Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 18, 2024

Administrator
Bethany On The Lake LLC
1020 Lark Street
Alexandria, MN 56308

RE: CCN: 245434
Cycle Start Date: June 5, 2024

Dear Administrator:

On June 5, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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.

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 an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- 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"and/or an "E" tag), i.e., the plan of correction should be directed to:

LeAnn Huseth, RN, Unit Supervisor
Fergus Falls District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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 September 5, 2024 (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 December 5, 2024 (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: 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

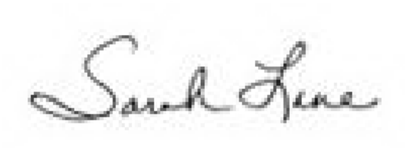
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE LLC	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID 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 On 6/3/24 to 6/5/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 6/3/24 to 6/5/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed: The following complaints were reviewed with no deficiencies issued. H54343964C (MN00101220). H54343963C (MN00103238). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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	F 000		

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

Electronically Signed | 06/25/2024

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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F 000	Continued From page 1 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect oxygen usage and hospice status for 1 of 1 resident (R28) reviewed for hospice services. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated October 2023, outlined an overview which included, "Intent: The intent of the items in this section is to identify any special treatment, procedures, and programs that the resident received or performed during the specified time periods." Facilities may code treatments, programs, and procedures that the resident performed themselves independently or after set-up by facility staff. The RAI had directions to check all the following treatments, procedures, and programs that were performed during the last 14 days: Section O0100C oxygen therapy, and section O0100K, hospice care. During a review of R28's facesheet, diagnoses information included, COPD, unspecified onset	F 641	F641 SS=D The process for completing accurate assessments has been reviewed and revised as needed to ensure that resident's assessments are completed accurately when coding hospice and oxygen in section O per the RAI manual. R28's MDS was modified to include oxygen and hospice. MDS' were reviewed and are accurate for residents receiving oxygen and hospice per the RAI manual. All residents receiving oxygen and hospice have the potential to be affected if this regulation is not met. All necessary Bethany on the Lake staff have received education per RAI manual regarding accurate coding of hospice and oxygen in section O of the MDS. Audits will be completed two (2) times per week for two (2) weeks; one (1) time per week for four (4) weeks; and monthly	6/26/24

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F 641	Continued From page 2 date of 12/13/23, encounter for palliative care onset date of 12/13/23, and dependence on supplemental oxygen onset date of 5/18/18. Review of the admission MDS dated 12/19/23, section O100C oxygen therapy had not been checked. In addition, section O100K, Hospice, had not been checked. Review of the quarterly MDS dated 3/20/23, section O100C special treatments and programs: oxygen therapy had not been checked. In addition, section O100K Hospice had not been checked. Review of the care plan dated 12/14/23, identified R28's hospice care was provided by Douglas County Hospice. Indicated R28 had an alteration in oxygen/ gas exchange. Staff were to monitor oxygen saturations as ordered, and PRN. Staff were to administer oxygen as ordered. Review of the Medical director (MD) progress note dated 1/10/24, identified R28 had been admitted to the facility on hospice care for COPD and R28 had supplemental oxygen for COPD. Orders were in place for oxygen, two liters per minute (LPM) continuously (since about 2014). In addition, diagnosis of Hospice Care (primary encounter diagnosis) COPD, severe and dependence on supplemental oxygen. During the review of Douglas County hospice physician certification of terminal illness dated 11/9/23, identified R28 had a diagnosis of COPD. R28 had shortness of breath and used oxygen. Dyspnea related to COPD was identified as a problem. The hospice goal was for R28 to remain free of signs of respiratory distress and/or report	F 641	thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.¿ Director of Nursing or Designee is the responsible party.	

