

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 26, 2021

Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, MN 56401

RE: CCN: 245500

Cycle Start Date: January 11, 2021

Dear Administrator:

On January 11, 2021, a 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 10, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 10, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 10, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Bethany will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 10, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

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corrected and will not recur.

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933

Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 11, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

Good Samaritan Society - Bethany January 26, 2021 Page 4 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:

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> 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: https://mdhprovidercontent.web.health.state.mn.us/ltc idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html

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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/09/2021 FORM APPROVED OMB NO. 0938-0391

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SS=G	as your allegation of Department's acceenrolled in ePOC, yat the bottom of the form. Your electron be used as verifical Upon receipt of an on-site revisit of your validate that substate regulations has been your verification. Notify of Changes (CFR(s): 483.10(g)(of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 vic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with (Injury/Decline/Room, etc.)	F 58	O TITLE		2/8/21 (X6) DATE

Electronically Signed

02/04/2021

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 580	§483.10(g)(15) Admission to a common that is a composite §483.5) must disclosite physical configurations that compart, and must spectroom changes betwoen the second change of conditions and the second change of conditions reviewed who were actual harm for R1 lower level of care at the second change of conditions actual harm for R1 lower level of care at the second change includes. Findings include: R1's undated, Adming admitted to the facing included emphysem pulmonary disease R1's admission Mir 11/24/20, indicated impairment and received on admission to the facing indicated R1 was second control of the seco	inposite distinct part. A facility distinct part (as defined in ose in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to oven its different locations). Note in the physician and family of a for 1 of 3 residents (R1) in discharged. This resulted in who was discharged to a find subsequently transferred day of discharge, where R1 ission Record indicated he lity with diagnoses which may and chronic obstructive (COPD). Inimum Data Set (MDS) dated he had moderate cognitive quired extensive assistance ctivities of daily living. The displayed no behaviors and kygen therapy prior to or since	F 580	Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in t statement of deficiencies. The plan correction is prepared and/or exect solely because it is required by the provisions of federal and state law. the purposes of any allegation that center is not in substantial complia with federal requirements of particithis response and plan of correctio constitutes the center sallegation compliance in accordance with sec 7305 of the State Operations Manual Resident R1 was the only resident to be effected and had discharged facility prior to survey All residents are at risk to not have change in condition reported to famphysician. A file review of all reside be conducted by DNS and/or desig looking for any changes in condition last 14 days and ensuring that any were reported to the family and physician and physician of the family and physician and the family and the fa	ent by he of uted For the nce pation, n of tition ial. found from a nilly and nts will nees n in the found

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F 580	believed to be related The note further is and indicated R1 lexacerbations, O2 good range." Staff of O2 for shortness saturation levels heatermined O2 was There was no evid An addendum to the had COPD and was levels ran in the 8 a recommendation clock (continuous above 90%. A facility Progress R1's oxygen (O2) average 90-100% brown phlegm in hand was placed or improvement in O was increased to levels of 89 - 91% of brown, sticky plung sounds were coughing R1 was above 95% on 2 li R1's O2 Saturation 12/29/20, R1 had room air at 7:00 a documented until saturation level was holding saliva swallow. The nurse staff in the related to the same staff in the related to the same staff in the related to the rela	ated to chronic atrial fibrillation. dentified a diagnosis of COPD had no "clear cut" 2 readings have remained in a f asked about potential for use as of breath but because had not dropped it was as not needed at that time. Hence of COPD exacerbation. He note, undated, indicated R1 has O2 dependent. Saturation 5-90% range. The MD provided in for R1 to be on O2 around the hoto maintain O2 levels at or Note dated 12/27/20, indicated saturation was 60 - 70 % [] on room air. R1 had thick his throat, he was coughing up in 2 liters of O2 with no 2 sats after four minutes. O2 6 liters to maintain saturation. R1 coughed up large amounts helegm for about 45 minutes. In a coughed but clear. After able to maintain O2 levels ters O2. In Summary indicated on a saturation level of 71% on .m. No further O2 levels were 10:00 p.m. when R1's O2	F 5	All licensed nursing staf notify family and physici condition as per policy. All licensed nursing staf re-educated on the policito report all changes in and physician during the sessions on 2/3/2021-2/by DNS and designees. morning meeting struction review EMAR weight dashboard and all trigge abnormalities, and ensureported to resident standard for the sessions of 3 different a week for 6 weeks to echanges in condition for notes or indicated by chwere followed by notification. Results to be committee for further results for further results.	f were cy and requirement condition to family e education /5/2021 conducted Additionally IDT ure was changed and vitals ers caused by ure they are being family and d by DNS and/or residents 3 times ensure that any und in progress langes in vitals ation of family and ereported to QAPI		

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F 580	lungs. A PT (physical theredated 12/30/20, ind nurse and nurse malevels in the 70's or oxygen. The therapy 4-5 liters. R1's satur 80%. R1's Progress Note was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was shome oxygen. The needed O2 to keep The encounter note emphysema; howe assessment of R1's R1's Progress Note was resting in bed wheel chair at 3:30 weak, audible trachencouraged to coug to clear. O2 was on brought to the front the entrance and withe unit. R1's Discharge Suridentified a health of [saturation] drop." Health of the strange of the saturation] drop." Health of the strange of the saturation] drop." Health of the saturation of the sa	apy) Daily Treatment Note icated the therapist notified a anager, about O2 saturation in three liters of supplemental sist increased R1's oxygen to ration levels only increased to a dated 12/30/20, indicated R1 practitioner (NP)-A by the facility nurse had reported inds, deterioration of condition for Server of Ser	F 5	80			

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F 580	An untitled hospital indicated upon arriv R1's blood pressur 120/80 - 140/90]. Till-appearing and lo stable and he was indicated R1 was in bacterial pneumoni threatening lactic a substance that can are not getting enoidentified evidence severe sepsis (infe acute respiratory falevel of oxygen in a hypercapnia (too mbloodstream). On 1/7/21, at 1:34 (ALF) RN stated will was not very respowhen she complete she reviewed the did documentation of Facility and it did documentation of Facility so she had in RN stated R1's initi heart rate was in the 1 and O2 saturation stated later in the evitals and his blood was in the 70's and pulse on their equipemergency room for passed away the notated she had see	record dated 12/30/20, val to the emergency room e was 57/40 [average range the note indicated he was oked toxic, vitals were not unresponsive. The notes a septic shock from presumed a and had severe, life cidosis (lactic acid is a build up in your body if you ugh oxygen). The notes or organ damage due to ction in the blood) including allure, hypoxia (a decreased all or part of your body) and auch carbon dioxide in your body. The ALF RN stated and the admission assessment or R1's condition when he left the no baseline for him. The ALF all blood pressure was low, his ne 40's [average range 60-100 a was in the high 80's. She evening staff rechecked R1's pressure was 50's/30's, O2 a staff were unable to detect a pment. R1 was then sent to the or further evaluation and	F 5	80			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
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F 580	him on 12/7/20. NP record and identified 12/23/20, and did not time. When asked related to the O2 on the facility had called was unable to come day so the facility chis note from the 12 order for the O2 was aw R1. Further, Note of the face and did not ideassessment of R1's During interview on nurse (RN)-A who was tated, "I think his so the Sunday before MD-A and NP-A we began to decline; however, in medical providers of When asked about stated she did not the were implemented talked to MD-A and oxygen upon dischastated she had not saturation levels draws not sure if any updated R1's medical addendum on the provider of the provider	P-A reviewed R1's medical of the was seen by NP-B on not have an O2 order at that about the face to face visit order on 12/30/20, NP-A stated and her on 12/30/20, and she plete the visit until later in the alled MD-A who then amended 2/22/20, visit. NP-A stated the as written by MD-A before she P-A indicated she only saw R1 requirement for the face to entify she completed an actual is lung status. 1/8/21 at 8:57 a.m. registered was the unit nurse manager, sats [saturation levels] dropped the discharged." RN-A stated are both notified when R1 owever she had notified the only about R1's repeated falls. R1's overall decline, RN-A hink any medical interventions and stated RN-A stated she NP-A about the need for arge from the facility, but updated them regarding the opping into the 70% range and of the nurses had called and cal providers. Further, the ohysician's note dated ed on 12/30/20, following her	F 5	580		
	facility had not cont needed O2. FM-As	member (FM)- A stated the facted them and told them R1 stated when R1 arrived at the ty his blood pressure was				

