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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 252J
Facility ID: 00167

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245578**

2.STATE VENDOR OR MEDICAID NO.
(L2) **422670600**

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

4. TYPE OF ACTION: **7** (L8)

1. Initial	2. Recertification
3. Termination	4. CHOW
5. Validation	6. Complaint
7. On-Site Visit	9. Other
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **03/01/2015**

6. DATE OF SURVEY **01/14/2019** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 03 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With
Program Requirements
Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Eva Loch, Unit Supervisor 01/31/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 01/31/2019 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/15/2019
(L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
January 31, 2019

Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578030

Dear Administrator:

On January 14, 2019, the Minnesota Department of Health, completed a Post Certification Revisit (PCR) by review of your plan of correction and on January 25, 2019 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245578

January 31, 2019

Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

Dear Administrator:

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

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

Effective January 7, 2019 the above facility is certified for:

56 Skilled Nursing Facility/Nursing Facility Beds

10 Nursing Facility II Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

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(L4) **2309 HAYES STREET NORTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55418**

4. TYPE OF ACTION: **2** (L8)

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3. Termination
4. CHOW
5. Validation
6. Complaint
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9. Other
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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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Program Requirements
Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

17. SURVEYOR SIGNATURE Date :
Jodie Fox, HFE NE II 12/28/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 01/14/2019 (L20)

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

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

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3. Both of the Above :

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09/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
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26. TERMINATION ACTION: (L30)

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01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 13, 2018

Administrator
Bethany Residence And Rehabilitation Center
2309 Hayes Street Northeast
Minneapolis, MN 55418

RE: Project Number S5578030

Dear Administrator:

On December 4, 2018 a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically attached CMS-2567 whereby corrections are required.

OPPORTUNITY TO CORRECT - DATE OF CORRECTION

The date by which the deficiencies must be corrected to avoid imposition of remedies is January 8, 2019.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable plan of correction (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.

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

corrected and will not recur.

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

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

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

- Discretionary denial of payment for new Medicare and Medicaid admissions (42 CFR 88.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 1, 2019 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by May 29, 2019 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

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:

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:

http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING ______ B. WING ______	11/29/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/26//18 through 11/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 11/26/18 through 11/29/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be	F 578		1/4/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/24/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING ____ B. WING ____	11/29/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 1 construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the resident's medical	F 578	The Advance Directives for Resident R22 was verified and updated on all areas of the medical record, including paper and electronic, at the direction of R22s legal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 2 record to ensure resident's wishes would be implemented correctly in an emergency for 1 of 1 (R22) reviewed for advanced directives. Findings include: The Admission Record (facesheet) printed 11/27/18, indicated R22's Advanced Directives (a legal document that allow an individual to spell out decisions about end-of-life care) was "Full Code (Full CPR)". R22's Provider Orders for Life Sustaining Treatment (POLST) signed 8/7/18, indicated R22's wished for "Do Not Attempt Resuscitation/ DNR (Allow Natural Death)" and indicated "Selective Treatment". The nurse practitioner and R22's court-appointed guardian signed the document. R22's Clinical Physician Orders in her Electronic Medical Records (EMR) dated 4/16/18, indicated R22's code status was "Full code". R22's Clinical Physician Orders in the EMR dated 7/3/18, identified R22's code status as "Full Code (Full CPR)". R22's care conference note dated 6/1/18, included: "guardian stated, resident has told me that she would like to be DNR". R22's care conference note dated 8/16/18, included: "code status remains the same". The facilities Resident Code Status Physician's Order for Life Sustaining Treatment policy dated 11/24/15, did not contain a process for entering a code status into the EMR.	F 578	guardian. A house wide audit was conducted to verify accuracy of Advance Directives for all residents on 11/28/2018. No further issues were identified. The policies and procedures for Advance Directives were reviewed and updated. As part of this review the electronic records process was streamlined to include only standard order inputs for Advanced Directives. This will eliminate duplicate orders and/or orders that do not flow to resident face sheets. Nursing Staff have been educated on the changes in policies and procedures and nurses have been educated on the new processes for inputting Advance Directives. Physicians have been educated on the proper processing of Advance Directives. Audits will be conducted by the Director of Social Services on all new admissions and following IDT or Care Conference Meetings. The Director of Nursing will also conduct monthly reviews on all residents to verify ongoing compliance for 6 months. Audit findings will be presented at QAPI Meetings for a minimum of 6 months to ensure ongoing compliance. Social Services Director and Director of Nursing will maintain ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING ______ B. WING ______	11/29/2018