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F 641	Continued From page 3 dyspnea was managed at an acceptable level. The hospice MD order: two LPM via nasal cannula (NC). During the review of R28's signed orders from MD dated 5/13/24, R28 had an order for two to four LPM of oxygen via NC to keep oxygen sats greater than or equal to 88-92% every shift related to chronic obstructive pulmonary disease, unspecified, order active as 2/21/24. In addition, an order for Hospice of Douglas County active since 12/13/23. During an interview on 6/5/24 at 10:50 a.m., registered nurse (RN)-B stated R28 had been admitted to the facility on hospice and with orders for oxygen. During an interview on 6/5/24 at 8:40 a.m., the director of nursing (DON) stated she had been the MDS coordinator and completed R28's quarterly MDS. DON stated R28 had been admitted on hospice. DON confirmed the MDS should have been marked for hospice. DON believed oxygen not being marked on the MDS was accurate as R28 did not wear 02 consistently and had oxygen for comfort. DON's expectation would be for staff to accurately complete the resident assessment. DON indicated the MDS would be updated to reflect an accurate assessment of R28. A policy regarding completing an MDS accurately was requested however, was not provided. The facility provided a copy of The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated October 2019, which the facility stated they followed.	F 641		

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F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		6/26/24

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F 655	Continued From page 5 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours to address the individualized needs for 1 of 2 residents (R174) who was recently admitted. Findings include: R174's progress note dated 5/31/24, indicated R174 was admitted to the facility from a hospital on 5/31/24, with a primary diagnosis of chronic obstructive pulmonary disease (COPD). Identified R174 required staff assistance to transfer and was on two liters of oxygen via nasal cannula. R174's baseline care plan initiated on 6/3/24, lacked areas to prevent skin breakdown or toileting. In addition, the care plan lacked any interventions for the use of oxygen. Further, the care plan was developed a day past the 48 hour time frame requirement. During an interview on 6/5/24 at 8:02 a.m., nursing assistant (NA)-C stated she was unsure what R174's care plan identified. During an interview on 6/5/24 at 8:27 a.m., registered nurse (RN)-A verified R174's baseline care plan was not completed within 48 hours of R174's admission. In addition, RN-A confirmed the care plan lacked interventions to prevent skin breakdown, toileting, and oxygen therapy. RN-A	F 655	F655 SS=D The process for completing a baseline care plan has been reviewed and revised as needed to ensure all residents have a baseline care plan completed within 48 hours of the resident's admission which includes information necessary to properly care for the residents. R174's care plan was revised to include information necessary to properly care for the resident on 6/3/2024. All newly admitted residents have the potential to be affected if this regulation is not met. All necessary Bethany on the Lake nursing staff have received education regarding the completion of a baseline care plan within 48 hours of the resident's admission in which the baseline care plan includes information necessary to properly care for the resident. Audits will be completed two (2) times per week for two (2) weeks; one (1) time per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence.	

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F 655	Continued From page 6 stated she was aware the baseline care plan should have been completed within 48 hours. RN-A indicated she was unsure why the care plan had not been completed within 48 hrs of R174's admission or why the care plan did not include all problems. RN-A stated her expectation was staff would complete the baseline care plan within 48 hours after R174's admission and the care plan would have contained all the required components to care for R174. During an interview on 6/5/24 at 10:47 a.m., director of nursing (DON) verified R174's baseline care plan had not contained all the required components to care for R174 and had not been completed within 48 hours of R174's admission. DON stated her expectation was R174's baseline care plan would have contained all the components to care for R174 and would have been completed within 48 hours of R174's admission. DON indicated it was important to ensure baseline care plans were developed timely to ensure staff were aware how to care for the residents. Review of a facility policy titled Care Planning revised 1/6/22, identified a baseline plan of care would be developed within 48 hours of admission to ensure that the resident's immediate basic needs were met and maintained. Indicated, in accordance with state and federal regulations, each resident would have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs.	F 655	Director of Nursing or Designee is the responsible party.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		6/26/24

