo (PROM) to upper ex Findings include: R88 did not receive	Adence unless a reduction in rably unavoidable. NT is not met as evidenced and document review, the vide a nursing restorative n ordered and as directed by 1 of 1 resident (R88) in the or passive range of motion xtremities.		Immediate Corrective Action Resident R88 was reassess on 12/22/16 and PROM red were re-implemented. (RN)-B and (NA)-A were con failing to provide resident R per the written plan of care. Corrective Action as it appli	sed by therapy commendations punseled for 88 with PROM es to others:	
		the physician and as directed		Residents with therapy reco for restorative nursing servi	ommendations	

Facility ID: 00913

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		245295	B. WING _			C	C 22/2016
	PROVIDER OR SUPPLIER			42	TREET ADDRESS, CITY, STATE, ZIP CODE 20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 318	When interviewed expressed serious quadriplegic and un body or extremities the head, staff were passive range of m as ordered by the p process of "stretchi occurring daily. Document review of (MDS) dated 11/4/1 cognitively intact. T 11/17/16, read, Res extremity) ROM da Document review of initiated of 10/20/16 read, Restorative: If bilateral shoulders, up to 10 reps. (repe PROM (passive ran capable of commun Document review of Nursing Program, of Occupational Thera ROM to the right an completed one time registered nurse (F 10/26/16, and four the form on 11/7/16 When interviewed of OT verified the form Program, was used nursing departmen	on 12/19/16, at 6:45 p.m. R88 concern due to being a nable to move any part of the except for slight movement of e not consistently providing notion to the upper extremities ohysician. R88 referred to the ing me out" that was not of the initial Minimum Data Set 16, indicated R88 as The physician orders dated storative, bilateral U/E (upper ily ROM 5-10 reps ea.(each). of the plan of care with a date 6 and Revision on 12/13/16, Passive Range of Motion to elbows, wrists, fingers, daily etitions) (Gently stretch before nge of motion) Resident is very nicating [R88] needs.	F 31	18	reviewed to ensure the recommend remain current and are being provi accordance with individualized care The policy and procedure Restorat Nursing Services was reviewed on 1/17/17 and remains current. Recurrence will be prevented by: Visual audits will be conducted 3x/o on each unit to ensure staff remain complaint with providing care cons with the resident's individualized pla care for restorative nursing service Additionally, documentation audits conducted to ensure restorative se are documented when completed. will continue for 90 days and be rev during the monthly QAPI meeting to determine the need to continue or discontinue auditing. The Correction will be monitored by DON and/or designee	ded in e plans. ive week stent an of s. will be rvices Audits <i>r</i> iewed o	

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		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 318		-	F3	318			
		ducation was completed R88's upper extremeties.					
	Sheet, indicated 12 PROM was not doc	of the form titled Treatment 2/1/16 - 12/31/16, revealed cumented as occurred until 12/18/16 12/19/16 and					
		on 12/22/16, at 9:45 a.m. R88 lid not occur on 12/21/16.					
	RN-B verified the P R88 on 12/21/16, a was responsible to	on 12/22/16, at 10:00 a.m. PROM was not completed for nd RN-B was not sure who complete the PROM and k if therapies or nursing were OM.					
	NA-A who worked w PROM was not con NA-A verified the P	on 12/22/16, at 12:55 p.m. with R88 on 12/21/16, verified npleted on 12/21/16 for R88. ROM was to be coordinated h had not occurred 12/21/16.					
F 371 SS=F	RN-A verified the m and document the m R88 daily. Furtherm not document daily on the December tr 483.60(i)(1)-(3) FO		F3	371			1/31/17
		d from sources approved or story by federal, state or local					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT CON	E SURVEY IPLETED
		245295	B. WING			C 22/2016
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	from local producer and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision d from consuming foo (i)(2) - Store, prepara accordance with pro- service safety. (i)(3) Have a policy foods brought to res- visitors to ensure sa handling, and consu- This REQUIREMEN by: Based on observati- review, the facility fa proper hand hygien reduce the risk of for residents who ate in and the facility failed hygiene during mea- potential to affect al facility. Findings include: During an observati- dietary aide (DA-A) to residents in the fi- bringing food and b	food items obtained directly s, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices. Des not preclude residents ods not procured by the facility. The, distribute and serve food in ofessional standards for food regarding use and storage of sidents by family and other afe and sanitary storage,	F 3	371	Immediate Corrective Action: Immediate hand hygiene re-education was provided to DA-A, C-B, and C-A. Corrective Action as it applies to others: The policy and procedure for Handwashing/Hygiene was reviewed and remains current. Dietary staff will be re-educated to the policy and procedure related to appropriate handwashing/hand hygiene and will complete a handwashing competency. Recurrence will be prevented by: Random weekly visual handwashing	

Facility ID: 00913

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		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	used clean hands to pulling a paper town hands. After drying of food out to a resi asked about whethe hygiene training, D/ pretty common kno facility explained has before new employ. During an observat cook (C-B) dished to floor dining room. B hands in the kitcher to shut off the water from the dispenser gloves and served to removing the glove kitchen sink for app shut off the water w a paper towel to dry During an observat C-A made gravy for C-A washed hands approximately six s water with bare han towel from the disp touch the handle of the stovetop, then c a cutting board. After and used bare hand can next to the stov onion waste. C-A th kitchen sink for app before returning to When interviewed of	o shut off the water before el from the dispenser to dry hands, DA-A brought a plate ident in the dining room. When er the facility provided hand A-A said handwashing seemed wledge, but thought that the andwashing in the training ees start to work in the facility. ion on 12/19/16, at 5:56 p.m. a up food on plates in the first Between plates, C-B washed n sink, then used clean hands r before pulling a paper towel to dry hands. C-B donned up two plates of food. After s, C-B washed hands in the proximately five seconds, then <i>i</i> th bare hands before pulling	F 3	371	audits will be conducted 3x/week for days. Audit results will be reviewed monthly with the IDT during the QA meeting for recommendations on the need to continue or discontinue audor. The Correction will be monitored by Dietary Manager and/or designee.	l PI ne dits.	

Facility ID: 00913

If continuation sheet Page 41 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING	 		C 22/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER			20 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371 F 441 SS=D	received handwash the job, and explain in-services that cov other things. The di confirmed that staff running while they of the water using a part Document review of Handwashing/Hygie revealed "Employee at least twenty (20) 483.80(a)(1)(2)(4)(e PREVENT SPREAL (a) Infection preven The facility must es and control program a minimum, the follow (1) A system for pre- investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin accepted national s implementation is F (2) Written standard for the program, wh limited to: (i) A system of surv possible communic	ing training when they start led staff also received monthly ered handwashing, among rector of dietary services should leave the water dry their hands, then shut off aper towel. f the facility policy titled; ene, revised August 2014, es must wash their hands for seconds." e)(f) INFECTION CONTROL, D, LINENS tion and control program. tablish an infection prevention n (IPCP) that must include, at owing elements: eventing, identifying, reporting, ontrolling infections and ases for all residents, staff, and other individuals under a contractual I upon the facility assessment og to §483.70(e) and following tandards (facility assessment	F 3			1/31/17

If continuation sheet Page 42 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245295	B. WING				C 22/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa facility;	ge 42	F4	41			
		om possible incidents of ase or infections should be					
		ansmission-based precautions event spread of infections;					
	(iv) When and how resident; including t	isolation should be used for a out not limited to:					
	depending upon the involved, and (B) A requirement th	ration of the isolation, infectious agent or organism nat the isolation should be the sible for the resident under the					
	must prohibit emplo disease or infected	ces under which the facility byees with a communicable skin lesions from direct hts or their food, if direct t the disease; and					
		ne procedures to be followed direct resident contact.					
		ording incidents identified PCP and the corrective a facility.					
		nel must handle, store, port linens so as to prevent the					
		The facility will conduct an IPCP and update their					

If continuation sheet Page 43 of 46

TATEMEN	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· · ·	E SURVEY PLETED
		245295	B. WING			C 22/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 441	program, as neces This REQUIREME by: Based on observa review, the facility f infection control me of 2 residents (R83 of daily living. Findings include: During observation was observed durin floor ventilator care On 12/19/16, at 1:1 assistant (NA)-Z le on holding two tras hallway toward R86 by R86's door and same gloves on. N R86's room and ca p.m. On 12/19/16, at 1:2 came from R83's room by R86's door. Rem room. During an interview registered nurse (F expectation was the gloves when finished another and after of contamination. RN-	NT is not met as evidenced tion, interview, and document failed to ensure appropriate easures were maintained for 2 8, R86) observed for activities as on 12/19/16, the following ng the initial tour on the second e unit: 15 p.m. observed nursing aving R83's room with gloves h bags walking down the 5's room and placed the bags entered R86's room with the A-Z took the gloves off while in the out of that room at 1:17 23 p.m. NA-Z acknowledged oom, walking in the hallway holding two trash bags and n after placing the trash bags noved gloves while in R86's of on 12/21/16, at 2:20 p.m. RN)-C. stated the facility at all staff should remove ed from one resident's room to loing cares to prevent -C added, Staff should not hallway unless actively	F 44	Immediate Corrective Action: (NA) – Z received immediate re- regarding glove use and hand hy Corrective Action as it applies to The policies Glove Use and Han were reviewed and remain curre Staff will be re-educated on the p January 31, 2017. Recurrence will be prevented by Glove use and handy hygiene au be conducted 3x/week for 90 day ensure staff remain complaint wi and procedures. Audit results wi shared with the IDT during the m QAPI meeting to determine the r continue or discontinue audits. The Corrective Action will be mon by: DON and/or designee	giene. others: dwashing nt. oolicies by dits will <i>v</i> s to th policy II be onthly eed to	