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

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F 578	Continued From page 3 On 11/27/18, at 9:23 a.m. registered nurse (RN) -A confirmed R22's POLST and code status in the EMR did not match and "they should be the same". To find a code status in an emergency, RN-A would first look at the facesheet in the front of the resident's paper chart. If the status could not be found, RN-A would reference the POLST in the paper chart. RN-A further explained if a resident was found without a pulse and the code status was unknown, CPR (cardiopulmonary resuscitation) would be initiated and the nurse would reference the chart for clarification. RN-A stated he would call the family if there were any discrepancies in the resident's code status. On 11/27/18, at 9:27 director of nursing (DON) verified R22's POLST and code status in the EMR did not match. DON explained when there would be a question of a resident's code status CPR would be initiated. The DON expressed the records updating process was not followed in R22's case.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		1/4/19

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	245578	A. BUILDING ______ B. WING ______	11/29/2018

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BETHANY RESIDENCE AND REHABILITATION CENTER	2309 HAYES STREET NORTHEAST MINNEAPOLIS, MN 55418

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F 609	Continued From page 4 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report allegations of mistreatment that caused a bruise to the State agency (SA) for 1 of 3 residents (R26) in the facility. Findings include: R26's quarterly Minimum Data Set (MDS) dated 10/24/18, indicated she was moderately cognitively impaired and required the range of extensive assistance to total dependence for activities of daily living. R26's care plan dated 9/20/16, identified areas of (potential) vulnerability related to abuse. The care plan directed staff to immediately report allegations of abuse to the supervisor, administrator, director of nursing (DON), social worker, and the SA. During an interview on 11/26/18, at 3:48 p.m. R26 stated staff members could be short with her but she would not classify those interactions as abuse, stated it was just "poor manners."	F 609	R26 Incident reported via the State VA Reporting System on 11/27/18. An investigation was initiated immediately and despite being inconclusive as related to the bruise, ultimately concluded that there was no evidence of abuse or neglect related to this incident. Facility policies and procedures related to Vulnerable Adult reporting were reviewed and updated. All staff have been or will be educated on VA Policies and Procedures with an emphasis on their individual responsibilities related to follow-up reporting if they have not been contacted by the Director of Nursing or Administrator during the investigative phase. Additional emphasis will be made as to the types of incidents which are automatically	

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F 609	Continued From page 5 Furthermore, she could not recall any episodes of physical abuse. A review of the nursing progress notes revealed a note dated 8/13/18, identified a light colored 7 centimeter (cm) x 3 cm bruise to R26's right forearm. R26 alleged the bruise occurred while staff was pulling her up in bed but was unable to state when the incident occurred. The note indicated that family was notified. A review of the facilities risk management documentation, under the heading unknown injury, dated 8/13/2018, indicated that management was notified of the bruise. No further documentation related to the bruise was located in the record. A review of the facilities 2018 log of all vulnerable adult reports made to the SA, no report could be located related to R26 during the month of August 2018. During an interview on 11/27/18, at 3:13 p.m. the DON stated staff were directed to report allegations of abuse. He stated, depending on the severity of the allegation, an incident may need more investigation prior to knowing whether to report. In regard to R26, the DON stated, "I do not recall being notified of this incident so it would not have been investigated." During an interview on 11/27/18, at 4:30 p.m. the administrator stated initially the incident was not reported to the SA. However the DON had discussed the incident with him and they had immediately reported the allegation to the SA. The administrator went on to say that the investigation had begun but it was difficult as the	F 609	reportable and individual responsibilities in documenting and investigating incidents. To identify potential under reporting of incidents the Director of Nursing will review all incident reports daily (Monday through Friday) to identify possible reports that should be reported through the VA Reporting System. Potential VA Reports will be discussed at stand-up meetings each morning and will be identified on the 24 hour nurses reports. VA Policies and Procedures will be reviewed at every Staff Meeting for the next 12 months with a focus on incident reporting and individual follow-up after reporting incidents that may fall under VA Reportable Incidents. Actual examples will be used when possible to emphasize the importance of reporting all incidents timely and what to expect during the investigative phase. Incident and VA Reporting will be reviewed by QAPI for a minimum of 6 months to insure substantial compliance. The Administrator will verify completion and will monitor ongoing compliance.	