AND DIAN OF CORRECTION INDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED		
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F 580	really, really low an emergency departr admitted to the interdouble pneumonia. At approximately 1 (PT)-A stated the describition had drop O2. PT-A stated her floor who said RN-been in contact with way it was community was something that monitored. At 10:20 a.m. NP-E on 12/23/20, due to she went on vacation had died. NP-B stated was notified of the At 11:29 a.m. MD-A trying to arrange for R1's discharge RN-A. MD-A did not evaluation as MD-A aware of the decrepurther, if he was resultance to the assent R1 to the emergen declining through the state of the decrepuration. On 1/11/21, at 10:4 been declining through the state of the state of the declining through the state of the declining through the state of the state of the declining through the state of t	d he was sent to the ment. FM-A stated R1 was ensive care unit and died from organ failure and sepsis. 0:00 a.m. physical therapist ay R1 discharged from the red with R1 and R1's O2 oped to 70% on two liters of exported it to the nurse on the A was aware and they had the physician. PT-A said the nicated to him he thought it twas continually being 8 stated she had last seen R1 on and when she returned R1 ted R1 had not required the vitals signs had been stable. The stated on and when she returned R1 ted R1 had not required the vitals signs had been stable. The stated on 12/30/20, he was refurable medical equipment and had been speaking with the complete a face to face a stated he had not been ased O2 saturation level. The stated had not have okayed him for resisted living and would have expended the facility would have expected staff to	F 5	80			