If continuation sheet Page 44 of 46

		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245295	B. WING			C 12/22/2016	
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441 F 465 SS=E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 4		Immediate corrective action:		1/31/17

Facility ID: 00913

If continuation sheet Page 45 of 46

		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245295	B. WING			C 12/22/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				20 MARSHALL AVENUE AINT PAUL, MN 55102		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE
F 465	review,the facility f (2nd, 3rd and 4th) of cleaned and free of resided on and/or v Findings include: On 12/22/16, at 9:3 tour with the mainte environmental direct	ailed to ensure 3 of 4 floors carpet was maintained, odor for residents who isited the floors. 5 a.m. during environmental enance director (MD) and ctor (ED), the following	F 4	165	Facility immediately started cleaning carpets on 2nd, 3rd, and 4th floors. Action as it applies to others: Carpet seams have been glued dow edges cut down. Carpet stains hav attempted to be removed.	wn with	
	concerns were noted and verified. The carpet on 2nd, 3rd and 4th floors were observed to be worn, torn and soiled. The third floor carpet was most noticeably observed to have a strong, urine-like odor permeating throughout the unit and a large round stain observed near the shower room door. On 12/19/16, at 4:46 p.m. the carpet outside R166's room had a musty urine-like odor.				Recurrence will be prevented by: Corporate is in final stages of nego with owner of building to complete a renovation project that will commen 2017. Preventative maintenance pr will be put into place to address cor with flooring as soon as they are no Maintenance was educated on 1/31 completing and documenting routin maintenance rounds and needing ro when identified. Negative Results of	a nce in rogram ncerns oted. I/17 ie epairs	
	stated every nurse request book where requests. Additiona the request books of Document reivew of directed: "Directions environmental to er sanitary, orderly, ar	f Audit Tool - Environmental s: Random weekly audits for nsure facility maintains a nd comfortable interior." licy was provided for			reviewed at QAPI. The correction will be monitored by Maintenance director and/or design	:	

Facility ID: 00913

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#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 10, 2017

Ms. Kelly Ellis, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, Minnesota 55102

RE: Project Number F5295025

Dear Ms. Ellis:

# Please Note: The health and life safety code survey findings will be processed under separate enforcement cycles.

On January 5, 2017, a standard survey was completed at your facility by the Minnesota Department of 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 life safety code (LSC) deficiency in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

# <u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit; <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

## DEPARTMENT OF PUBLIC SAFETY CONTACT

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

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

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

# **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 February 14, 2017, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

# ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of 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 April 5, 2017 (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 July 5, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

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

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

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

Sincerely,

# Mark meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Email: mark.meath@state.mn.us Telephone: (651) 201-4118 ax: (651) 215-9697

		AND HUMAN SERVICES	3	Ŧ	6705777	FORM	01/23/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D				DATE SURVEY OMPLETED	
		245295	B. WING			01/0	05/2017
NAME OF F	PROVIDER OR SUPPLIER	, ii		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER				120 MARSHALL AVENUE SAINT PAUL, MN 55102		
(24.0) (15	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000			
ø	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	POC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR HE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio Bethel Care Center with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National I	Survey was conducted by the nent of Public Safety - State on. At the time of this survey, was found not in compliance nts for participation in at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC), g Health Care.					
- -	PLEASE RETURN CORRECTION FO DEFICIENCIES ( K-TAGS) TO: Health Care Fire In State Fire Marshal 445 Minnesota St., St Paul, MN 55101	R THE FIRE SAFETY spections Division Suite 145			EPOC		
LABORATOR		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
	ically Signed						01/20/2017

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.

		AND HUMAN SERVICES				FORM	01/23/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMF	E SURVEY PLETED
		245295	B. WING _			01/0	)5/2017
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BETHEL	CARE CENTER			420			
040.15	CUMMADY CT	TEMENT OF DEFICIENCIES	ID	34	NINT PAUL, MN 55102 PROVIDER'S PLAN OF CORRECTION	)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE
K 000	Continued From pa	age 1	K 00	00			
	By email to:						
	Marian.Whitney@s Angela.Kappenma						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defic	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.					
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.					
	partial basement. T 2 different times. T constructed in 196 Type II(222) constr was constructed to that was determine construction. Beca the addition meet t	r is a 4-story building with a The building was constructed at he original building was 8 and was determined to be of uction. In 1982, an addition the East side of the building ed to be of Type II(222) use the original building and he construction type allowed gs, the facility was surveyed as					
	a complete fire ala detection in the con corridor, that is mo department notifica licensed capacity c of 96 at the time of				×		
	The requirement a	t 42 CFR Subpart 483.70(a) is					

Facility ID: 00913

If continuation sheet Page 2 of 3

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY
		245295	B. WING			01/05/2017
	PROVIDER OR SUPPLIER			42	REET ADDRESS, CITY, STATE, ZIP CODE 0 MARSHALL AVENUE AINT PAUL, MN 55102	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
	Corridors - Areas C Spaces (other than treatment rooms ar areas, nurse's stati facilities, open to th with the criteria und 18.3.6.1, 19.3.6.1 This STANDARD i Corridors - Areas C Spaces (other than treatment rooms ar areas, nurse's stati facilities, open to th with the criteria und 18.3.6.1, 19.3.6.1 Findings Include: On facility tour betw on 1/5/2017, based revealed that the fo A penetration was f running from 2nd fl been fire stopped. This deficient pract the residents, staff compartment.	Anced by: s - Areas Open to Corridor Open to Corridor patient sleeping rooms, and hazardous areas), waiting ons, gift shops, and cooking the corridor are in accordance der 18.3.6.1 and 19.3.6.1. s not met as evidenced by: Open to Corridor patient sleeping rooms, and hazardous areas), waiting ons, gift shops, and cooking the corridor are in accordance der 18.3.6.1 and 19.3.6.1.		000	Immediate Corrective Action: PVC drain pipe running from 2nd floor f 3rd floor was repaired with a fire barrier on 1/6/17. Corrective Action as it applies to others Maintenance director verified no other f barriers had breaches in them. Recurrence will be prevented by: Maintenance director ensure that when is repairing they are not breaching fire barrier or ensuring the fire barrier is restored. Contractors in buildings will have frequent checks to ensure they has sealed fire barriers before completion of their projects. The Correction will be monitored by: Maintenance Director and/or Designee	: ire he ave of

Facility ID: 00913

If continuation sheet Page 3 of 3



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered January 10, 2017

Ms. Kelly Ellis, Administrator Bethel Care Center 420 Marshall Avenue Saint Paul, MN 55102

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5295026 and Complaint Number H5295122

Dear Ms. Ellis:

The above facility was surveyed on December 19, 2016 through December 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5295122, which was found to be substantiated at Minnesota Statute 626.557 Subd. 4a (St - 2 - 1995), Minnesota Rule 4658.0405 Subp. 3 (St - 2 - 0565) and Minnesota Rule 4658.0525 subp. 3 (St - 2 - 0900). At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

Minneso	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY LETED
		00913	B. WING		( 12/2	) 2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RETHEI	CARE CENTER		HALL AVEN	-		
DETTIEL	CARE CENTER	SAINT PA	UL, MN 551	02		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall I with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet <http: www.health.i<br="">fobul.htm&gt; The St delineated on the a</http:>	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at: state.mn.us/divs/fpc/profinfo/in ate licensing orders are				
ABORATOR	epartment of Health 7 DIRECTOR'S OR PROVID ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE 01/20/17

Electronically Signed

STATE FORM

If continuation sheet 1 of 45

I ) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
00913	B. WING			22/2016
STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Statutes/Rules, please ed" in the box available for icate in the electronic s, under the heading ate your orders will be ronically submitting to the of Health. , 12/21/16 & 12/22/16, rtment's staff, visited the following correction ase indicate in your ction that you have and identify the date wher westigation was also of the recertification survey aplaint H5295122 was aint was substantiated. ed at State Statute 626.557 tate Licensing Rule g 0565) State Licensing 3 (tag 0900). of Health is documenting rrection Orders using umbers have been state statutes/rules for	1 <i>1</i> .	DEFICIENC	ΣΥ)	
	00913 STREET A 420 MAF SAINT P ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) 1 orders being submitted to ough no plan of correction Statutes/Rules, please ed" in the box available for icate in the electronic s, under the heading ate your orders will be ronically submitting to the of Health. 12/21/16 & 12/22/16, tment's staff, visited the following correction ase indicate in your ction that you have and identify the date wher vestigation was also of the recertification survey uplaint H5295122 was aint was substantiated. ed at State Statute 626.557 tate Licensing Rule g 0565) State Licensing 3 (tag 0900). of Health is documenting rrection Orders using umbers have been state statutes/rules for Der appears in the far left efix Tag." The state bliance is listed in the	p PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE A. BUILDING:         00913       B. WING         STREET ADDRESS, CITY, ST 420 MARSHALL AVENU SAINT PAUL, MN 5510         ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)       ID PREFIX TAG         1       2 000         orders being submitted to ough no plan of correction Statutes/Rules, please ed" in the box available for icate in the electronic s, under the heading ate your orders will be ronically submitting to the of Health.       2 000         12/221/16 & 12/22/16, tment's staff, visited the following correction ase indicate in your ction that you have and identify the date when       In vestigation was also of the recertification survey.         Nplaint H5295122 was aint was substantiated. ed at State Statute 626.557 tate Licensing Rule g 0565) State Licensing 3 (tag 0900).       In of Health is documenting rrection Orders using umbers have been state statutes/rules for         of Health is documenting rrection Orders using umbers have been state statutes/rules for       In the state biance is listed in the	p. PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:         00913       B. WING         STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE SAINT PAUL, MN 55102         ENT OF DEFICIENCIES STIBE PRECEDED BY FULL SENTIFYING INFORMATION)         PREFIX DENTIFYING INFORMATION)       PROVIDER'S PLAN OF CROSS-REFERENCED OF TAG         PROVIDER'S PLAN OF CROSS-REFERENCED TO DEFICIENCIES       ID PREFIX (EACH CORRECTIVE ACT CROSS-REFERENCED OF DEFICIENCIES         1       2 000         12/21/16 & 12/22/16, trant vasubst	PROVIDER/SUPPLEX/CLA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:       (X3) DAT COM         00913       B. WING       12/         STREET ADDRESS, CITY, STATE, ZIP CODE         420 MARSHALL AVENUE SAINT PAUL, MN 55102       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         ENT OF DEFICIENCES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         1       2 000         orders being submitted to ough no plan of correction Statutes/Rules, please ed" in the box available for icate in the electronic s, under the heading the your orders will be ronically submitting to the of Health.       2 000         12/21/16       12/22/16, tment's staff, visited the following correction ase indicate in your ction that you have and identify the date when vestigation was also of the recertification survey.       Image: Indicate C26.557 tate Licensing Rule g 0565) State Licensing 3 (tag 0900).       Image: Indicate C26.557 tate Licensing Rule g 0565) State Licensing 3 (tag 0900).       Image: Indicate C26.557 tate Licensing Rule g 0565) State Licensing         0 Health is documenting recetion Orders using umbers have been state statutes/rules for       Image: Image