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F 609	Continued From page 6 incident had occurred in August and staff were finding it difficult to recall the bruise. The administrator stated he realized that educating the staff regarding when and how to report to management is an ongoing struggle. A facility policy titled Bethany Residence and Rehabilitation, Abuse Prevention Program, dated 10/1/17, was reviewed. The policy directed staff to report immediately to the administrator any incident of alleged abuse and file an initial report with the state agency. Following the report staff are directed to complete a thorough investigation of the allegation.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 610	R26 Incident reported via the State VA	1/4/19

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F 610	Continued From page 7 facility failed to thoroughly investigate a bruise and implement measures to prevent potential further mistreatment for 1 of 3 residents (R26) in the facility. Findings include: R26's quarterly Minimum Data Set (MDS) dated 10/24/18, indicated she was moderately cognitively impaired and required the range of extensive assistance to total dependence for activities of daily living. R26's care plan dated 9/20/16, identified areas of (potential) vulnerability related to abuse. The care plan directed staff to immediately report allegations of abuse to the supervisor, administrator, director of nursing (DON), social worker, and the SA. During an interview on 11/26/18, at 3:48 p.m. R26 stated staff members could be short with her but she would not classify those interactions as abuse, stated it was just "poor manners." Furthermore, she could not recall any episodes of physical abuse. A review of the nursing progress notes revealed a note dated 8/13/18, identified a light colored 7 centimeter (cm) x 3 cm bruise to R26's right forearm. R26 alleged the bruise occurred while staff was pulling her up in bed but was unable to state when the incident occurred. The note indicated that family was notified. A review of the facilities risk management documentation, under the heading unknown injury, dated 8/13/2018, indicated that management was notified of the bruise. No further documentation related to the bruise was located in the record, and there was no evidence that the bruise had been investigated by the facility.	F 610	Reporting System on 11/27/18. An investigation was initiated immediately and despite being inconclusive as related to the bruise, ultimately concluded that there was no evidence of abuse or neglect related to this incident. Facility policies and procedures related to Vulnerable Adult reporting were reviewed and updated. All staff have been or will be educated on VA Policies and Procedures with an emphasis on their individual responsibilities related to follow-up reporting if they have not been contacted by the Director of Nursing or Administrator during the investigative phase. Additional emphasis will be made as to the types of incidents which are automatically reportable and individual responsibilities in documenting and investigating incidents. To identify potential under reporting of incidents the Director of Nursing will review all incident reports daily (Monday through Friday) to identify possible reports that should be reported through the VA Reporting System. Potential VA Reports will be discussed at stand-up meetings each morning and will be identified on the 24 hour nurses reports. VA Policies and Procedures will be reviewed at every Staff Meeting for the next 12 months with a focus on incident reporting and individual follow-up after reporting incidents that may fall under VA	

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F 610	Continued From page 8 A review of the facilities 2018 log of all vulnerable adult reports made to the SA, no report could be located related to R26 during the month of August 2018. During an interview on 11/27/18, at 3:13 p.m. the DON stated staff were directed to report allegations of abuse. He stated, depending on the severity of the allegation, an incident may need more investigation prior to knowing whether to report. In regard to R26, the DON stated, "I do not recall being notified of this incident so it would not have been investigated." During an interview on 11/27/18, at 4:30 p.m. the administrator stated initially the incident was not reported to the SA. However the DON had discussed the incident with him and they had immediately reported the allegation to the SA. The administrator went on to say that the investigation had begun but it was difficult as the incident had occurred in August and staff were finding it difficult to recall the bruise. The administrator stated that allegations such as these should be investigated. The administrator stated he realized that educating the staff regarding when and how to report to management is an ongoing struggle. A facility policy titled Bethany Residence and Rehabilitation, Abuse Prevention Program, dated 10/1/17, was reviewed. The policy directed staff to report immediately to the administrator any incident of alleged abuse and file an initial report with the state agency. Following the report staff are directed to complete a thorough investigation of the allegation.	F 610	Reportable Incidents. Actual examples will be used when possible to emphasize the importance of reporting all incidents timely and what to expect during the investigative phase. Incident and VA Reporting will be reviewed by QAPI for a minimum of 6 months to insure substantial compliance. The Administrator will verify completion and will monitor ongoing compliance.	