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F 580	status and staff sho saturation levels in	ow of the decline in lung ould have reported the	F 5	80		
F 660 SS=D	condition was required Discharge Planning	ested but none received.	F6	60		2/8/21
	The facility must de effective discharge on the resident's di of residents to be a transition them to preduction of factors readmissions. The process must be corights set forth at 4 (i) Ensure that the cresident are identified development of a direction of the coresident are identified evelopment of a direction of the coresident (ii) Include regular redidentify changes the discharge plan. The updated, as needed (iii) Involve the interpoly \$483.21(b)(2)(ii) developing the discontinuous discharge region of the resident's coresident of the resident's core person(s) capacity required care, as prodischarge needs. (v) Involve the residents in the resident of the residents in the resi	re-evaluation of residents to at require modification of the edischarge plan must be d, to reflect these changes. In the ongoing process of charge plan. It is in the ongoing process of charge plan. It is in the organized process of charge plan. It is in the organized process of charge plan. It is in the organized process of charge plan. It is in the organized process of charge plan. It is in the organized process of charge plan. It is in the organized process of charge plan. It is in the organized process of charge plan are of the identification of the organized plan in the organized process of charge plan in the organized process of charge plan in the organized plan in the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245500	B. WING			C / 11/2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (804 WRIGHT STREET BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 660	(vi) Address the retreatment preferer (vii) Document that about their interes regarding returning (A) If the resident to the community, referrals to local comprehensive cat appropriate entitie (B) Facilities must comprehensive cat appropriate, in restrom referrals to local comprehensive cat appropriate entitie (C) If discharge to to not be feasible, made the determin (viii) For residents SNF or who are discrepresentatives in provider by using a limited to SNF, Hipatient assessment measures, and datthe data is availabent the post-acute car assessment data, data on resource of the resident's goal preferences. (ix) Document, conton the resident's record, the evaluation must be about the resident of the resident	rative of the final plan. esident's goals of care and noces. It a resident has been asked to in receiving information go to the community. Indicates an interest in returning the facility must document any contact agencies or other somade for this purpose. I update a resident's update and discharge plan, as ponse to information received ocal contact agencies or other somality. I the community is determined the facility must document who	F6	60		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	` ′сомі	SURVEY PLETED
		245500	B. WING		01/1	C 1/2021
NAME OF F	PROVIDER OR SUPPLIER	I.		STREET ADDRESS, CITY, STATE, ZIP CODE	1 017	11/2021
GOOD S	AMARITAN SOCIETY	- BETHANY		804 WRIGHT STREET BRAINERD, MN 56401		
(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) COMPLETION DATE
F 660	Continued From pa	age 10	F 660	0		
F 660	information must be discharge plan to for avoid unnecessed discharge or transf. This REQUIREME by: Based on interview facility failed to face discharge plan for who discharged to Findings include: R1's admission Min 11/24/20, indicated impairment and reform two staff for a MDS indicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated R1 had not received of admission to the faindicated staff. The care related to frequent impaired cognition remind R1 not to be seen to save the displayed behavior to be saff. The care related to frequent impaired cognition remind R1 not to be saff.	e incorporated into the acilitate its implementation and ary delays in the resident's fer. NT is not met as evidenced w and document review, the dilitate a safe and effective 1 of 3 residents (R1) reviewed a lower level of care. Inimum Data Set (MDS) dated The had moderate cognitive quired extensive assistance ctivities of daily living. The displayed no behaviors and exygen therapy prior to or since incility. The MDS further of sustained any falls since incility. In the displayed no behaviors and exygen therapy prior to or since incility. The MDS further of sustained any falls since incility. In the displayed no behaviors and exygen therapy prior to or since incility. In the displayed no behaviors and a self to provide assistance of one athing, toileting and personal in the care plan identified assistance of plan identified a risk for falls falls, multiple medications and in the care plan directed staff to end over and pick up items,	F 660	Resident R1 was the only resident to be effected and had discharged facility prior to survey All residents are at risk to not have change in condition monitored and assessed. A file review of all reside be conducted by DNS and/or desiglooking for any changes in condition last 14 days and ensuring that any are/were being monitored and asses All licensed nursing staff are required monitored and/or assessed change condition as per policy. All licensed nursing staff were re-educated on the policy and requite of monitor and/or assess all change condition during the education ses on 2/3/2021-2/5/2021 conducted by and designees. Additionally IDT meeting structure was changed to EMAR weight and vitals dashboard triggers caused by abnormalities a assure that they are being monitor and/or assessed. Audits will be conducted by DNS and designees of 3 different residents.	from a a /or ents will gnees on in the found essed. red to es in uirement es in sions y DNS orning review d and all nd ed nd/or 3 times	
	assistance of one	s, ensure proper foot wear, staff and a walker to and from physical therapy for strength		a week for 6 weeks to ensure that changes in condition found in prog notes or indicated by changes in viwere followed by monitoring and/o	ress tals	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED				
		245500	B. WING			1	C 11/2021
NAME OF I	PROVIDER OR SUPPLIER	₹		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 417	
GOOD S	AMARITAN SOCIET	Y - BETHANY			04 WRIGHT STREET		
	I			В	BRAINERD, MN 56401		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 660	A Common Entry indicated R1 was unstable condition shortly after arriva (ALF). The report between the disch "subpar" and did r in condition. The r sent to the ALF did changes and did r documentation of at the ALF quite ill room where he wand sepsis and plaindicated the ALF discharging facility to discharge as we the facility did not R1's overall well-b indicated the facili physician's recom after R1 had disch A Physical therapic Discharge Summa ambulated with pafeet on level surfawas able to transfevariable assistance assist of two staff. pivot assist of two further indicated F progress toward g	Intake Form dated 12/31/20, discharged from the facility in resulting in a hospitalization I to the assisted living facility indicated the communication larging facility and the ALF was not include significant changes report indicated provider notes do not indicate awareness of not include supporting the need for oxygen. R1 arrived and was sent to the emergency as diagnosed with pneumonia acced on life support. The report RN had spoken to the remultiple times the week prior rell as the day of discharge and communicate the severity of reing. The report further ty notified the ALF of the mendation for hospice only harged from the facility. St (PT) Therapist Progress and arry dated 12/9/20, indicated R1 artial/moderate assistance 175 ces. The summary indicated R1 refrom sitting to standing with refrom contact guard to max recommendation was stand staff for safety. The summary R1 did not make significant roals due to cognition, at times rete bed mobility, transfers and	F 6	660	assessment. Results to be reporte QAPI committee for further recommendation.	d to	
	walking with conta times due to agita communicate nee	nct guard assist but at other tion and inability to ds required up to maximum mmendation for two staff for					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	СОМ	E SURVEY PLETED
		245500	B. WING				11/2021
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY	STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401				
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F 660	transfers for safety. Physical therapist (Discharge Summar R1 was fully dependent on the summary indicated health had impacted bed mobility, transfedependent on mechans and longer apprambulate. An undated facility Disclosures Log incomers and longer apprambulate. An undated facility Disclosures Log incomers and Physical Order for Life Sustante (Solution of the ALF or the summary and the ALF withough R1 had a design health status. R1's care plan, sendemitted to the ALF 11/18/20, and indicated to the ALF 11/18/20, and indicated from one staff for beand transfers and in the was unable to come the summary indicated like toileting then resulted the resulted in	_	F6	60			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPLAY OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		245500	B. WING			C 11/ 2021
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 660	Continued From pa	age 13	F 660			
	staff for dressing, g mobility but did not Health conditions i levels dropped.	ndicated R1 was dependent on grooming, bathing, toileting and identify level of dependence. Indicated oxygen saturation				
	registered nurse (F the ALF he was no answering question answer yes or no obrought to his room transfer him and he and she had been walker using two s	n 1/7/20, at 1:34 p.m. the ALF RN) stated When R1 arrived at t very responsive and not has. She was told he could questions. When R1 was he required two staff to be was not bearing any weight told he was ambulatory with a taff only for safety, not for				
	and could transfer While completing there were no note upon discharge frostated the facility hadementia and somyelling for help and	independent with bed mobility to the bath with one staff. he admission assessment is related to R1's condition im the facility. The ALF RN ad told her R1 had some e behaviors that included wanting attention and also resistive at times. The facility				
	had reported R1 had any injuries but aware of how man her he had fallen a admission. She was	ad slid out of bed and had not at stated she had not been by falls R1 had until family told t least 15 times since as told he was on safety checks by how many falls R1 had she				
	would not have act the ALF. Prior to a medication sheet, from the physician Zyprexa. The facili discharge and spohad to use a mech wheel chair. She s	cepted him for admission the dmission she had received a list of diagnosis and a note about a rash and starting ty had called the day of R1's ke to staff and told them they anical lift to get him into the tated afterward she called the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		245500	B. WING				_ 11/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 660	regard to the use of "had not" reported I mechanical lift and reported previously if the physician had R1's condition and recommended hosphysicians note she there was a need for On 1/8/20, at 5:57 acame to her unit he with a walker but quistated a couple day therapy had recommechanical lift. RN-discharged form the she did not think he living and said she lift and was a high for During interview at physical therapist (I from the transitional two it seemed as the and medically. PT-/was appropriate for At 10:20 a.m. nurse last time she had so the appropriateness documented in her progress note writte indicated family pla assisted living in the was concerned with unstable there.	If the lift and stated the facility he was transferring with a not an assist of two as anot an assist of two as a Further she asked the facility been notified of the change in was told the physician had bice. The ALF RN stated the erceived had no indication or hospice. In a.m. RN-A stated when R1 was able to stand and walked bickly went "downhill." RN-A is before he discharged mended the use of a sea and a stated before R1 are facility she had told the ALF awas appropriate for assisted told the nurse he was using a stall risk. In approximately 10:00 a.m. PT)-A stated after R1 moved I care unit (TCU) to station ough he declined in cognition a stated, "I did not think he	F6	660			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	- BETHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	01/11/2021
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	main issue with R1 fact R1 had not bee stated if he had bee lung status or he watransfer him to the would not signed har R1 to the assisted I The facility policy D Rehab/Skilled Nurs when creating a disto be comprehensive residents needs. If discharged to a set needs document the being discharged to Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treatmacility residents. Be assessment of a rethat residents receive accordance with propractice, the comprehensive facility failed to assilung condition for 1 for a change of conharm for R1 who wo fo care and subsequence.	was his behaviors and the en eating or drinking. MD-A en aware of the change in R1's would have had the facility hospital for evaluation. He ave signed off on discharging iving facility. ischarge Planning ing dated 12/22/20, indicated scharge plan it was important we, to address all of the a resident wishes to be ting that does not meet his/her e discussion of the risks of this setting. care fundamental principle that then and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered	F 68		will