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00913	B. WING			22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
BETHEL	CARE CENTER		RSHALL AVEN AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ige 2	2 000			
	after the statement evidenced by." Follo	n violation of the state statute , "This Rule is not met as owing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 380	MN Rule 4658.0200 Residents; Telepho	0 Subp. 2 Policies Concerning nes	2 380			1/31/17
	provide at least one which is accessible case of emergency access to a telepho within the building f home may charge t	es. A nursing home must e non-coin-operated telephone to residents at all times in a. A resident must have one at a convenient location for personal use. A nursing the resident for actual long nat the resident incurs.	•			
	by: Based on documen interview, the facilit residents (R82, R12 R167) on the 3rd flo privacy when using	ent is not met as evidenced at review, observation and y failed to ensure 7 of 47 2, R55, R91, R43, R115 and oor had reasonable access to the telephone for ersonal phone calls.		Corrected		
	Findings include:					

Minnesota Department of Health STATE FORM

ZHIN11

If continuation sheet 3 of 45

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00913	B. WING			C <b>22/2016</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 380	Continued From pa	ige 3	2 380			
		of R82's most recent Minimum ated 9/17/16, revealed severe nt.				
	R82 was being ass nurse (LPN)-B to m nursing desk. R82 on the phone by the common area near	ion on 12/19/16, at 6:45 p.m. isted by licensed practical nake a phone call from the could be overheard speaking ose at the desk and in the the phone. LPN-B reported any other phone for residents				
	dated 9/13/16, reve impairment and rec from staff to comple	of R12's most recent MDS, ealed R12 had severe cognitive quired extensive assistance ete all activities of daily living n on and off the unit.	9			
	nursing assistant ( phone call at the nuright next to R82, w	ion on 12/19/16, at 6:56 p.m., NA)-E assisted R12 to make a ursing desk. R12 was seated who was still using the phone. e was a cordless phone but nt might be using it.	ı			
	dated 10/10/16, rev	of R55's most recent (MDS), realed R55 was cognitively ransfer from bed or other				
	reported there was but that it was ofter use by another resi calls and that peop	on 12/20/16 at 10:32 a.m., R55 a cordless phone on the unit, n not able to be located or in dent. R55 reported missed le were unable to contact ymore. R55 reported there m for phone use.	5			
	Document review o	f R91's most recent MDS,				

	a Department of He OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			C
		00913	B. WING			22/2016
AME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, ST			
ETHEL (	CARE CENTER		RSHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 380	Continued From pa	age 4	2 380			
	dated 11/24/16, rev impairment.	realed moderate cognitive				
	R91 reported not b	on 12/20/16, at 11:53 a.m., eing able to make a private re was sometimes 3-4 people phone on the unit.				
		of R43's most recent MDS, realed moderate cognitive				
	LPN-A informed R4 directed R43 to a p stood at the nursing	tion on 12/20/16, at 12:37 p.m. 43 about a phone call and then hone at the nursing desk. R43 g desk to make the phone call another, more private area, to to R43.				
		tion on 12/20/16, at 3:50 p.m. le call from the nursing desk.				
	R167 made a phon nursing desk. Ther other residents and R167 was observed not being used by t prefering to make a pointed to a cordles dining room and re	tion on 12/22/16, at 10:15 a.m. he call from the phone at the e was background noise as d staff were in the area and d to use hand to cover the ear the phone. R167 reported a private phone call. R167 ss phone on a table in the ported it did not work when on multiple occasions.				
	A policy on telephonot provided.	ne privacy was requested but				
		THOD OF CORRECTION: The				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			С
		00913	B. WING			22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE		
BETHEL	CARE CENTER		ISHALL AVEI AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 380	Continued From pa	ige 5	2 380			
	and/or revise policie resident rights for p telephone are comp acted upon. The ac educate all appropr procedures. The ac	signee could develop, review, es and procedures to ensure privacy when using the municated appropriately and liministrator or designee could riate staff on the policies and diministrator or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) Days.	R CORRECTION: Twenty-one	•			
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			1/31/17
		omprehensive plan of care I personnel involved in the t				
	by: Based on interview observation, the fac restorative nursing physician and as di 1 of 1 resident (R88 passive range of m extremities and for reviewed for pressu hygiene.	ent is not met as evidenced and document review, and cility failed to provide a program as ordered by the rected by the plan of care, for 3) in the sample identified for otion (PROM) to upper 1 of 3 residents, R64, ure ulcers and personal		Corrected		
	Findings include:					
		PROM to upper extremities, the physician and as directed				

STATE FORM

If continuation sheet 6 of 45

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00913	B. WING			C <b>22/2016</b>
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BETHEL	CARE CENTER		RSHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 6	2 565			
	by the plan of care					
	expressed serious quadriplegic and un body or extremities the head, staff were passive range of m as ordered by the p process of "stretch occurring daily eve staff the PROM to be completed daily Document review of initiated of 10/20/16 read, Restorative: I bilateral shoulders,	of the plan of care with a date 6, and Revision on 12/13/16, Passive Range of Motion to , elbows, wrists, fingers, daily	F			
	PROM (passive rai capable of commu	etitions) (Gently stretch before nge of motion) Resident is very nicating [R88] needs.	/			
	Nursing Program, or Occupational Thera right and left upper one time a day for nurse (RN) signed	of the form titled; Restorative dated 10/13/16, by the apist directed PROM to the rextremities to be completed 10 repetitions. The registered the form on 10/26/16, and four (NA) signed the form on training occurred				
	Planning, dated rev Individual, resident initiated upon admi interdisciplinary tea	of the policy titled; Care vision August 2016, read, -centered care planning be ission and maintained by the am throughout the resident's timal quality of life while in				

<b>420 MARSHALL AVENUE</b> SAINT PAUL, MN 55102(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX PREFIX TAGPROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)2 565Continued From page 7 occupational therapist (OT) verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing education was completed regarding PROM to R88's upper extremities.2 565Document review of the form titled TreatmentId	TION ULD BE	C 22/2016 (X5) COMPLET DATE
<b>420 MARSHALL AVENUE</b> SAINT PAUL, MN 55102(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX PREFIX TAGPROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO DEFICIENCY)2 565Continued From page 7 occupational therapist (OT) verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing 	ULD BE	COMPLET
BETHEL CARE CENTER         SAINT PAUL, MN 55102         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECT         2 565       Continued From page 7       2 565       Continued From page 7       2 565         occupational therapist (OT) verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing education was completed regarding PROM to R88's upper extremities.       2 565         Document review of the form titled Treatment       Document review of the form titled Treatment	ULD BE	COMPLET
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)         2 565       Continued From page 7       2 565         occupational therapist (OT) verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing education was completed regarding PROM to R88's upper extremities.       Document review of the form titled Treatment	ULD BE	COMPLET
occupational therapist (OT) verified the form titled, Restorative Nursing Program, was used to communicate with the nursing department to transfer the restorative care to the nursing department effective 11/7/16, when the nursing education was completed regarding PROM to R88's upper extremities.		
Sheet, and indicated 12/1/16 - 12/31/16, revealed         PROM was not documented as occurred until         12/16/16, 12/17/16, 12/18/16 12/19/16 and         12/20/16. No other dates for December 2016         were documented.         When interviewed on 12/22/16, at 9:45 a.m. R88         stated the PROM did not occur on 12/21/16.         When interviewed on 12/22/16, at 10:00 a.m.         RN-B verified the PROM was not completed for         R88 on 12/22/16 and RN-B was not sure who         was responsible for completing the PROM and         would need to check if therapies or nursing were         to complete the PROM.         When interviewed on 12/22/16, at 12:55 p.m.         NA-A who worked with R88 on 12/21/16, verified         PROM was not completed on 12/21/16 for R88.         NA-A verified the PROM was to be coordinated         with the nurse which had not occurred 12/21/16.         When interviewed on 12/22/16, at 10:20 a.m.,         RN-A verified the nursing staff were to complete         and document the restorative nursing PROM for		