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F 625	Continued From page 9	F 625		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 residents (R139) was provided a bed hold notice upon transfer of a resident for hospitalization or therapeutic leave. Findings include:	F 625	Resident R139 was given a copy of the facility bed hold policy and the copy was placed in their file. Policies and Procedures related to Bed Hold Policies were reviewed and found to be in compliance. Social Worker and	12/15/18

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F 625	Continued From page 10 During an interview with R139 on 11/26/18, at 5:22 p.m., R139 stated he was not given a bed hold notice when he was transferred to the hospital. R139 stated he had returned to the same room and bed when he came back to the facility. R139's Diagnosis List included diagnoses of: cerebral palsy, gastro-esophageal reflux disease without esophagitis, dysphagia following unspecified cerebrovascular disease, oropharyngeal phase, diaphragmatic hernia without obstruction or gangrene. The quarterly Minimum Data Set (MDS) dated 9/13/18, identified R139 had intact cognition. A Review of the progress notes revealed R139 was admitted to the hospital on 11/7/2018, and returned to the facility on 11/9/2018. In addition, R139's progress notes revealed R139 was readmitted to the hospital on 11/11/2018, and returned to the facility on 11/15/2018. The progress notes lacked evidence of the facility providing or attempting to inform R139 of the bed hold agreement during neither of the two hospital transfers. During an interview on 11/29/18, at 11:03 a.m., Social Worker-A stated bed hold agreements were provided to residents at the time of admission, a copy was signed by resident or legal representative, a copy was placed in each residents chart, a copy was given to the social worker which she filed in a file cabinet in her office. When asked if she had a copy of the bed hold notices that were provided to R139 when he transferred to hospital, social worker stated	F 625	Nursing Staff have been updated on the Facility□s Bed Hold Policy which states that all efforts will be made to provide a copy of the facility□s bed hold policy on each transfer in and out of the facility. Social Worker will conduct an audit of all resident files to verify each resident has received and signed the facility Bed Hold policy (upon admission). Bed Hold Audits will be conducted after each admission or transfer and a whole house audit will be conducted monthly for 3 months. Results of audits will be reported to QAPI for a minimum of 3 months to insure ongoing compliance. The Director of Social Services will verify completion and will monitor ongoing compliance.	

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F 625	Continued From page 11 resident is his own legal representation, social worker was unable to find a copy. During an interview on 11/11/18, at 11:10 a.m. Administrator stated the bed hold agreement was given to residents or the legal representative before and upon transfer to a hospital or when taking a therapeutic leave of absence from the facility, The administrator stated the bed hold agreement was initially provided only upon residents admission to facility but policy had changed to include every transfer from the facility, the administrator stated there was no evidence R139 had received a bed hold notice for any of his two hospitalizations, therefore social worker would be educated on bed hold policy. According to the bed hold policy and agreement, the facility will provide in writing to the resident and /or the resident's representative the facility's bed hold and return to the facility policy at the time of transfer or leave of absence specifying the duration of the bed policy. .	F 625		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		1/7/19

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F 688	Continued From page 12 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services in order to maintain and/or prevent further decline in ROM abilities for 2 of 4 residents (R19, R29) who had limitations in ROM and had not received ROM services. Findings Include: R19 On 11/26/18, at 3:01 p.m., R19 was observed in her room sitting in her wheel chair. R19's bilateral (affecting both sides) hands had notable contractures (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints). When asked if she had a brace or was provided ROM exercises to her hands, R27 shook her head, shrugged her shoulders and stated, "No". R19's Admission Record includes the diagnosis: Unspecified Osteoarthritis, Age-Related osteoporosis, and Other Chronic pain. Although the Minimum Data Set (MDS) for admission, dated 7/11/18 identified R19 with functional limitations on both sides of upper and	F 688	Resident R19 and R29's Care Plans were reviewed and updated based upon physical therapy recommendations related to contractures and mobility as related to the Restorative Nursing Program for ongoing treatment and services for ROM and Mobility. Restorative Therapy orders were added to the Treatment (TAR) Orders and the Care Plan. The facility initiated a whole house review of residents care plans and therapeutic recommendations as related to Restorative Nursing programs. ROM and Mobility programs were re-instated and added as needed for residents throughout the building. Staff were trained on treatment programs as part of the Restorative Nursing Program. Staff were provided with treatment sheets for all applicable residents, were trained in providing said treatments and were provided with flow sheets for documenting the completion of the treatments on a daily basis.	