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED	
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F 684	Findings include: R1's undated, Adm admitted to the faci included emphysen pulmonary disease R1's admission Min 11/24/20, indicated impairment and red from two staff for adm MDS indicated R1 It therapy prior to or selections. R1's care plan date performance deficit impaired mobility and plan directed staff to staff to complete be hygiene needs. The interventions related R1's COPD. R1's Oxygen (O2) Selections of the summary indicated R1's COPD. R1's Oxygen (O2) Selections of the summary indicated levels were maintainal [average range 90% supplemental O2. A physician Nursing indicated R1 was selected to be related to the related R1 was selected to the related R1 was selected to the related R1 was selected R1 wa	dission Record indicated R1 lity with diagnoses that an and chronic obstructive (COPD). imum Data Set (MDS) dated he had moderate cognitive uired extensive assistance civities of daily living. The nad not received oxygen ince admission to the facility. d 11/27/20, identified a self related to weakness, and deconditioning. The care of provide assistance of one athing, toileting and personal a care plan lacked nursing d to assessment or monitoring. Saturation Summary dated indicated R1 did not use om 11/18/20 to 12/27/20. The on 12/27/20, R1's saturation ned at 89 - 98 % on room air 6-100%], without the need for the provided indicated at times R1 ness and shortness of breath end to chronic atrial fibrillation. Entified a diagnosis of COPD	F 6	84	looking for any changes in conditionalst 14 days and ensuring that any are/were being monitored and assed All licensed nursing staff are required monitored and/or assessed changed condition as per policy. All licensed nursing staff were re-educated on the policy and requited to monitor and/or assess all changes condition during the education session 2/3/2021-2/5/2021 conducted by and designees. Additionally IDT momeeting structure was changed to EMAR weight and vitals dashboard triggers caused by abnormalities at assure that they are being monitored and/or assessed. Audits will be conducted by DNS at designees of 3 different residents 3 at week for 6 weeks to ensure that changes in condition found in prognotes or indicated by changes in viwere followed by monitoring and/or assessment. Results to be reported QAPI committee for further recommendation.	found essed. ed to es in irement es in sions y DNS orning review I and all nd ed nd/or B times any ress tals	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 804 WRIGHT STREET BRAINERD, MN 56401		
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F 684	good range." Staff of O2 for shortnes saturation levels h determined O2 wa There was no evid An addendum to the had COPD and walevels ran in the 85 a recommendation clock (continuous) above 90%. A facility Progress R1's oxygen (O2) room air. R1 had throat, he was couliters of O2 with no four minutes. O2 waintain saturation coughed up large phlegm for about 4 diminished but cleated to maintain O2 lev The medical recorn R1's symptoms. R1's O2 Saturation 12/29/20, R1 had a room air at 7:00 a. documented until saturation level warecord lacked evid further assessment. R1's Progress Not was holding saliva swallow. The nurs no results. R1 had	asked about potential for use is of breath but because and not dropped it was is not needed at that time. Hence of COPD exacerbation. The note, undated, indicated R1 is O2 dependent. Saturation is O2 dependent. Saturation is O2 dependent. Saturation is O2 dependent. Saturation is O2 around the to maintain O2 levels at or Note dated 12/27/20, indicated saturation was 60 - 70% on hick brown phlegm in his ghing up and was placed on 2 improvement in O2 sats after was increased to 6 liters to in levels of 89 - 91%. R1 amounts of brown, sticky is minutes. Lung sounds were ar. After coughing R1 was able els above 95% on 2 liters O2. In a saturation level of 71% on in Summary indicated on a saturation level of 71% on in No further O2 levels were 10:00 p.m. when R1's O2 is 89% while O2. The medical ence of ongoing monitoring or	F 68	4		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	- BETHANY		804	REET ADDRESS, CITY, STATE, ZIP CODE 4 WRIGHT STREET RAINERD, MN 56401	1 017	11/2021
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F 684	A PT (physical ther dated 12/30/20, inc nurse and nurse m saturation levels in supplemental oxyg therapist had increa R1's saturation level R1's Progress Note was seen by nurse telehealth video. The nurse reported abn deterioration of corfor O2 and a wheel registered nurse (R1's Progress Note was resting in bed wheel chair at 3:30 weak, audible track was encouraged to able to clear. O2 who brought to the front point the writer returned again lacked assessment or phydischarging R1 from R1's Discharge Suridentified a health of [saturation] drop." It identify R1's current further assessment of the progress of the saturation of the progress of the progre	apy) Daily Treatment Note licated the therapist notified a anager about R1 having O2 the 70's on three liters of en during therapy. The ased R1's oxygen to 4-5 liters. els only increased to 80%. A dated 12/30/20, indicated R1 practitioner (NP)-A by ne note indicated the facility ormal lung sounds, adition and requested orders chair. The note was written by EN)-A. A dated 12/30/20, indicated R1 until being assisted into a p.m. R1 was restless but neal gurgling was heard. R1 cough and deep breathe and as on at 2 liters. R1 was a entry and outside at which trined to the unit. The medical devidence of further sician notification prior to	F6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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F 684	stable and he was indicated R1 was indicated Indicated R1 was indicated evidence substance that car are not getting endicated evidence severe sepsis (infeacute respiratory falevel of oxygen in a hypercapnia (too not bloodstream). On 1/7/21, at 1:34 (ALF) RN stated when she completed was not very responsively was not very responsively was not very responsively was not very responsively and it didocumentation of Infacility so she had RN stated R1's initiated later in the evitals and his blood was in the 70's and pulse on their equipmergency room for passed away the notated she had seen his condition had on thim on 12/7/20. Note that is a stated she had seen his condition had on thim on 12/7/20, and did in 12/23/20, and did in 12/23/20, and did in the stated she had seen his condition had on the stated she had seen his condition his stated she had seen his condition his stated she had seen his condition his stated	proked toxic, vitals were not unresponsive. The notes in septic shock from presumed in and had severe, life acidosis (lactic acid is a in build up in your body if you bugh oxygen). The notes is or organ damage due to action in the blood) including allure, hypoxia (a decreased all or part of your body) and nuch carbon dioxide in your p.m. the assisted living facility then R1 arrived at the ALF he onsive. The ALF RN stated and the admission assessment allischarge documentation from donot include an assessment or R1's condition when he left the no baseline for him. The ALF ital blood pressure was low, his ne 40's [average range 60-100 in was in the high 80's. She evening staff rechecked R1's do pressure was 50's /30's, O2 do staff were unable to detect a pment. R1 was then sent to the or further evaluation and	F 68	4			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 684	related to the O2 of the facility had calle was unable to come day so the facility of his note from the 1 order for the O2 was aw R1. Further, Note fulfill a Medicare face and did not ideassessment of R1' During interview or assistant (NA)-A stoxygen and stated few days before her At 8:57 a.m. RN-A, had not used oxygen and stated, "I think dropped the Sundastated she talked to need for oxygen up but stated she had the saturation level and was not sure if and updated R1's in not identify why she O2 saturations with addendum on the part of the saturation level and was not sure if and updated R1's in not identify why she O2 saturations with addendum on the part of the saturation level and was not sure if and updated R1's in not identify why she O2 saturations with addendum on the part of the saturation level and was not sure if and updated R1's in not identify why she O2 saturations with addendum on the part of the saturation level and saturations with addendum on the part of the saturation level and saturations with addendum on the part of the saturation level and saturations with addendum on the part of the saturation level and saturations with addendum on the part of the saturation level and saturations with addendum on the part of the saturation level and saturation l	rder on 12/30/20, NP-A stated ed her on 12/30/20, and she plete the visit until later in the salled MD-A who then amended 2/22/20, visit. NP-A stated the as written by MD-A before she P-A indicated she only saw R1 requirement for the face to entify she completed an actual is lung status. 1/8/21, at 8:26 a.m. nursing ated R1 did not always use the O2 use had started only a	F 6	84		