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F 658	Continued From page 7 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration of an inhalation medication for 1 of 1 resident (R176) observed for medication administration. Findings include: R 176's admission Minimum Data Set (MDS) dated 5/30/24, identified R176 had intact cognition and had diagnoses which included asthma, end stage renal disease, and chronic obstructive pulmonary disease (COPD). R176's comprehensive care plan dated 6/3/24, identified R176 required staff assistance with dressing, hygiene and transfers. Indicated R176 had a diagnosis of COPD, and instructed staff to give aerosol or bronchodilator (medication that relaxes and opens the airways, or bronchi, in the lungs) as ordered, with goals which included would be free of symptoms of respiratory infections. R176's Order Summary Report signed 5/31/24, identified Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE (Advair is a combination medicine used to prevent asthma attacks) one inhalation inhale orally every 12 hours related to COPD. Rinse mouth after each use.	F 658	F658 SS=D The process for administering inhalation medication has been reviewed and revised as needed to ensure compliance with following the standards of practice related to medication administration of an Advair inhalation medication. R176 was educated on following standard of practice related to medication administration of an Advair inhalation medication by swishing and spitting after administration. R176 has SAM completed, staff will direct resident to complete swish/spit and provide resident with glass of water. Advair inhalation medication order was updated to contain swish and spit in the additional directions. All resident's orders contain the directive to swish and spit after administration of the Advair inhalation medication. HIM will input 'swish/spit after administration' for new admissions. All residents receiving Advair inhalation medication have the potential to be affected if this regulation is not met. All necessary Bethany on the Lake staff have been educated on the standards of	

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F 658	Continued From page 8 During an observation on 6/3/24 at 7:30 p.m., licensed practical nurse (LPN)-A entered R176's room, handed an inhaler which included the Advair medication to R176 and instructed R176 to take one puff of the inhaler. R176 took one puff of the inhaler as instructed and handed the inhaler back to LPN-A who took the inhaler and exited the room. R176 was not observed to rinse her mouth out as ordered after taking the Advair inhaler. During an interview on 6/3/24 at 7:34 p.m., R176 indicated she received the Advair inhaler twice a day. R176 confirmed she had not rinsed her mouth out after receiving the inhaler. R176 was not aware she was expected to rinse her mouth after each use of the inhaler and stated only once in a while staff would instruct her to rinse her mouth out however, not every time she used the inhaler. During an interview on 6/3/24 at 7:36 p.m., LPN-A confirmed she had not instructed R176 to rinse her mouth after receiving the Advair inhaler. LPN-A stated she had not seen the order instructions to rinse mouth after use. LPN-A indicated it was important to rinse the mouth after use of a steroid inhaler to prevent any infections. During a phone interview on 6/5/24 at 8:59 a.m., pharmacy consultant (PC)-A stated it was important to rinse the mouth after receiving Advair inhaler as it contained steroid medication. PC-A indicated it could cause thrush, a fungal infection inside the mouth. PC-A stated it was her expectation nursing staff would instruct the resident to rinse their mouth after each use.	F 658	practice related to medication administration of Advair inhalation medication by offering and directing swish/spit after administration of Advair inhalation medication. All necessary Bethany on the Lake staff have been educated on inputting ‘swish/spit after administration’ of Advair inhalation medication when completing order entry of this medication. Audits will be completed two (2) times per week for two (2) weeks; one (1) times per week for four (4) weeks; and monthly thereafter for one (1) month. Audit results will be reviewed at QAPI meetings. Any deficient practice will be identified and corrected at the time of occurrence. Director of Nursing or Designee is responsible party.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	C 06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 9 During an interview on 6/5/24 at 10:47 a.m., director of nursing (DON) confirmed R176's Advair inhaler was a steroid medication. DON stated it was important for residents to rinse their mouth after use of a steroid inhaler to prevent infections in the mouth. DON stated her expectation was for nursing staff to instruct R176 to rinse mouth after receiving the Advair inhaler. R176's Advair inhaler box instructions indicated take one puff twice daily and rinse mouth out after using the inhaler. Review of a facility policy titled Oral Inhalation Administration dated 8/22, indicated the facility would allow for safe, accurate, and effective administration of medication using an oral inhaler (with or without a spacer/chamber). Indicated for steroid inhalers, provide resident with cup of water and instruct him/her to rinse mouth and spit water back into cup.	F 658		

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	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**06/04/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY ON THE LAKE LLC	**1020 LARK STREET ALEXANDRIA, MN 56308**

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K 000	INITIAL COMMENTS An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 04, 2024. At the time of this survey, Bethany on the Lake Building 01 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. 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. 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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division	K 000		

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

Electronically Signed | 06/25/2024

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

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	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**06/04/2024**

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K 000	Continued From page 1 445 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 detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. The Bethany Home facility was surveyed as 2 buildings as follows: Bethany on the Lake was originally constructed in 1964 and has gone through several additions and has had one remodel in 2012. Building One, the long and short term care is mainly a two story building. It had a 3 story addition constructed in 2003, with nursing home care on the first level only. The entire structure is of type II (111) construction and the three story section is separated by two 2 hour fire barriers. One located along the assisted living and the	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**06/04/2024**