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F 688	Continued From page 13 lower extremities. A care assessment area was not developed. The MDS also indicated R19 did not participate in therapy or a restorative nursing program. The quarter one MDS dated 10/10/18 also identified R19 with ROM limitations on both sides of upper extremities. The Care Plan revised on 11/19/18, identified R19 to be "free of contractures" and directed staff to monitor, document and report to MD (medical doctor) PRN (as needed) s/sx (signs and symptoms) of immobility: contractures forming or worsening, thrombosis formation, skin break down or fall related injury. R19's Care Plan revised date 1/11/18, identified R19 as having "contractures of elbows" and directed staff to complete ROM assessments every quarter. ROM assessments were requested, but not provided. The care plan did not address hand contractures, and there was no reason why services to maintain or prevent decline in ROM were not provided. On 11/27/18, at 8:59 a.m., a trained medication aid (TMA)-A stated the facility did not offer a ROM or a restorative nursing program at the facility, "We did have a few at one time, but not anymore." On 11/27/18, at 9:35 a.m., a registered nurse (RN)-C stated she completed the Minimum Data Set (MDS) assessments. RN-C stated the facility had no formal ROM/restorative nursing program at this time. RN-C further stated she assumed if ROM was needed, the nurses on would ensure these services were provided. On 11/27/18, at 1:30 p.m., RN-B stated the facility had an active ROM/restorative nursing program	F 688	The facility has reviewed all policies and procedures for the Restorative Nursing program including but not limited to; therapeutic referrals, therapeutic recommendations, nursing ongoing treatments and programs, education of staff responsible for treatment and documentation, documentation methods, and re-evaluations for program effectiveness. The Director of Nursing will monitor the restorative nursing flow sheets daily to insure program compliance for the first 30 days. Periodic audits of treatments will also be conducted by the Director of Nursing throughout the first 30 days to insure nursing staff are providing proper treatment and documentation. Director of Nursing will conduct weekly audits after the first 30 days until it is determined substantial compliance is met. Results of audits and effectiveness of the Restorative Nursing Program will be reported to QAPI Committee. Program effectiveness will be measures by reviewing individual cases and by tracking ADL Quality Measures. The Director of Nursing will be responsible for completion and on-going compliance.	

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F 688	Continued From page 14 provided by Nursing, including Nursing Assistants Registered (NAR). RN-B further explained if a resident received ROM/restorative nursing services from staff, it would be written in the resident's current care plan or NAR Care Sheet. During a telephone conversation on 11/27/18, at 2:00 p.m., an Occupational Therapist Registered (O-A) stated she was not aware of R19's bilateral contractures of hands/fingers or if the facility staff had measures in place to maintain her current level of ROM. During this same telephone conversation, a Certified Occupational Therapist Assistant (O-B) stated R19 had occupational therapy ordered in September for wheelchair positioning but not for contractures of her fingers. O-B stated she was informed R19 was fully functional because she could color and feed herself. On 11/29/18, at 8:55 a.m., R19 was observed eating breakfast in the dining room on the second floor in the facility. Adaptive eating utensils were provided to R19 which included a double-handled cup with a plastic straw and a divided plate. R19 attempted to pick up her double-handled cup to get a drink of milk, but could not grasp the handles. R19 then clenched her hands into a fisted position and with the outside portion of her fists, drew the adaptive cup to her mouth. R19 drank a few sips of milk from the straw. R19 is not able grasp the spoon with her tight hand because she could not extend digits three through five. R19's fingers on her left hand were partially bent and could not be fully extended. R19 did not attempt to use her left hand. During an interview on 11/29/18, at 9:45 a.m., the administrator stated anyone with a contracture or	F 688		

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	245578	A. BUILDING ______ B. WING ______	11/29/2018

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

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F 688	Continued From page 15	F 688		

decline in ROM should be on a program to ensure they maintain their level of function and do not decline. The administrator stated, "This is one of those things you need consistency of leadership we have not gotten to this point with this program. "

The Bethany Residence and Rehabilitation Center Restorative/Functional Maintenance policy, modified 11/25/15, stated the purpose of the restorative program will be to assist with various forms of activity, ambulation, PROM, feeding, ROM, etc. in order that the residents will be able to maintain their maximum potential for as long as they can within this facility.