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
		00913	B. WING			C 22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVENI AUL, MN 5510			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	ge 8	2 565			
	hygiene.					
	plan, last revised 8/ 2 to turn and reposi wheelchair. Staff er	and activity of daily living care (24/16, directed staff "Staff of ition every 2 hours in bed and nsure comfort and assist to ith pillows in bed. Use draw ction/shearing with				
	staff "I am total ass needs. Staff will tra	st revised 8/24/16, directed istance with 2 staff for toileting nsfer me to bed, and change de pericares and adjust ."				
	The care guide, und [every 1 hour] repos	dated,directed staff "Q1 hr sition."				
		dated, further directed staff [Bowel and Bladder] Check ry] 2 hours."				
	7:32 a.m. to 12:44 p sitting in R64's whe without being repose for incontinence. At assistants, (NA)-C change R64's incor perineal area as the cares and then tran wheelchair. At 8:19 the dining room. At provided care to R6 the dining room. At with assistance from	bbservation on 12/21/16 from o.m., R64 was noted to be eelchair for 4 continuous hours sitioned, offloaded or checked 7:32 a.m., two nursing and (NA)-D were observed to ntinence brief and clean her ey provided R64 with morning isferred R64 from a bed into a 0 a.m., R64 was wheeled to 8:48 a.m., the nurse (RN)-G, 64 briefly in the hallway near 9:04 a.m. R64 ate breakfast n staff. At 9:32 a.m. R64 was				
	table. At 9:54 a.m.,	akfast, yet remained at the the activity assistant, (AA)-A, the elevator and to the dining				

Minnesota Department of He	alth			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00913	B. WING			C 22/2016
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
BETHEL CARE CENTER		SHALL AVENU AUL, MN 5510			
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETE DATE
2 565 Continued From pa	ge 9	2 565			
room for a church s dining room until 10 R64 back onto the 10:45 a.m. RN-G p medication cart unt her wheelchair nea 12:13 p.m. when N table to her room. N had repositioned, o incontinence since cares at 7:32 a.m. used a mechanical wheelchair to a bec adjusted R64's pan incontinence brief, a applied cream to R brief and adjusted R back to the dining r When interviewed of RN-G reported she repositioning, offloa incontinence that d be repositioned or of incontinence every nurse manager, RN reposition R64 ever incontinence brief a care guide. SUGGESTED MET The director of nurs develop and impler related to care plan designee, could pro staff related to the t interventions. The of	service. R64 remained in the 0:42 a.m. when AA-A wheeled elevator and to the unit. At rovided cares near the il 10:47 a.m. R64 then sat in r the dining room table until A-C wheeled R64 from the NA-C and NA-D reported they ffloaded or checked R64 for they assisted her with morning At 12:19 p.m. NA-C and NA-D lift to transfer R64 from a I. NA-C and NA-D then ts, removed R64's used cleaned the perineal area and 64's bottom, applied a new R64's pants. R64 was wheeled				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00913	B. WING			22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 565	Continued From pa	ge 10	2 565			
	audits to ensure co	mpliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 840	MN Rule 4658.0520 Proper Nursing Ca	0 Subp. 2 B Adequate and re; Clean skin	2 840			1/31/17
		r determining adequate and criteria for determining er care include:				
	odors. A bathing pl resident's plan of c condition requires t must be given a co other day and more incontinent residen every two hours, ar	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every e often as indicated. An t must be checked at least ad must receive perineal care ode of incontinence.				
	Notwithstanding Mi 4658.0520, an inco checked according written in the reside attending physician interval longer than if competent, or a fa appointed conserva agent of a resident in writing to waive p determining this int	I. Incontinent residents. nnesota Rules, part ntinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident, amily member or legally ator, guardian, or health care who is not competent, agrees obysician involvement in erval, and this waiver is resident's care plan. ]				
	promptly each time	hing must be provided the bed or clothing is soiled. des the washing and drying of				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		00913	B. WING		12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVE AUL, MN 55 <sup>.</sup>			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	E APPROPRIATE	COMPLET DATE
2 840	Continued From pa	age 11	2 840			
	to keep the bed dry comfort. Special a skin to prevent irrita types of protectors completely covered contact with the res	Pads or diapers must be used v and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and moved immediately from revent odors.				
	by: Based on documer observation, the fac personal hygiene w daily living preferen	ent is not met as evidenced nt review, interview and cility failed to ensure necessary vas maintained and activities of nces were provided for 1 of 3 for activities of daily living,		Corrected		
	Findings include:					
	Data Set [MDS], da short term memory impaired cognitive The MDS, dated 11 extensive assistant personal hygiene a	of R64's most recent Minimum ated 11/23/16, had long and problems and severely skills for daily decision making 1/23/16, revealed R64 required ce from 2 or more staff for and bed mobility and was totally stance from 2 or more staff for ers.	,			
	family member of F R64 was not provid hygiene cares beca "poop" when F-A vi facility several time	on 12/20/16 at 10:40 a.m., a R64's (F)-A, reported concerns led with the help needed with ause R64 had smelled of sited and F-A had spoke to the s about those concerns. On a.m., F-A, reported visiting				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
	00913		B. WING		12/2	22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 840	Continued From pa	ge 12	2 840			
	recently and R64 had an odor of bowel movement/urine and that was a frequent occurrence.					
	7:32 a.m. to 12:44 p sitting in her wheeld without being check or bladder or provid a.m., two nursing a were observed to c brief and clean the R64 with morning c wheeled to the dinin nurse (RN)-G, prov hallway near the dir ate breakfast with a a.m. R64 was finish remained at the tab assistant, (AA)-A, w and to the dining ro remained in the din when AA-A wheeled and to the unit. At 1 cares near the med R64 then sat in the room table until 12: R64 from the table NA-D reported they incontinence or pro since they assisted 7:32 a.m. At 12:19 mechanical lift to tra to the bed. NA-C ar pants, removed R6 cleaned R64's perin R64's bottom, appli	bbservation on 12/21/16 from b.m., R64 was noted to be chair for 4 continuous hours ked for incontinence of bowel led perineal cares. At 7:32 ssistants, (NA)-C and (NA)-D hange R64's incontinence perineal area as they provided ares. At 8:19 a.m., R64 was ng room. At 8:48 a.m., the ided care to R64 briefly in the ning room. At 9:04 a.m. R64 assistance from staff. At 9:32 ned eating breakfast, yet le. At 9:54 a.m., the activity wheeled R64 onto the elevator om for a church service. R64 ing room until 10:42 a.m. d R64 back onto the elevator 0:45 a.m. RN-G provided lication cart until 10:47 a.m. wheelchair near the dining 13 p.m. when NA-C wheeled to R64's room. NA-C and had not checked R64 for vided perineal cares for R64 R64 with morning cares at p.m. NA-C and NA-D used a ansfer R64 from a wheelchair nd NA-D then adjusted R64's 4's used incontinence brief, neal area and applied cream to ed a new brief and adjusted 'as wheeled back to the dining				

AND PLAN OF CORRECTION		Alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00913	B. WING	B. WING		22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 840	On 12/21/16 at 1:49 not assist R64 with incontinence brief th should be checked and staff should cha and apply cream to bowel movement. A manager, RN-F, verey every 2 hours and co brief as needed. The care area assee " Resident triggered always incontinent of all toileting needs. F of bladder. She has no pattern of incont assistance of 2 staf change brief, provid after each incontine two hours and chan applied after each in R64's care plan, lass staff " Bowel & Blad of bowel and bladde and need total assis have a bowel move the bathroom. I am to] limited mobility." am total assistance Staff will transfer m and provide pericar needed." The hygie living care plan, lass staff " My routine is the dayroom and pericar music or activity for	ge 13 9 p.m. RN-G reported she did checking or changing her hat day. RN-G reported R64 for incontinence every 2 hours ange R64's incontinence brief R64's bottom if there was a at this time, the nurse rified staff should check R64 change R64's incontinence ssment, dated 3/15/16, noted for urinary CAA related to of B & B and total assist with Resident is always incontinent no control present and has inence. She receives total f for toileting needs. Staff will be pericare and adjust clothing ence. Staff will check her every ge as needed. EPC cream is nocontinent episode." st revised 8/24/16, directed lder Function: I am incontinent er. I do wear incontinent briefs st with pericares. I usually ment everyday. I do not use at risk for constipation d/t [due The interventions included "I with 2 staff for toileting needs e to bed, and change my brief es and adjust clothing as ne, skin and activity of daily t revised 8/24/16, directed to get up for meals and sit in exple-watch or enjoy the a while before I lay down as to nap between meals as I				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
		00913	B. WING			C 12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST				
BETHEL	CARE CENTER		RSHALL AVENU AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE	
2 840	Continued From pa	ige 14	2 840				
		dated, further directed staff [Bowel and Bladder] Check ry] 2 hours."					
	The director of nurs all residents at risk change to assure the necessary treatmen nursing or designed audits of the delive	THOD OF CORRECTION: sing or designee, could review for incontinence check and ney are receiving the nt/services. The director of e, could conduct random ry of care; to ensure nd services are implemented.					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
2 895	MN Rule 4658.052 Motion	5 Subp. 2.B Rehab - Range of	2 895			1/31/17	
	that is directed tow through positioning implemented and n comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which					
	receives appropriat	h a limited range of motion te treatment and services to notion and to prevent further of motion.					
	This MN Requirem by:	ent is not met as evidenced					
		and document review, the		Corrected			