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BETHANY ON THE LAKE LLC	**1020 LARK STREET ALEXANDRIA, MN 56308**

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K 000	Continued From page 2 other along the south end separating the 2 & 3 story sections. Building Two, the chapel area, was constructed in 2003 and is one level, type V (111) construction. This building is separated with a 2 hour fire barrier from the main building. The buildings are fully sprinkled with a monitored fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. Level one is separated by two smoke barriers and two 2 hour fire barriers creating 5 smoke compartments. Level two is separated by 4 two hour fire barriers and two smoke barriers creating 7 smoke compartments. The facility has a capacity of 83 beds and had a census of 70 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied	K 321		6/25/24

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	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**06/04/2024**

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K 321	Continued From page 3 protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous storage room doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 8.7.1.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 06/04/2024 at 11:45 AM, it was revealed by observation patient room 114 has combustible storage and did not have a door closer on the door. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 321	1. Patient Room 114 has been turned into a storage room. Maintenance Director installed self closing hinges to door frame 6/11/24 2. All Bethany on the Lake Storage room doors will all have self closing hinges. All Bethany on the Lake staff have been educated as to the need for the appropriate door closing devices for storage rooms. 3. Maintenance Director or Designee will monitor all storage rooms to ensure compliance Quarterly and as needed 4. Maintenance Director or Designee will be responsible for ongoing compliance 5. 6/25/24 is completion date	
K 324 SS=E	Cooking Facilities	K 324		6/25/24

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	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**06/04/2024**

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K 324	Continued From page 4 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install the required safety features for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.3 (9)(C) and 19.3.2.5.4. These deficient findings could have a patterned impact on the residents within the facility.	K 324	1. CentraSota Electric has been contracted to install lockout devices with 120-minute capacity timers on all residential stoves in the activity room and therapy gym. Lockout devices have been ordered and work is scheudled to be perfomed on 7/17/24. 2. All Bethany on the Lake residental stoves will have lockout devices and	

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K 324	Continued From page 5 Findings include: On 06/04/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that the lockout on the residential stoves(2) in the Activity room and Therapy did not include a timer of a 120-minute capacity, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	120-mintue capacity timers. All Bethany on the Lake staff have been educated as to the need for the appropriate lockout devices and timers. 3. Maintenance Director or Designee will monitor all residential stoves to ensure compliance Quarterly and as needed 4. Maintenance Director or Designee will be responsible for ongoing compliance 5. 6/25/24 is completion date	

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	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**06/04/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 04, 2024. At the time of this survey, Bethany on the Lake Building 02 was found 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. The Bethany Home facility was surveyed as 2 buildings as follows: Bethany on the Lake was originally constructed in 1964 and has gone through several additions and has had one remodel in 2012. Building One, the long and short term care is mainly a two story building. It had a 3 story addition constructed in 2003, with nursing home care on the first level only. The entire structure is of type II (111) construction and the three story section is separated by two 2 hour fire barriers. One located along the assisted living and the other along the south end separating the 2 & 3 story sections. Building Two, the chapel area, was constructed in 2003 and is one level, type V (111) construction. This building is separated with a 2 hour fire barrier from the main building. The buildings are fully sprinkled with a monitored	K 000		

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

Electronically Signed | 06/25/2024

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K 000	Continued From page 1 fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. Level one is separated by two smoke barriers and two 2 hour fire barriers creating 5 smoke compartments. Level two is separated by 4 two hour fire barriers and two smoke barriers creating 7 smoke compartments. The facility has a capacity of 83 beds and had a census of 70 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 25, 2024

Administrator
Bethany On The Lake LLC
1020 Lark Street
Alexandria, MN 56308

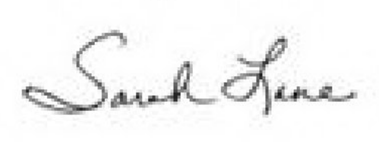
RE: CCN: 245434
Cycle Start Date: June 5, 2024

Dear Administrator:

On July 1, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,



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