245500 NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - BETHANY STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET BRAINERD, MN 56401	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 804 WRIGHT STREET 804 WRIGHT STREET			245500	B. WING		01	C /11/2021
					804 WRIGHT STREET		71172021
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
double pneumonia, organ failure and sepsis. At approximately 10:00 a.m. physical therapist (PT)-A stated the day R1 discharged from the facility he had worked with R1 and R1's O2 saturation had dropped to 70% on two liters of O2. PT-A stated he reported it to the nurse on the floor who said RN-A was aware and they had been in contact with the physician. PT-A said the way it was communicated to him he thought it was something that was continually being monitored. At 10:20 a.m. NP-B stated she had last seen R1 on 12/23/20, due to his multiple falls and was not related to R1's lung status. NP-B stated she went on vacation and when she returned R1 had died. NP-B stated the time of her last visit R1 had not required the use of O2 and his vitals signs had been stable. NP-B stated, "honestly, I don't believe anyone was notified of the change of condition" for R1's lung status. At 11:29 a.m. MD-A stated on 12/30/20, he was trying to arrange for durable medical equipment for R1's discharge and had been speaking with RN-A. MD-A did not complete a face to face evaluation as MD-A stated he had not been aware of the decreased O2 saturation level. Further, if he was made aware in the change in R1's lung condition he would not have okayed him for discharge to assisted living and would have sent R1 to the emergency department for further evaluation. On 1/11/21, at 10:48 a.m. the director of nursing (DON) stated R1 had been declining throughout his stay at the facility. The DON stated over the	F 684	At approximately 1 (PT)-A stated the of facility he had work saturation had dro O2. PT-A stated he floor who said RN-been in contact with way it was community was something the monitored. At 10:20 a.m. NP-on 12/23/20, due to related to R1's lung on vacation and w NP-B stated at the not required the ushad been stable. No believe anyone was condition for R1's discharge RN-A. MD-A did not evaluation as MD-aware of the decrease R1's lung condition him for discharge thave sent R1 to the further evaluation. On 1/11/21, at 10:4 (DON) stated R1 in the condition in th	o:00 a.m. physical therapist day R1 discharged from the ked with R1 and R1's O2 pped to 70% on two liters of a reported it to the nurse on the A was aware and they had the physician. PT-A said the nicated to him he thought it at was continually being B stated she had last seen R1 on his multiple falls and was not g status. NP-B stated she went hen she returned R1 had died. It time of her last visit R1 had see of O2 and his vitals signs NP-B stated, "honestly, I don't as notified of the change of lung status. A stated on 12/30/20, he was or durable medical equipment and had been speaking with bot complete a face to face A stated he had not been eased O2 saturation level. It made aware in the change in the would not have okayed to assisted living and would be emergency department for	F 6	34		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245500	B. WING		0.4	C (44/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 804 WRIGHT STREET BRAINERD, MN 56401	-	/11/2021	
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F 684	O2 when he couldn "periodic." The DON drastic change in his saturations levels wishe felt it was "just stated she was awawere evaluating R1 reports she receive had been doing for using O2. The DON consistent decline it would have expected levels in the 70's and the decline. The facility policy C-CICE dated 12/11. CICE and collect periodic contacting the physic experienced a charm to monitor the reside evaluation, a notification there is information communicated to the saturation of the communicated to the saturation in the policy of the communicated to the saturation of the policy of the communicated to the saturation of the policy of th	"t clear his mucous but it was a stated R1 did not display a s vital signs and his O2 were not real low. She stated a slow decline." The DON are the day of discharge they is need for O2 and said the d was R1 was doing what he weeks and was regularly it stated "It was a slow and in my opinion," but stated she ed staff to report the saturation and to let the physician know of the certinent clinical data prior to ician when a resident and update the CICE opriate. Upon completion of the ation hyperlink will turn red if that needs to be the provider.	F6	84			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 26, 2021

Administrator Good Samaritan Society - Bethany 804 Wright Street Brainerd, MN 56401

Re: State Nursing Home Licensing Orders

Event ID: NJ9U11

Dear Administrator:

The above facility was surveyed on January 7, 2021 through January 11, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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

Good Samaritan Society - Bethany January 26, 2021 Page 2

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:

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933

Email: Jennifer.bahr@state.mn.us

Office: (218) 308-2104 Mobile: (218) 368-3683

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,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/09/2021 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _____

	00087	B. WING		C 01/11/2021
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - E	BETHANY 804 WRIG	DRESS, CITY, S BHT STREET D, MN 5640		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES MUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
2 000 Initial Comments		2 000		
****ATTENT	ΓΙΟΝ*****			
NH LICENSING CO	ORRECTION ORDER			
144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of fine the Minnesota Depart	linnesota Statute, section ion order has been issued If, upon reinspection, it is ncy or deficiencies cited ted, a fine for each violation e assessed in accordance es promulgated by rule of tment of Health.			
corrected requires co requirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Lere-inspection with any result in the assessm				
that may result from r orders provided that a	earing on any assessments non-compliance with these a written request is made to n 15 days of receipt of a t for non-compliance.			
survey was conducted with State Licensure. NOT in compliance we Please indicate in you correction that you ha	/11/21, an abbreviated d to determine compliance Your facility was found to be vith the MN State Licensure.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for New Homes. The assigned tag number appears in the far left column entitles.	ftware. to Nursing

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

TITLE

Electronically Signed

(X6) DATE 02/04/21

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING	·		
00087		B. WING		C 01/11/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- RETHANY	RIGHT STREE ¹ ERD, MN 5640		
(V4) ID	SI IMMADV STA	ATEMENT OF DEFICIENCIES	•	PROVIDER'S PLAN OF CORRECTION	ON (VE)
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2 000	Continued From pa	age 1	2 000		
2 000	The following companies substantiated: H5500093C (MN68 issued at MN Rule 4658.0520 Subp.B H5500094C (MN57 licensing orders we by the facility prior to the following compunsubstantiated an issued: H5500091C (MN67 The facility is enroll signature is not requage of the CMS-25 correction is require acknowledge receip Minnesota Departmenthe State Licensing federal software. To assigned to Minnesota Departmenthe State Licensing federal software. The state states are the correction order the findings which a statute after the states as evidence by." For example, which are states as evidence by substantiated:	plaints were found to be 3683) with licensing orders 4658.0085 subd. 0265, 0830 3746) with licensing orders 4658.0085 subd. 0265 7718 and MN57582), no are issued due to actions take to survey entrance. Plaints were found to be and no licensing orders were 4226) 7541) Ided in ePOC and therefore a puired at the bottom of the firs 567 form. Although no plan ed, it is required that the facil pt of the electronic document ment of Health is documenting ag numbers have been sota state statutes/rules for the assigned tag number eft column entitled "ID Preficatute/rule out of compliance is active transported to the state attement, "This Rule is not me following the surveyors finding	en st of ity is. g	Prefix Tag." The state statute/rule compliance is listed in the "Summa Statement of Deficiencies" column replaces the "To Comply" portion of correction order. This column also includes the findings which are in of the state statute after the staten "This Rule is not met as evidence Following the surveyors findings a Suggested Method of Correction a period for Correction. You have agreed to participate in the electronic receipt of State licensur consistent with the Minnesota Depof Health Informational Bulletin 14 available at http://www.health.state.mn.us/divsinfo/infobul.htm The State licensir orders are delineated on the attack Minnesota Department of Health obeing submitted to you electronical Although no plan of correction is necessary for State Statutes/Rules enter the word "corrected" in the bavailable for text. You must then in in the electronic State licensure prunder the heading completion date date your orders will be corrected electronically submitting to the Min Department of Health. PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES FEDERAL DEFICIENCIES ONLY.	ary and of the violation nent, by." re the and Time he e orders eartment -01, /fpc/prof ag ned orders lly. s, please ox dicate ocess, e, the prior to inesota DING OF
		Method of Correction and		WILL APPEAR ON EACH PAGE. IS NO REQUIREMENT TO SUBM PLAN OF CORRECTION FOR	THERE