STATE FORM

ZHIN11

If continuation sheet 15 of 45

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED	
		00913	B. WING			C 12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE			
BETHEL	CARE CENTER		ISHALL AVENI AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 895	Continued From pa	age 15	2 895				
	service as physicia the plan of care, fo	vide a nursing restorative In ordered and as directed by r 1 of 1 resident (R88) in the or passive range of motion extremities.					
	Findings include:						
		e PROM to upper extremeties, y the physician and as directed					
	expressed serious quadriplegic and un body or extremities the head, staff were passive range of m as ordered by the p	on 12/19/16, at 6:45 p.m. R88 concern due to being a nable to move any part of the s except for slight movement of e not consistently providing notion to the upper extremities ohysician. R88 referred to the ing me out" that was not	:				
	(MDS) dated 11/4/ <sup>-</sup> cognitively intact. T 11/17/16, read, Res	of the initial Minimum Data Set 16, indicated R88 as The physician orders dated storative, bilateral U/E (upper ily ROM 5-10 reps ea.(each).					
	initiated of 10/20/10 read, Restorative: bilateral shoulders, up to 10 reps. (rep PROM (passive rat	of the plan of care with a date 6 and Revision on 12/13/16, Passive Range of Motion to , elbows, wrists, fingers, daily etitions) (Gently stretch before nge of motion) Resident is very nicating [R88] needs.	,				
	Nursing Program, or Occupational Thera	of the form titled; Restorative dated 10/13/16, by the apist (OT) directed passive nd left upper extremities to be					

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00913	B. WING			C 12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
BETHEL	CARE CENTER		SHALL AVENU				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 895	Continued From pa	ge 16	2 895				
	registered nurse (R	e a day for 10 repetitions. The N) signed the form on nursing assistants (NA) signed 5.					
	OT verified the form Program, was used nursing department care to the nursing when the nursing e	on 12/22/16, at 12:41 p.m. the in titled, Restorative Nursing I to communicate with the t to transfer the restorative department effective 11/7/16, ducation was completed o R88's upper extremeties.					
	Sheet, indicated 12 PROM was not doo	f the form titled Treatment /1/16 - 12/31/16, revealed sumented as occurred until 12/18/16 12/19/16 and					
		on 12/22/16, at 9:45 a.m. R88 id not occur on 12/21/16.					
	RN-B verified the P R88 on 12/21/16, a was responsible to	on 12/22/16, at 10:00 a.m. ROM was not completed for nd RN-B was not sure who complete the PROM and k if therapies or nursing were OM.					
	NA-A who worked w PROM was not con NA-A verified the P	on 12/22/16, at 12:55 p.m. with R88 on 12/21/16, verified npleted on 12/21/16 for R88. ROM was to be coordinated h had not occurred 12/21/16.					
	RN-A verified the n and document the R88 daily. Furtherm	on 12/22/16, at 10:20 a.m., ursing staff were to complete restorative nursing PROM for nore, RN-A verified nursing did services for PROM for [R88]					

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00913	B. WING			C <b>22/2016</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BETHEL	CARE CENTER		RSHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 17	2 895			
	on the December t	reatment record.				
	The director of nur- all residents at risk they are receiving t treatment/services director of nursing random audits of t appropriate care an to reduce the risk f	THOD OF CORRECTION: sing or designee, could review for contractures to assure the necessary to prevent contractures. The or designee, could conduct he delivery of care; to ensure nd services are implemented; or contracture development. R CORRECTION: Twenty-one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			1/31/17
	comprehensive res of nursing services	sores. Based on the sident assessment, the director must coordinate the nursing care plan which	r			
	without pressure s pressure sores unl condition demonstr	to enters the nursing home cores does not develop ess the individual's clinical rates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores by treatment and services to revent infection, and prevent veloping.				
	This MN Requirem by:	ent is not met as evidenced				

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	COM	E SURVEY PLETED
		00913	B. WING		12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BETHEL	CARE CENTER		HALL AVEN			
			UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 18	2 900			
	interview, the facility was provided to pre-	t review, observation, and y failed to ensure repositioning event pressure ulcer of 3 residents, R64, reviewed		Corrected		
	Findings include:					
	short term memory impaired cognitive s The MDS, dated 11 extensive assistance personal hygiene as	ted 11/23/16, had long and problems and severely skills for daily decision making. /23/16, revealed R64 required ce from 2 or more staff for nd bed mobility and was totally stance from 2 or more staff for ers.				
	7:32 a.m. to 12:44 p sitting in R64's whe without being repose a.m., two nursing a were observed to p transferred R64 into R64 was wheeled to a.m., the nurse (RN briefly in the hallwar a.m. R64 ate break At 9:32 a.m. R64 w yet remained at the activity assistant, (A elevator and to the service. R64 remain 10:42 a.m. when AA the elevator and to provided cares nea 10:47 a.m. R64 the	bbservation on 12/21/16, from b.m., R64 was noted to be elchair for 4 continuous hours sitioned or offloaded. At 7:32 ssistants, (NA)-C and (NA)-D rovide morning cares and then b a wheelchair. At 8:19 a.m., o the dining room. At 8:48 I)-G, provided care to R64 y near the dining room. At 9:04 fast with assistance from staff. as finished eating breakfast, table. At 9:54 a.m., the NA)-A, wheeled R64 onto the dining room for a church hed in the dining room until A-A wheeled R64 back onto the unit. At 10:45 a.m. RN-G r the medication cart until n sat in R64's wheelchair near le until 12:13 p.m. when NA-C				

Minnesota Department of Health STATE FORM

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	. ,	CONSTRUCTION	COM	E SURVEY PLETED C 22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	ADDRESS, CITY, STATE, ZIP CODE				
			SHALL AVEN				
BEIHEL	CARE CENTER	SAINT P	AUL, MN 5510	02			
(X4) ID PREFIX TAG	RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ge 19	2 900				
	offloaded R64 since morning cares at 7: and NA-D used a m from R64's wheelc back to the dining r When interviewed of RN-G verified did m repositioning or offl reported R64 shoul every 2 hours. The	on 12/21/16, at 1:49 p.m. ot assist R64 with oading that day. RN-G d be repositioned or offloaded nurse manager, RN-F, I reposition R64 every 1 hours					
	Document review of the care area assessment (CAA), dated 3/15/16, revealed "Resident triggered for pressure ulcers related to presence of stage II, total assist with all mobility, incontinence of B & B. Resident dx include end stages of dementia, DB, HTN. Some risk factors include decreased activity and mobility, decreased sensation d/t dx [due to diagnosis] of diabetes, B&B [bowel and bladder] incontinence. The interventions include turning and repositioning q2hrs [every in bed and w/c, barrier cream to buttocks and periarea, pressure reduction mattress, abductor pillow between knees, palm protectors, foam boots. [R64] skin is intact at this time."						
	activity of daily living 8/24/16, directed st stage 2 coccyx ulce buttocks which hav right heel ulcer and hand. Per Braden A completed, I am at	f R64's hygiene, skin and g care plan, last revised aff " I was admitted with a er and pink areas on my e resolved. I also have a hx of blisters on my left arm and assessment recently a high risk for developing [due to] these risk factors;					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00913	B. WING			C 22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BETHEL	CARE CENTER	-	SHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900		-	2 900			
	mobility and activity bladder, and dx [dia have pressure ulce fingers (3rd,4th, 5th contracture. Interve turn and reposition wheelchair. Staff er	g, contractures, decreased y, incontinent of bowel and agnosis of diabetes. I recently r wound stage II on my left h) possibly from friction d/t entions included: "Staff of 2 to every 2 hours in bed and hsure comfort and assist to rith pillows in bed. Use draw ction/shearing with				
		of the undated care guide, Ir [every 1 hour] reposition."				
	revised 9/2016, dire and services to pre development, to pro	of the Skin Program policy, last ected staff "To provide care event pressure ulcer omote the healing of pressure are present, and prevent ditional pressure				
	The director of nurs all residents at risk they are receiving t treatment/services from developing an pressure ulcers. The designee, could con delivery of care; to	to prevent pressure ulcers ad to promote healing of he director of nursing or nduct random audits of the ensure appropriate care and nented; to reduce the risk for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION (X:	B) DATE SURVEY COMPLETED	
		00913	B. WING		12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEI AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
21000	Continued From pa	ge 21	21000			
21000	MN Rule 4658.0610 Requirements-Hygi	0 Subp. 4 Dietary Staff iene.	21000		1/31/17	
th w a: a: h: si	wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed.					
	by: Based on observati review, the facility f proper hand hygien reduce the risk of for residents who ate in and the facility faile hygiene during mea	ent is not met as evidenced ion, interview, and document ailed to ensure staff utilized be during meal service to bod borne illness for all in the first floor dining room, d to ensure proper hand al preparation, which had the ll residents who eat in the		Corrected		
	dietary aide (DA-A)	ion on 12/19/16, at 5:50 p.m. a brought food and beverages				
	bringing food and b DA-A washed hand used clean hands to pulling a paper tow	irst floor dining room. Between everages out of the kitchen, Is in the kitchen sink, then o shut off the water before el from the dispenser to dry hands, DA-A brought a plate				
	of food out to a resi asked about wheth hygiene training, D	ident in the dining room. When er the facility provided hand A-A said handwashing seemed wledge, but thought that the				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING:			
		00913	B. WING	B. WING		C 22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETI DATE
21000	Continued From pa	ge 22	21000			
		ndwashing in the training ees start to work in the facility.				
	cook (C-B) dished u floor dining room. B hands in the kitcher to shut off the water from the dispenser gloves and served u removing the gloves kitchen sink for app shut off the water w a paper towel to dry During an observati C-A made gravy for C-A washed hands	ion on 12/22/16, at 10:12 a.m. an upcoming meal service. in the kitchen sink for				
	water with bare han towel from the dispu- touch the handle of the stovetop, then of a cutting board. After and used bare hand can next to the stov onion waste. C-A the kitchen sink for app	econds, then shut off the hds before pulling a paper enser to dry. C-A proceeded to a pot while melting butter on donned gloves to cut onion on er cutting, C-A removed gloves ds to lift the lid of the garbage re to dispose of the gloves and hen washed hands in the proximately five seconds, the pot on the stovetop.	\$			
	director of dietary s received handwash the job, and explain in-services that cov other things. The di confirmed that staff	on 12/22/16, at 10:39 a.m., the ervices verified that new staff ing training when they start ed staff also received monthly ered handwashing, among rector of dietary services should leave the water dry their hands, then shut off aper towel.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED C	
		00913	B. WING			22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
BETHEL	CARE CENTER		RSHALL AVEN			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21000	Continued From pa	age 23	21000			
	Handwashing/Hygi	of the facility policy titled; ene, revised August 2014, es must wash their hands for seconds."				
	director of nutrition dietary staff on the handlers. The direc perform random au	THOD OF CORRECTION: The al services could in-service all proper hand hygiene for food tor of nutritional services could idits of the hygiene practices to lity Assurance committee.	d			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.080 Program	0 Subp. 1 Infection Control;	21375			1/31/17
	home must establis	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.				
	by: Based on observat review, the facility f infection control me	ent is not met as evidenced ion, interview, and document ailed to ensure appropriate easures were maintained for 2 , R86) observed for activities		Corrected		
	Findings include:					
		ns on 12/19/16, the following ng the initial tour on the second e unit:	Ł			