R29
On 11/26/18, 12:28 p.m., R29 was observed lying in his bed. When asked, R29 stated it was difficult to move his hand, fingers and possibly his elbow on his left side after a recent stroke. R29 stated he did not receive therapy/ROM exercise and did not wear a brace to the affected area.

The Occupational Therapy Evaluation for the initial assessment, dated 8/3/18, identified R29's AROM (active range of motion) to bilateral upper extremities was within functional limitations. The Therapy Discharge/Recertification record dated 8/10/18, noted R29 was discharged from therapy due to his lack of participation.

The Bethany Clinic/Visit referral sheet dated 11/1/18, included a referral to HCMC (Hennepin County Medical Center) Orthopedic Clinic for left hand with index finger and numbness and decrease in ROM, left thumb weakness and unwilling to move left wrist with possible radial nerve involvement. An OT (Occupational

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F 688	Continued From page 16 Therapy) referral was made by HCMC Orthopedic Clinic at the time of the visit. A Nurse Practitioner order from 11/8/18, directed OT to assess and treat for ROM exercise and pain reduction of left hand. On 11/27/18, at 1:30 p.m. RN-C verified a referral for OT was written on 11/1/18, and that R29 had not started therapy or other interventions for ROM to his left upper extremely, "He has not started,. It has not been carried out." On 11/27/18, at 1:45 p.m., the Director of Nursing (DON) reviewed R29's records. The DON stated he expected this referral/order to be in place by now, "after nearly three weeks". The DON explained the process after receiving a referral for therapy included: call placed the therapy for notification of referral, documentation of the call or if a voice message was left, follow-up to ensure therapy received the order. The DON stated he could not confirm therapy received the message/order because the facility lacked any documentation involving the order/referral. During a telephone conversation on 11/27/18, at 2:00 p.m. O-A stated when an order for OT was received, the expectation was to see the resident the same or the next day. O-A stated she was not aware of a referral/order for R29. O-A also explained when a referral/order was received, OT would assess the resident and either start a therapeutic program or initiate and instruct the facility for a restorative nursing program. O-A explained when a restorative program was recommended, a referral sheet was given to the facility's nursing staff by OT. O-A verified R29 had not been assessed for an evaluation for ROM services to his left upper extremity or that R29	F 688		

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F 688	Continued From page 17 currently received OT or restorative nursing services. The MDS dated 11/1/18, identified functional limitation to one side of upper extremities for R29. R29's care plan revised 11/8/18, identified R29 had impaired ROM to left hand and wrist however a goal or interventions were not addressed in the care plan. In addition there was no reason why the services not to provided. On 11/29/18, at 9:07 a.m., R29 was observed in his room sitting at the edge of his bed. When asked, R29 stated his upper left extremity was "useless" and explained that he was not able to "do things I did before. I just have no use. They told me they were going to give me therapy, but that didn't happen." During an interview on 11/29/18, at 9:42 a.m., the administrator stated, "It is one of those system things. It got lost in the shuffle. I don't have an answer." The undated Superior Healthcare Management Minnesota Region policy for Orders, Receiving and Transcribing medication and Treatment Orders was provided by the facility but failed to address a process to transcribe and operationalize therapy/rehabilitation orders.	F 688		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff	F 919		12/15/18