Minnesota Department of Health

		(X1) PROVIDER/S	SUPPLIER/CLIA TION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY
AND I EAN OF CONNECTION IDENTIFICATION NOWBER.		ION NOWBER.	A. BUILDING:				
		00087		B. WING		C 01/11/2021	
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2 000	You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,		2 000	VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.			
2 265	"PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREM CORRECTION FO MINNESOTA STAT	ERAL DEFICIEN R ON EACH PA ENT TO SUBM R VIOLATIONS E STATUTES/F	NCIES ONLY. AGE. THERE IIT A PLAN OF S OF RULES.	2 265			
2 265	MN Rule 4658.0088 Resident Health Sta		r Chg in	2 265			2/5/21
	A nursing home mupolicies to guide staphysicians, physicia practitioners, and if legal representative member of a reside accident, or death. nursing services, an attending physician development of the	aff decisions to an assistants, a known, notify to or an intereste ent's acute illnes. At a minimum, and the medical a must be involv	consult and nurse the resident's ed family ss, serious , the director of director or an yed in the				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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				STATE, ZIP CODE	1 0171	
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
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2 265	Continued From pa	ge 3	2 265			
	have criteria which appropriate notifica	address at least the tion times for:				
		involving the resident which has the potential for requiring on;				
	physical, mental, o example, a deterior	change in the resident's r psychosocial status, for ration in health, mental, or in either life-threatening al complications;				
	C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;					
	D. a decision to transfer or discharge the resident from the nursing home; or					
	E. expected and unexpected resident deaths.					
	by: Based on interview facility failed to noti change of condition reviewed who were actual harm for R1 lower level of care a	and document review the fy the physician and family of a for 1 of 3 residents (R1) discharged. This resulted in who was discharged to a and subsequently transferred lay of discharge, where R1		Corrected		
	admitted to the faci	ission Record indicated he lity with diagnoses which na and chronic obstructive				

Minnesota Department of Health

STATE FORM 6899 NJ9U11 If continuation sheet 4 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED	
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00087			B. WING		01/1	1/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
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2 265	Continued From pa	ige 4	2 265			
	pulmonary disease	(COPD).				
	Continued From page 4 pulmonary disease (COPD). R1's admission Minimum Data Set (MDS) dated 11/24/20, indicated he had moderate cognitive impairment and required extensive assistance from two staff for activities of daily living. The MDS indicated R1 displayed no behaviors and had not received oxygen therapy prior to or since admission to the facility. A physician Nursing Home Note dated 12/22/20, indicated R1 was seen via video visit by medical doctor (MD)-A. The note indicated at times R1 complained of dizziness and shortness of breath believed to be related to chronic atrial fibrillation. The note further identified a diagnosis of COPD and indicated R1 had no "clear cut" exacerbations, O2 readings have remained in a good range." Staff asked about potential for use of O2 for shortness of breath but because saturation levels had not dropped it was determined O2 was not needed at that time. There was no evidence of COPD exacerbation. An addendum to the note, undated, indicated R1 had COPD and was O2 dependent. Saturation levels ran in the 85-90% range. The MD provided a recommendation for R1 to be on O2 around the clock (continuous) to maintain O2 levels at or above 90%. A facility Progress Note dated 12/27/20, indicated R1's oxygen (O2) saturation was 60 - 70 % [average 90-100%] on room air. R1 had thick					
	brown phlegm in hi and was placed on improvement in O2 was increased to 6 levels of 89 - 91%.	s throat, he was coughing up 2 liters of O2 with no sats after four minutes. O2 liters to maintain saturation R1 coughed up large amounts				
	of brown, sticky phlegm for about 45 minutes. Lung sounds were diminished but clear. After					

Minnesota Department of Health

STATE FORM 6899 NJ9U11 If continuation sheet 5 of 18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE					
		00087		B. WING		l l	C 11/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO	NCIES D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 265	coughing R1 was all above 95% on 2 lite R1's O2 Saturation 12/29/20, R1 had a room air at 7:00 a.m documented until 10 saturation level was R1's Progress Note was holding saliva i swallow. The nurse no results. R1 had flungs. A PT (physical theradated 12/30/20, ind nurse and nurse malevels in the 70's on oxygen. The therap 4-5 liters. R1's satur 80%. R1's Progress Note was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video. The abnormal lung sour and requested order A Documentation of Medicare Clients daindicated R1 was seen by nurse telehealth video.	ble to maintain Oers O2. Summary indical saturation level on. No further O2 0:00 p.m. when Fis 89% while O2. I dated 12/30/20, in his mouth and attempted to such that the same of the s	ted on of 71% on levels were R1's O2 indicated R1 would not ction R1 with bases of the ment Note ist notified a saturation applemental soxygen to increased to indicated R1-A by ad reported of condition wheel chair. Incounter for itten by NP-A chair and 1 required as above 88%. In a sabove 88%.	2 265			
	R1's Progress Note was resting in bed unwheel chair at 3:30	until being assiste	ed into a				

Minnesota Department of Health

STATE FORM 6899 NJ9U11 If continuation sheet 6 of 18

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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	Г	BRAINER	D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 265	Continued From pa	ge 6	2 265			
	weak, audible tracheal gurgling heard. R1 was encouraged to cough and deep breathe and able to clear. O2 was on at 2 liters. Resident was brought to the front entry. After R1 was brought to the entrance and was outside, writer returned to the unit. R1's Discharge Summary dated 12/30/20, identified a health conditions of "COPD O2 sats [saturation] drop." However, the summary did not identify R1's current lung condition status.					
	An untitled hospital record dated 12/30/20, indicated upon arrival to the emergency room R1's blood pressure was 57/40 [average range 120/80 - 140/90]. The note indicated he was ill-appearing and looked toxic, vitals were not stable and he was unresponsive. The notes indicated R1 was in septic shock from presumed bacterial pneumonia and had severe, life threatening lactic acidosis (lactic acid is a substance that can build up in your body if you are not getting enough oxygen). The notes identified evidence or organ damage due to severe sepsis (infection in the blood) including acute respiratory failure, hypoxia (a decreased level of oxygen in all or part of your body) and hypercapnia (too much carbon dioxide in your bloodstream).					
	On 1/7/21, at 1:34 p.m. the assisted living facility (ALF) RN stated when R1 arrived at the ALF he was not very responsive. The ALF RN stated when she completed the admission assessment she reviewed the discharge documentation from the facility and it did not include an assessment or documentation of R1's condition when he left the facility so she had no baseline for him. The ALF RN stated R1's initial blood pressure was low, his heart rate was in the 40's [average range 60-100					