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STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913		CONSTRUCTION	COM	E SURVEY PLETED C 22/2016
	PROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, S			
			SHALL AVEN			
BEIHEL	CARE CENTER	SAINT PA	AUL, MN 5510	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ige 24	21375			
21375	assistant (NA)-Z lea on holding two trash hallway toward R86 by R86's door and e same gloves on. N/ R86's room and ca p.m. On 12/19/16, at 1:2 came from R83's ro with gloves on and entered R86's room	5 p.m. observed nursing aving R83's room with gloves h bags walking down the 5's room and placed the bags entered R86's room with the A-Z took the gloves off while in me out of that room at 1:17 23 p.m. NA-Z acknowledged bom, walking in the hallway holding two trash bags and n after placing the trash bags noved gloves while in R86's				
	registered nurse (R expectation was that gloves when finished another and after d contamination. RN- wear gloves in the l cleaning up bodily f Document review o procedure titled, GL May 2014, indicated complete, gather so waste container and WASH HANDS, tak	r on 12/21/16, at 2:20 p.m. N)-C. stated the facility at all staff should remove ed from one resident's room to oing cares to prevent C added, Staff should not hallway unless actively fluids. If the facility policy and LOVE USE, with revision date; d, "6. When resident care biled items in linen bag or d contain. Remove gloves, se soiled bagged items to room. Once placed, WASH				
	procedure titled, HA revision date; Augu must wash their ha seconds using antir soap and water und	of the facility policy and ANDWASHING/HYGIENE with ast 2014, stated, "5. Employees nds for at least twenty (20) microbial or non-antimicrobial der the following conditions: c. rect resident contact (for which				

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00913	B. WING		12/	12/22/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
BETHEL	CARE CENTER		SHALL AVENU AUL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21375	hand hygiene is ind professional practic assisting a resident care, bathing); After SUGGESTED MET director of nursing of policies and proced control, specific to v from resident's roor hand washing techn to assure proper tech The director of nurs conduct random au ensure appropriate implemented.	ge 25 icated by acceptable e); h. Before and after with personal care (e.g., oral r removing gloves or aprons". THOD OF CORRECTION: The or designee, could review ures related to infection wearing gloves in the hallway in to another resident's and hiques, train staff and monitor chiniques are being utilized. sing or designee, could dits of the delivery of care; to care and services are R CORRECTIONS: Twenty	21375				
21426	Prevention And Cor (a) A nursing home maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide	A.04 Subd. 3 Tuberculosis htrol e provider must establish and hensive tuberculosis ogram according to the most infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis n that covers all paid and contractors, students, hteers. The Department of technical assistance ntation of the guidelines.	21426			1/31/17	

If continuation sheet 26 of 45

STATEMEN	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00913	B. WING		C 12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY,	STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLET DATE
21426	Continued From pa	ige 26	21426			
	(b) Written complia be maintained by th	ance with this subdivision must ne nursing home.				
	by: Based on documer agency failed to en reviewed, had prop	ent is not met as evidenced at review and interview, the sure 1of 5 employee files er documentation of results as uberculosis Guidelines.		Corrected		
	Document review of revealed a start dat Employee/Candida Questionnaire was were read 8/21/16, "size 0 [millimeter] TST's that had bee interpretation (read When interviewed of registered nurse (R had been administer (read as either post RN-C added, "We a	of the maintenance (E5) file, te of 8/15/16. The file revealed te Mantoux (TST) completed, a step 2 TST's and 9/2/16, with results as mm 0 mm of induration." The n administered lacked the as either positive or negative). On 12/21/16, at 1:40 p.m. EN)-C verified the TST's that ered lacked the interpretation itive or negative). Furthermore, are also planning to have a for nurses and I will bring it				
	Health Care Setting Health Care Worke employee may beg	erculosis Control in Minnesota gs dated July 2013, Screening ers (HCWs) directed "An in working with patients after a om screen (i.e., no symptoms e) and a negative				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913			COM	E SURVEY PLETED C 22/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
	CARE CENTER	420 MAR	SHALL AVENU AUL, MN 5510	JE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Interferon-Gamma test) or TST (i.e., fir before hire. The set after the HCW start Serial TB screening Components: 1. Assessing for cu disease, 2. Assessing TB his 3. Testing for the pr Mycobacterium tub- either a one-step TS General principles •All reports or copie any related chest X should be maintaine •TST documentatio the test (i.e., month millimeters of indur document "0" mm) positive or negative SUGGESTED MET director of nursing ( review policies and components of the monitoring program educated on the TE Mantoux process. T designee could dev ensure ongoing cor	Release Assays [IGRA] (blood rst step) dated within 90 days cond TST may be performed ts working with patients g consists of three rrent symptoms of active TB story, and resence of infection with erculosis by administering ST or single IGRA es of TST or IGRA results and -ray and medical evaluations ed in the employee's record. n should include the date of , day, year), the number of ation (if no induration, and interpretation (i.e., e)"				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED	
		00913	B. WING		C 12/22/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEI UL, MN 55 <sup>-</sup>			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
21665	Continued From pa	ige 28	21665			
21665	MN Rule 4658.140	0 Physical Environment	21665		1/31/17	
	functional, comforta environment, allowi	ust provide a safe, clean, able, and homelike physical ing the resident to use s to the extent possible.				
by: Based on docum observation, the comfortable odor resident (R55) ar environment was comfortable man R140, R91, R166	by: Based on documer observation, the fac comfortable odor fr resident (R55) and environment was m comfortable manner R140, R91, R166, I	ent is not met as evidenced nt review, interview, and cility failed to provide a ee room environment for failed to ensure the naintained in a safe and er for 9 of 10 residents (R160, R103, R50, R157, R155, environmental concerns.		Corrected		
	dated 10/10/16, rev intact and did not tr surfaces. On 12/20 reported the urine s headaches. R55 re room and the condi "very depressed", a Anyone else can co was noted to have also expressed cor infection and did no room was sanitary,	Minimum Data Set (MDS), vealed R55 was cognitively ransfer from bed or other /2016, at 9:41 a.m., R55 smell in the room gave R55 ported was unable to leave the ition of the room made R55 adding "I got no choice. ome in and leave." R55's room a strong foul urine odor. R55 neern as was vulnerable to ot feel the condition of the based on observations of 6, at 9:53 a.m., R55's room foul urine odor.				
	tour with the mainte	5 a.m. during environmental enance director (MD) and ctor (ED), the following				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00913	B. WING	B. WING		C 12/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE			
BETHEL	CARE CENTER		SHALL AVENU AUL, MN 5510				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21665	Continued From pa	ge 29	21665				
	urine odor. R55 sta headaches from the now. Registered nu working with staff to R105 will pull cathe that contributed to t strip bed and clean day. ED confirmed staff cleaning it thre On 12/22/16, at 9:3 tour with the mainte environmental direc concerns were note On 12/20/16, at 12: observed to have tw R160's pillow. R160 pillow cases becaus the linens. The pillow On 12/20/16, at 10: to have a stain on a window covering to On 12/20/16, at 1:1 observed with smal wall near the bed. I had several chips ir On 12/19/16, at 4:4	<ul> <li>31 p.m. R160's room was vo pillowcases covering</li> <li>asked staff to double up se there often were stains on wcase had light brown stains case.</li> <li>57 a.m. R140 was observed a sheet being used for a keep the breeze out.</li> <li>0 p.m. R91's room was I areas of paint peeling on the n addition, the wood molding n it.</li> <li>6 p.m. R166's room door was</li> </ul>	I				
	to have a stain on a window covering to On 12/20/16, at 1:1 observed with smal wall near the bed. I had several chips in On 12/19/16, at 4:4 observed with seve inside edge. The wi from the bottom sid was next to the win	a sheet being used for a keep the breeze out. 0 p.m. R91's room was I areas of paint peeling on the n addition, the wood molding n it.					