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F 919	Continued From page 18 work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review, the facility failed to ensure resident call lights were maintained and functioning for 1 of 1 residents (R22) reviewed during the survey. Findings include: R22's Minimal Data Set (MDS) dated 10/17/18, identified R22 had intact cognition and required one-person physical assist with dressing, toileting, and personal hygiene. R22's Care Plan Interventions initiated 4/24/18, included "be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed". During an observation on 11/26/18, at 12:31 p.m. R22's call lights were tested multiple times by both the resident and surveyor. R22 had two call lights attached to one wall outlet. When the white button at the farthest end of the cord was depressed, the surveyor did not hear an alarm from the nurse's station near R22's room and the light above R22's door did not illuminate. During an interview on 11/27/18, at 1:59 p.m. nursing assistant (NA)-A stated R22 used the call light for assistance. NA-A tested both call lights in R22's room with the surveyor observing. After the sound at the nurse's station and light above R22's door functioned intermittently, NA-A stated, "sometimes it works and sometimes it doesn't".	F 919	Resident R22□s call light system was fixed immediately on being reported non-functional. A whole house audit of all call lights was completed on 11/28/2018 and found no further issues. The facilities call light policies and procedures were reviewed and updated. Staff were educated on the policies and procedures. Particular emphasis was placed on the importance of immediately notifying maintenance and/or administrator for non-functioning call lights as this is a vital life safety device AND in providing resident(s) with an alternative communication method or other close monitoring until call light is functional. Monthly audits per the facility policy and procedure have been reinstated starting in November. Audits will be reported to QAPI for a minimum of 6 months until substantial compliance has been confirmed. The Administrator will verify completion and will monitor ongoing compliance.	

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F 919	Continued From page 19	F 919		

On 11/28/18, at 8:56 a.m. NA-B tested both call lights multiple times with the surveyor observing. The sound at the nurse's station and light above R22's door functioned intermittently. NA-B explained if a piece of equipment is not operating properly, it would be reported to a nurse, maintenance, and the administrator.

On 11/28/18, at 8:59 a.m. registered nurse (RN) -A attempted to use R22's call light and confirmed when R22's call lights buttons were depressed neither the light at the nurses station or above R22's door were illuminated and no alert sound was emitted. RN-A stated they were broken. RN-A further stated he would directly report known equipment problems to the administrator.

During an interview 11/28/18, at 9:36 a.m. the administrator explained dysfunctional equipment would be reported directly to him or placed in the maintenance log. He further explained call light audits were expected to be completed monthly. At the time of the interview, he was aware of the issue. Later that afternoon, Call Light Audits dated 5/15/18 and 6/7/18, were provided. The administrator confirmed June is the most recent audit completed.

A Call Light Policy was requested but not supplied.

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

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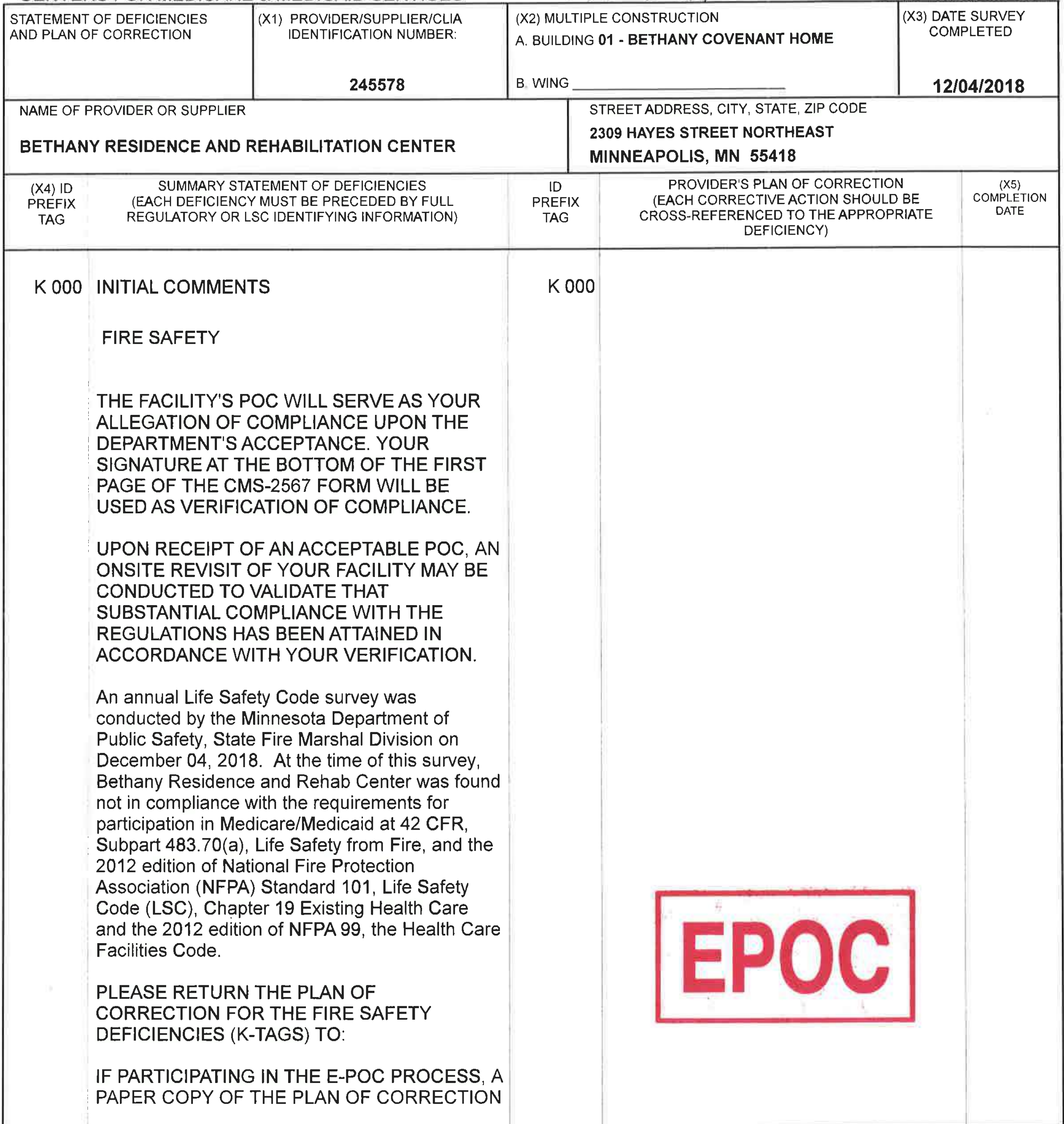
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245578	A. BUILDING 01 - BETHANY COVENANT HOME B. WING ______	12/04/2018