Minnesota Department of Health

STATE FORM 6899 NJ9U11 If continuation sheet 7 of 18

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00087		B. WING			C 11/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COODS	AMADITAN COCIETY	DETHANY	804 WRIG	HT STREET			
GOOD S	AMARITAN SOCIETY	- DE I HAN I	BRAINER	D, MN 5640	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEI MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
] and O2 saturation stated later in the evitals and his blood was in the 70's and pulse on their equipemergency room for passed away the new During interview on stated she had seen his condition had dehim on 12/7/20. NP record and identified 12/23/20, and didnatime. When asked related to the O2 or	vening staff rech- pressure was 50 staff were unablement. R1 was the r further evaluation of the control of the	ecked R1's 0's/30's, O2 e to detect a en sent to the on and e.m. NP-A n 12/30/20, she last saw e medical y NP-B on der at that o face visit				
	the facility had calle was unable to comp day so the facility can his note from the 12 order for the O2 was aw R1. Further, NI to fulfill a Medicare face and did not ide assessment of R1's	d her on 12/30/2 blete the visit unt alled MD-A who to 2/22/20, visit. NP is written by MD-2-A indicated she requirement for the string status.	0, and she il later in the hen amended -A stated the A before she e only saw R1 the face to ted an actual m. registered				
	nurse (RN)-A who we stated, "I think his stated, "I think his state Sunday before I MD-A and NP-A we began to decline; he medical providers of When asked about stated she did not the were implemented at talked to MD-A and oxygen upon discharated she had not stated she had not saturation levels drouger in the state of the state o	ats [saturation le ne discharged." F re both notified v owever she had a nly about R1's re R1's overall declanink any medical and stated RN-A NP-A about the arge from the fac updated them re	evels] dropped RN-A stated when R1 notified the epeated falls. line, RN-A interventions stated she need for ility, but garding the				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00087		B. WING			C 11/2021
	PROVIDER OR SUPPLIER	- BETHANY	804 WRIG	DRESS, CITY, S BHT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE	ENCIES ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 265	Continued From particles was not sure if any updated R1's medic addendum on the property of th	of the nurses had all providers. Furthysician's note of the on 12/30/20, if the member (FM)- A acted them and stated when R1 at the them are all the member to the end of the was sent to the end of the was aware and the physician. In the physician of the physician. In the physician of the physic	A stated the told them R1 arrived at the sure was of the ed R1 was and died from and sepsis. All therapists of the ed R1's O2 two liters of the enurse on the ed they had PT-A said the ed thought it is being Last seen R1 to be enured R1 to be enured the told they had enured the ed thought it is being Last seen R1 to be enured R1 to be enured the thought it is being to be enured R1. All equipment to be a leading with the to face the enured the told the enured the enu	2 265			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00087	B. WING			C 01/11/2021	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- BETHANY 804 WRI	DDRESS, CITY, S GHT STREET RD, MN 5640		•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 265	Further, if he was n R1's condition he w discharge to the as sent R1 to the eme evaluation. On 1/11/21, at 10:4 been declining thro however, she she w let the physician kn status and staff sho saturation levels in A facility policy relat condition was requely SUGGESTED MET director of nursing of review and revise p medical providers a changes in condition inservice nursing stand family are notifichanges in resident ensure compliance	nade aware of the change in vould not have okayed him for sisted living and would have rgency department for further 8 a.m. the DON stated R1 had ughout his stay at the facility would have expected staff to ow of the decline in lung ould have reported the the 70's. Ited to notification of change of ested but none received. THOD OF CORRECTION: The (DON) or designee could have reported the solicies/procedures on notifying and family regarding significant and family of significant to condition, then audit charts to					
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des	O Subp. 1 Adequate and re; General general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 anding home resident must be out	1			2/5/21	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU IDENTIFICATIO		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00087		B. WING		01/1	C 1 1/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 10		2 830			
	of bed as much as written order from the resident must rema prefers to remain in	he attending phy in in bed or the	sician that the				
	This MN Requirements by: Based on interview facility failed to asselung condition for 1 for a change of conharm for R1 who way of care and subsequents in the day of contact of the day of	and document ress and monitor of 3 residents (Fidition. This resurts discharged to uently transferres	review the a change in R1) reviewed Ited in actual a a lower level		Corrected		
	Findings include:						
	R1's undated, Admi admitted to the facilincluded emphysem pulmonary disease	lity with diagnosena and chronic c	es that				
	R1's admission Min 11/24/20, indicated impairment and req from two staff for ad MDS indicated R1 I therapy prior to or s	he had moderat uired extensive ctivities of daily l nad not received	e cognitive assistance iving. The l oxygen				
	R1's care plan date performance deficit impaired mobility ar plan directed staff to staff to complete bathygiene needs. The interventions related R1's COPD.	related to weak nd deconditionin o provide assista athing, toileting a e care plan lacke	ness, g. The care ance of one and personal ed nursing				