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C	
		00913	B. WING			12/22/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
BETHEL	CARE CENTER		SHALL AVENU UL, MN 5510				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21665	On 12/19/16, at 5:4 blinds were observe approximately 4 inc and left sides of ear with a bin of clothes stated they needed the wash. On 12/19 his room was cold. On 12/20/16, at 11: observed to not clo loose and there we the hallway wall near On 12/20/16, at 11: observed to have a placed a towel on the floan the floan a draft. On 12/20/16, at 12: the room was cold leaked a bit. On 12/19/16, at 4:3 was cool, told staff, During an interview family member of F floor near the windor reported the floor h	<ul> <li>7 p.m. R103's room window ed with holes measuring thes by 4 inches on the right ch. The room was cluttered is near the window and R103 name labels and should go to 1/16, at 5:08 p.m. R103 stated</li> <li>45 a.m. R50's room door was set, the inside handle was re several holes midway up ar the bed.</li> <li>59 a.m. R160's bathroom was dirty air vent. R160 stated she he shower room chair to sit on or for her feet, and would not uch the dirty surfaces.</li> <li>9 a.m. R157 stated room was dow by the bed and there was 35 p.m. R155 stated at night and thought the window</li> <li>0 p.m. R159 stated the room but it still was cold.</li> <li>on 12/22/16, at 1:49 p.m, a R159 (F)-Q, noted cracks in the box and marks on the floor. F-Q ad been that way since R159 F-Q did not think it was in</li> </ul>					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913			(X3) DATE SURVEY COMPLETED C 12/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE. ZIP CODE	1	
	CARE CENTER	420 MAR	SHALL AVENU	JE		
	SUMMADY STA		AUL, MN 5510	PROVIDER'S PLAN OF		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21665	Continued From pa	ge 31	21665			
	<ul> <li>Continued From page 31</li> <li>When interviewed on 12/22/16, at 10:58 a.m. MD stated would go into a room for maintenance checks when it was vacant and checked blinds, doors, and all other things. MD stated every nurse station had a maintenance request book where staff entered maintenance requests. Additional maintenance staff checked the request books daily at 1:00 p.m.</li> <li>Document review of an undated policy titled, Room Readiness Check List Housekeeping check list directed: "wipe down bed frame, head and foot boards, mattress, side rails Sweep and mop floor checking corners, edges, and behind the door Record any maintenance issues. Document reivew of Audit Tool - Environmental directed: "Directions: Random weekly audits for environmental to ensure facility maintains a sanitary, orderly, and comfortable interior" No maintenance policy was provided for preventative maintenance routines.</li> </ul>					
	administrator or dire services or designer regarding the impor functional and hom administrator or dire services or designer maintenance and h periodic audits of a ensure a safe, clea environment is mai	THOD OF CORRECTION: The ector of environmental ee, could educate staff rtance of a safe, clean, elike environment. The ector of environmental ee, could coordinate with ousekeeping staff to conduct reas residents frequent to n, functional and homelike ntained to the extent possible.				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913		LE CONSTRUCTION (X3	) DATE SURVEY COMPLETED C 12/22/2016
					12/22/2010
	PROVIDER OR SUPPLIER		SHALL AVEI	STATE, ZIP CODE	
BETHEL	CARE CENTER		UL, MN 55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21695	Continued From pa	ge 32	21695		
21695	MN Rule 4658.141 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695		1/31/17
	provide housekeep necessary to mainta comfortable interior	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, ixtures, equipment, lighting,			
	by: Based on observati review,the facility fa (2nd, 3rd and 4th) of cleaned and free of resided on and/or v Findings include: On 12/22/16, at 9:3 tour with the mainter environmental direct concerns were note The carpet on 2nd, observed to be wor floor carpet was mon have a strong, urine	5 a.m. during environmental enance director (MD) and ctor (ED), the following ed and verified. 3rd and 4th floors were n, torn and soiled. The third ost noticeably observed to e-like odor permeating and a large round stain		Corrected	
	R166's room had a When interviewed of stated every nurse request book where requests. Additiona the request books of Document reivew of	6 p.m. the carpet outside musty urine-like odor. on 10/22/16, at 10:58 a.m. MD station had a maintenance e staff entered maintenance I maintenance staff checked daily at 1:00 p.m. f Audit Tool - Environmental s: Random weekly audits for			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED C
		00913	B. WING			22/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE
21695	Continued From pa	age 33	21695			
	sanitary, orderly, ar	nsure facility maintains a nd comfortable interior." blicy was provided for enance routines.				
	administrator or de regarding the impo functional and hom Administrator or de maintenance and h periodic audits of a ensure a safe, clea	THOD OF CORRECTION: The signee, could educate staff rtance of a safe, clean, elike environment. The signee, could coordinate with nousekeeping staff to conduct reas residents frequent to an, functional and homelike intained to the extent possible.				
	TIME PERIOD FOI (21) days	R CORRECTION: Twenty one				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			1/31/17
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a				
	by: Based on documer interview, the facilit environment for 2 c reviewed for dignity accommodate resid	ent is not met as evidenced nt review, observation, and cy failed to ensure a dignified of 4 residents (R140, R160) c by not providing furniture to dents of all sizes, and by not privacy from the window view in		Corrected		
	Findings include:					

Minnesota Department of Health STATE FORM

6899

ZHIN11

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913	(X2) MULTIPLE A. BUILDING: _ B. WING		СОМ	E SURVEY PLETED C 22/2016
				12/	2/22/2010	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
BETHEL	CARE CENTER		SHALL AVENU			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21805	Continued From pa	ge 34	21805			
	(eMR) revealed R14 on 7/21/2016. R140 intact during the qu (MDS) assessment pounds on 12/21/16 electronic medical r During an observat R140 was laying in lacked seating othe wheelchair. R140 s chair to sit in yet, ar counted as a norma in July, R140 did no the wheelchair safe legs underneath me on my own." R140 s tried to assist with t wheelchair, R140 fe wheelchair, hit back snapped head back	ion on 12/20/16, at 10:05 a.m. bed. R140's room furnishings or than the resident's bed and aid the facility did not have a nd did not think a wheelchair al chair. Since being admitted of feel able to get in and out of ely, explaining "I can't get my e to get out of the wheelchair said that the last time two staff he transfer out of the ell back down onto the scide of body on the chair, and a fater falling on the aid it took six facility staff to				
	R140 was eating br whether R140 prefe explained eating in area on the unit did accommodate weig R140 was intereste common area, R14 there! But they aren real chair out there.	ht/size. When asked whether d in spending time in the 0 stated, "I want to get out n't even bothering to get me a . They tell me I can sit in my on't want the wheelchair! I want				

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		00913	B. WING		12/22/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21805	Continued From par couldn't find one. During an interview occupational therap was unable to find a R140 that was cove Furthermore, the O did not have a chain accommodate R14 During showers, R1 privacy from view of property. Document review of 12/6/16, indicated F During an interview R160 described a coused as a smoking courtyard, you can fourth floor shower the person in the sh possible to tell if the was male or female for curtains multiple reassure that it was from the courtyard	ge 35 on 12/21/16, at 2:39 p.m. the bist (OT) explained the facility a wheelchair to accommodate ered by insurance. T verified the facility currently r that was wide enough to	21805			
	the fourth floor show have two shower st The shower stall far against the outside had a large window overlooked the cou started approximate	ion on 12/21/16, at 1:39 p.m. wer room was observed to alls separated by a curtain. rthest from the doorway was wall of the building. This wall with frosted glass that rtyard below. The window ed 1.5 feet up from the floor, 4 feet wide, and approximately				

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913			́ сом	E SURVEY PLETED C 22/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		12/	22/2010
			SHALL AVENU			
BETHEL	CARE CENTER		AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 36	21805			
	5 feet tall. The wind	low lacked a curtain.				
	12/21/2016, at 2:34 room window was w below. From the co (RN-A) looked up a stood in the shower person in the shower verified it was possi person while lookin confirmed staff wou	ion from the courtyard on p.m. the fourth floor shower visible from the courtyard urtyard, a registered nurse t the window while someone r room. The figure of the er room was visible. RN-A ible to see the outline of the g up from the courtyard. RN-A ild contact maintenance to e window for privacy.				
	director of nursing of staff on resident dig	HOD OF CORRECTION: The or designee could in-service al gnity and respect. The director nee could perform random r compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21880	MN St. Statute 144 Residents of HC Fa	.651 Subd. 20 Patients & ac.Bill of Rights	21880			1/31/17
	shall be encouraged their stay in a facilit to understand and e patients, residents, residents may voice changes in policies and others of their of interference, coerci including threat of of grievance procedur	nces. Patients and residents d and assisted, throughout y or their course of treatment, exercise their rights as and citizens. Patients and e grievances and recommend and services to facility staff choice, free from restraint, on, discrimination, or reprisal, discharge. Notice of the re of the facility or program, as and telephone numbers for the				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00913	B. WING			C 22/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE	· · · · ·	
BETHEL	CARE CENTER		SHALL AVEN AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 37	21880			
	nursing home omb Americans Act, sec posted in a conspic					
	Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.					
	by: Based on interview facility failed to ens made by the facility	ent is not met as evidenced and document review, the sure that prompt efforts were to resolve grievances for 1 of viewed, who expressed a		Corrected		