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on December 04, 2018. At the time of this survey, Bethany Residence and Rehab Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/24/2018

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Bethany Residence and Rehab Center is a 2-story building with no basement that built in 1960 and was determined to be of Type II(222) construction. This facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors spaces open to the corridor that is monitored for automatic fire department notification. The health care facility is separated from the adjacent apartment building by 2-hour fire-rated construction. The facility has a capacity of 66 beds and had a census of 39 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not maintain the fire alarm system in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code with records of maintenance and testing being readily available. 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice could effect all 39 residents. Findings include: On a facility tour at 10:29 AM on December 04, 2017, it was revealed that the facility could not provide evidence of having completed a current annual fire alarm inspection. This deficient practice was verified by the Administrator at the time of discovery.	K 345	Annual Fire Alarm Inspection has been scheduled with LVC Incorporated and will be completed on or prior to January 4, 2019. Policies and procedures for Fire Alarm systems were reviewed and updated. Fire Life Safety Compliance checks will be reviewed at quarterly QAPI meetings to insure ongoing compliance. The Administrator will verify completion and will monitor ongoing compliance.	1/4/19
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101	K 355		1/4/19

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K 355	Continued From page 3 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not inspect and maintain portable fire extinguishers in accordance with NFPA 10. 19.3.5.12. This deficient practice could affect all 39 residents. Findings include: On a facility tour at 10:35 AM on December 04, 2018, it was revealed that the facility could not provide evidence of having completed a current annual portable fire extinguisher inspection. This deficient practice was verified by the Administrator at the time of discovery.	K 355	Annual Fire Extinguisher Inspection has been scheduled with Fire Control Systems Inc and will be completed on or prior to January 4, 2019. Policies and procedures for Fire Extinguishers was reviewed and updated. Fire Life Safety Compliance checks will be reviewed at quarterly QAPI meetings to insure ongoing compliance. The Administrator will verify completion and will monitor ongoing compliance.	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K 761		1/4/19

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K 761	Continued From page 4 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed test and inspect fire doors on and annual basis on accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. This deficient practice could affect all 39 residents. Findings included: On a facility tour at 11:14 AM on December 04, 2018, it was revealed that the facility could not provide evidence of having completed a current annual fire door inspection. This deficient practice was verified by the Administrator at the time of discovery.	K 761	A comprehensive Fire Door Inspection will be completed under the direction of the Administrator on or prior to January 4, 2019. Policies and procedures for Fire Safety audits have been reviewed and updated. Fire Life Safety Compliance checks will be reviewed at quarterly QAPI meetings to insure ongoing compliance. The Administrator will verify completion and will monitor ongoing compliance.	