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Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S	SUPPLIER/CLIA ION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
				A. BUILDING:			_
		00087		B. WING			C 11/2021
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY		HT STREET D, MN 5640	1		
(X4) ID PREFIX TAG		ATEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 11		2 830			
	R1's Oxygen (O2) 11/18/20 - 12/30/20 supplemental O2 fi summary indicated levels were mainta [average range 90's supplemental O2. A physician Nursing indicated R1 was s doctor (MD)-A. The complained of dizz believed to be relat The note further ide and indicated R1 h exacerbations, O2 good range." Staff of O2 for shortness saturation levels had determined O2 was There was no evide An addendum to th had COPD and wa levels ran in the 85 a recommendation clock (continuous) above 90%.	o, indicated R1 or om 11/18/20 to om 12/27/20, R ined at 89 - 98 of on 12/27/20, R ined at 89 - 98 of onte indicated iness and short readings have a readings have a readings have a reading to chronic at readings have a reading to chronic at readings have a reading to the read	did not use 12/27/20. The 21's saturation 30' on room air ut the need for ated 12/22/20, isit by medical at times R1 ness of breath trial fibrillation. osis of COPD tri remained in a tential for use because it was that time. exacerbation. d, indicated R1 tt. Saturation ne MD provided to O2 around the				
	A facility Progress R1's oxygen (O2) s room air. R1 had the throat, he was cougliters of O2 with no four minutes. O2 with maintain saturation coughed up large a phlegm for about 4 diminished but cleated maintain O2 lave	saturation was 6 nick brown phley ghing up and wa improvement in ras increased to levels of 89 - 9 amounts of brow 5 minutes. Lungar. After coughin	50 - 70% on gm in his as placed on 2 n O2 sats after o 6 liters to 01%. R1 vn, sticky g sounds were ng R1 was able				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087	B. WING		01/1	1/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
2 830	Continued From pa	ge 12	2 830			
	The medical record R1's symptoms.	lacked further assessment of				
	R1's O2 Saturation Summary indicated on 12/29/20, R1 had a saturation level of 71% on room air at 7:00 a.m. No further O2 levels were documented until 10:00 p.m. when R1's O2 saturation level was 89% while O2. The medical record lacked evidence of ongoing monitoring or further assessment.					
	R1's Progress Note dated 12/30/20, indicated R1 was holding saliva in his mouth and would not swallow. The nurse attempted to suction R1 with no results. R1 had faint crackles in bases of lungs. No further assessment was identified.					
	A PT (physical therapy) Daily Treatment Note dated 12/30/20, indicated the therapist notified a nurse and nurse manager about R1 having O2 saturation levels in the 70's on three liters of supplemental oxygen during therapy. The therapist had increased R1's oxygen to 4-5 liters. R1's saturation levels only increased to 80%.					
	was seen by nurse telehealth video. The nurse reported abnotheterioration of confor O2 and a wheel	dition and requested orders chair. The note was written by				
	registered nurse (RN)-A. R1's Progress Note dated 12/30/20, indicated R1 was resting in bed until being assisted into a wheel chair at 3:30 p.m. R1 was restless but weak, audible tracheal gurgling was heard. R1 was encouraged to cough and deep breathe and able to clear. O2 was on at 2 liters. R1 was brought to the front entry and outside at which					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
			A. BUILDING:	·		
		00087	B. WING			C 11/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY	GHT STREET RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	point the writer returecord again lacked assessment or phy discharging R1 from R1's Discharge Suited identified a health of [saturation] drop." It identify R1's current further assessment An untitled hospital indicated upon arriv R1's blood pressur 120/80 - 140/90]. Till-appearing and lostable and he was indicated R1 was in bacterial pneumonathreatening lactic as substance that can are not getting enoidentified evidence severe sepsis (infer acute respiratory fallevel of oxygen in a hypercapnia (toom bloodstream). On 1/7/21, at 1:34 (ALF) RN stated will was not very response when she complete she reviewed the did documentation of Facility so she had a RN stated R1's initial returns the second of the stated R1's initial returns the second of the sec	urned to the unit. The medical devidence of further residual notification prior to				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUIDENTIFICATIO		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00087		B. WING			C 11/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOODS	AMARITAN SOCIETY	- RETHANY	804 WRIG	HT STREET			
	AMARTAN GOOLLT	- BETTIANT	BRAINER	D, MN 5640	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From page 14		2 830				
	stated later in the evitals and his blood was in the 70's and pulse on their equipemergency room for passed away the new During interview on stated she had seen his condition had do him on 12/7/20. NP record and identified 12/23/20, and did not time. When asked related to the O2 or the facility had called was unable to compart day so the facility had called was unable to compart day so the facility of his note from the 12 order for the O2 was aw R1. Further, Note of Infill a Medicare face and did not ideassessment of R1's	pressure was 50 staff were unable ment. R1 was the further evaluation of the result of	D's /30's, O2 le to detect a nen sent to the ion and D.m. NP-A n 12/30/20, she last saw s medical y NP-B on rder at that o face visit , NP-A stated 20, and she cil later in the then amended 2-A stated the A before she e only saw R1 the face to				
	During interview on assistant (NA)-A sta oxygen and stated t few days before he At 8:57 a.m. RN-A,	1/8/21, at 8:26 a ated R1 did not a the O2 use had s discharged.	llways use started only a				
	had not used oxyge and stated, "I think dropped the Sunday stated she talked to need for oxygen up but stated she had the saturation levels and was not sure if and updated R1's m	n when he came his sats [saturati y before he disch MD-A and NP-A on discharge fro not updated ther any of the nurse	e to the unit on levels] narged." RN-A A about the m the facility, n regarding ne 70 % range as had called				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087	B. WING		01/1	1/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 15	2 830			
	not identify why she did not discuss R1's dropping O2 saturations with MD-A. Further, the addendum on the physician's note dated 12/22/20, was added on 12/30/20, following her request for O2.					
	At 9:32 a.m. family member (FM)- A stated the facility had not contacted them and told them R1 needed O2. FM-A stated when R1 arrived at the assisted living facility his blood pressure was really, really low and he was sent to the emergency department. FM-A stated R1 was admitted to the intensive care unit and died from double pneumonia, organ failure and sepsis.					
	At approximately 10:00 a.m. physical therapist (PT)-A stated the day R1 discharged from the facility he had worked with R1 and R1's O2 saturation had dropped to 70% on two liters of O2. PT-A stated he reported it to the nurse on the floor who said RN-A was aware and they had been in contact with the physician. PT-A said the way it was communicated to him he thought it was something that was continually being monitored.					
	on 12/23/20, due to related to R1's lung on vacation and wh NP-B stated at the not required the use had been stable. NI	stated she had last seen R1 his multiple falls and was not status. NP-B stated she went en she returned R1 had died. time of her last visit R1 had e of O2 and his vitals signs P-B stated, "honestly, I don't s notified of the change of ung status.				
	trying to arrange for for R1's discharge a	stated on 12/30/20, he was durable medical equipment and had been speaking with toomplete a face to face				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00087	b. WING		01/1	1/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- BETHANY	HT STREET D, MN 5640			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 16	2 830			
	aware of the decrear Further, if he was in R1's lung condition him for discharge to have sent R1 to the further evaluation. On 1/11/21, at 10:4 (DON) stated R1 has his stay at the facility weekend prior to his O2 when he couldnumeriodic." The DOI drastic change in his saturations levels with saturations levels with stated she was away were evaluating R1 reports she received had been doing for using O2. The DON consistent decline it would have expected.	A stated he had not been ased O2 saturation level. hade aware in the change in he would not have okayed a assisted living and would be emergency department for 8 a.m. the director of nursing ad been declining throughout ty. The DON stated over the s discharge he was requiring but clear his mucous but it was N stated R1 did not display a sis vital signs and his O2 overe not real low. She stated a slow decline." The DON are the day of discharge they be need for O2 and said the did was R1 was doing what he weeks and was regularly of the stated she are staff to report the saturation and to let the physician know of				
	The facility policy Change In Condition Evaluation - CICE dated 12/11/20, directed staff to begin the CICE and collect pertinent clinical data prior to contacting the physician when a resident experienced a change of condition and continue to monitor the resident and update the CICE evaluation as appropriate. Upon completion of the evaluation, a notification hyperlink will turn red if there is information that needs to be communicated to the provider.					
	R1's medical record to a change in cond	d lacked a CICE form related dition in lung status.				

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	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION :	(X3) DATE COMP	SURVEY
			B. WING		(
		00087	B. WING		01/1	11/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- RETHANY	GHT STREET RD, MN 5640			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPREDEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 830	Continued From pa SUGGESTED MET Director of Nursing review policies and implement measure receiving the neces experiencing a char of nursing or design audits of the deliver appropriate care an better ensure imple	,	2 830		OPRIATE	DATE

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