STATE FORM

ZHIN11

If continuation sheet 38 of 45

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			С
		00913	B. WING			22/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVENU AUL, MN 5510			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21880	Continued From pa	age 38	21880			
	expressed filing a g facility had not gotto resolution to the gri conference was su scheduled and that During an interview	on 12/19/16, at 6:45 p.m. R88 grievance on 12/2/16, and the en back to R88 in regard to the ievance and that a care pposed to have been had not happened yet either.				
	further expressed f not resolved a griev family care confere	rr (FM)-B was present and rustration that the facility had vance filed 12/2/16 and no once had been set up as the by would do 12/2/16.				
	Set (MDS) dated 1 <sup>-</sup> cognitively intact. D	of the quarterly Minimum Data 1/4/16, indicated R88 was Diagnoses from the MDS dated quadriplegia, decubitus ulcer, d depression.				
	Form, dated 12/2/1 someone (nurse or wheelchair for a lor [R88] to [R88] bed. forgetting to give [F stated [R88] either	of the form titled; Grievance 6, read, "Resident reported nurse aide) left [R88] in [R88] ng time without transferring [R88] also reports they keep R88] showers. Resident has has or would like to call to voice [R88] concerns.				
	Grievance: read, R Department of Hea Care Plan meeting	reads; Action taken to address eported to MDH (Minnesota Ith) Investigation initiated. being set up by social ent and [R88] family.				
	was the Director of	erson signature on the form Nursing (DON) and dated histrator signed the Grievance				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			B. WING			C
		00913			12/	22/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST SHALL AVENU			
BETHEL	CARE CENTER		UL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21880	Continued From pa	age 39	21880			
	indicated a written recommended active returned to Administ within 72 hours. A resident/representat findings and actions be taken. If they are other actions will be During an interview Administrator on 12 they were not aware have any other dood the 12/2/16, concere During an interview with the current sood been working as a since 12/11/16, ver resident or family a	h, Revision date: July 2015, report of investigation and on will be completed and strator/Social Service Director meeting with the ative will occur to review the s taken and/or those that will e not satisfied with the results, e developed as needed. with the DON and 2/22/16, at 8:40 a.m. verified e of the follow up and did not sumentation for investigation of m. on 12/22/16, at 11:30 a.m. cial worker (SW)-A who had temporary fill in social worker ified no knowledge of the nticipating a meeting to SW-A was not aware to set up				
	Furthermore, SW-A Grievance/Concerr informed of the follo the facility did not for conference for the	A verified not seeing the n for R88 and not being ow up required. SW-A verified ollow up with a care resident and family to discuss SW-A would follow up				
	director of social se staff on the require concerns and make resolve the grievan	THOD OF CORRECTION: The ervices/nursing could in-service ment to address resident e a good faith attempt to ces. Then develop monitoring ongoing compliance and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
						С
		00913	B. WING		12/	22/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S RSHALL AVEN	STATE, ZIP CODE		
BETHEL	CARE CENTER		AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21880	Continued From pa	uge 40	21880			
	report the findings to Committee.	to the Quality Assurance				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
21942	MN St. Statute 144 Resident and Fami	A.10 Subd. 8b Establish ly Councils	21942			1/31/17
	boarding care hom advisory council an fewer than three per participating. If one function, the nursin home shall docume council or councils year. This subdivisi	council. Each nursing home or e shall establish a resident d a family council, unless ersons express an interest in or both councils do not g home or boarding care ent its attempts to establish the at least once each calendar on does not alter the rights of ies provided by section in 27.				
	by: Based on interview annual attempt at fo	ent is not met as evidenced , the facility failed to make an orming a family council. This impact all residents in the		Corrected		
	Findings include:					
	reported the facility The activities direct charge of family co	8 p.m., the activities director did not have a family council. tor reported he was newly in uncil and had no evidence the empt to form a family council ndar year.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00913	B. WING			C 22/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
BETHEL	CARE CENTER		SHALL AVEN AUL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
21942	Continued From pa	ge 41	21942		<u>.</u>	
	A policy was reques	sted, but not provided.				
	activity director or c	HOD OF CORRECTION: The lesignee could make an amily council and review and es.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21995	MN St. Statute 626 Maltreatment of Vu	.557 Subd. 4a Reporting - Inerable Adults	21995			1/31/17
	(a) Each facility sh ongoing written pro applicable licensing of suspected maltre facility has an interr mandated reporter requirements of this internally. However	I reporting of maltreatment. all establish and enforce an ocedure in compliance with y rules to ensure that all cases eatment are reported. If a nal reporting procedure, a may meet the reporting s section by reporting r, the facility remains nplying with the immediate ents of this section.				
	by: Based on documen facility failed to ens of mistreatment, ne thoroughly investiga administrator imme immediately to the	ent is not met as evidenced at review and interview, the ure that all alleged violations eglect and abuse are ated, reported to the diately and reported state agency for 1 of 3 iewed for incidents.		Corrected		
	Findings include:					

If continuation sheet 42 of 45

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED C
		00913	B. WING			22/2016
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
BETHEL	CARE CENTER		ISHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21995	Continued From pa	age 42	21995			
	nurse threatened to the incident was no	R55 reported on 9/7/16, at 8:11 p.m. that the nurse threatened to take away the oxygen and the incident was not reported to the administrator or state agency until 9/12/16, at 12:00 p.m.				
	to the minimum da 10/10/16, and diag	l as cognitively intact according ta set (MDS) annual review noses from the MDS included ease, heart failure and	1			
		an order for 3 liters of oxygen nc) continuously due to chronic ary disease.				
	written by registere 8:11 p.m. read; Wr spoke with the pati cannot take away r doctors order". Pt v loud. Writer apolog and ensured pt tha [R55] room and we ensure [R55] is cor verbalized that [R55 [R55] room "ever a comfort pt and ass stay out of [R55] ro verbalized being co SOB [shortness of [saturation] 94% or spoke with nurse a remain out of the p the shift and we wo	bcument titled, Progress notes ad nurse (RN)-I dated 9/7/16, a iter notified of incident and ent who verbalized, "the nurse my oxygen, where is the was upset and speaking very jized for any misunderstanding t the oxygen would remain in e will do anything we can to mfortable and safe. Pt further 5] did not want the nurse in igain". Writer continued to ured pt that this nurse would bom. Pt thanked writer and omfortable and without pain or breath]. O2 [oxygen] sats in 3 L [liters] O2 via nc. Writer and ensured that [RN-J] would batients room the remainder of build follow up tomorrow. Nurse anding. No further issues	t			
		ocument titled, Progress notes ted 9/7/16, at 6:42 p.m. read,				

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00913		CONSTRUCTION	СОМ	E SURVEY PLETED C 22/2016
					12/	22/2010
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
BETHEL	CARE CENTER		SHALL AVENI AUL, MN 5510			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21995	Continued From pa	ge 43	21995			
	[nursing assistant ripatients room to ve was for another res (threw a cup at me) words in the book. ' nurses working on behavior. According to the do Investigation Form, mental health pract administrator and d expressed the incid charge nurse pointi	reatened writer and NAR egistered] after walking to rify the oxygen compressor ident. Patient was aggressive and abusive using all the Writer told the incident to other the unit. Will monitor residents our global state of the state of the itioner reported to the lirector of nursing that R55 lent on 9/7/16 where the ng finger in res face and O2 from the resident.				
	the administrator ar verified RN-I failed report abuse imme- the state agency or immediately start a failed to inform ther mental health pract 9/12/16, at 12:00 p.	to on 12/22/16, at 8:40 a.m. with and director of nursing (DON) to follow the facility policy to diately to the administrator and n 9/7/16, at 8:00 p.m. failed to n internal investigation and n of the situation until the itioner reported the abuse on m. Furthermore, no written ained or interview conducted rted as a witness.				
	dated, Nov 2016, a Plan, read; "The ad charge of the Abuse informed of all alleg of abuse, neglect, o In the case of the a the designee will be The State Agency r Furthermore, for In-	f the facility policy revision nd titled, Abuse Prevention ministrator is ultimately in e Prohibition Plan and must be ged or substantiated incidents or maltreatment immediately. dministrator being unavailable e notified in this timeframe. nust be notified immediately". vestigation the document staff would complete an				

Minnesota Department of Health STATE FORM

	It a Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00913	 B. WING			C 22/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 420 MARSHALL AVENUE						
BETHEL	CARE CENTER		SHALL AVENU AUL, MN 5510			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21995 Continued From page 44 incident report by a licensed staff immediately following the incident. The unit manager/night supervisor would implement immediate changes to keep the resident safe, with follow up implementation reviewed to make sure that they are appropriate for the resident and condition of resident. Under the Internal Reporting the policy directed; 1. All incidents that are suspicious in nature will be investigated by the internal process 2. Upon receipt of the report, the DNS or designee on duty will begin investigating the						
	situation by conduct the resident, speak situation and docur documentation will the resident, identif and location of sus and extent of the sus other information b the suspected malt accomplish this by accident/Incident re form. Analyze the oc changes are needed	ting a physical assessment of ing to all staff involved in the nent such findings. 3. That include the following; Identify y the caregiver, Time, date pected maltreatment, Nature uspected maltreatment, Any elieved helpful in investigating reatment. Facility will				
	director of nursing of staff on the direction to report abuse imr	THOD OF CORRECTION: The or designee could in-service al ns in the maltreatment statute nediately to the Common Entry alth Facility Complaints). Also pliance.	I			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				