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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on the Lake LLC	1020 Lark Street Alexandria, MN 56308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35569 Based on interview and document review the facility failed to ensure an appropriate facility-initiated discharge for 1 of 3 residents (R1) reviewed who admitted to the facility, was told to discharge due to a sexual abuse charge and was re-hospitalized . Findings include: R1's admission record indicated he admitted to the facility on [DATE] and discharged [DATE]. R1's diagnosis included paraplegia, muscle weakness, need for assistance with personal care and pressure ulcer of right buttock, stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present. Often includes undermining. R1's hospital discharge summary note dated 11/19/24 indicated due to mobility issues the patient is not ready to discharge back to independent living. He is discharging to skilled nursing facility. R1's physical therapy (PT) Evaluation and Plan of Treatment dated 11/19/24 indicated he required supervision or touching assistance for transfers and bed mobility. The evaluation indicated; reason for Referral / Current Illness: R1 was referred to skilled PT following hospitalization for a right ischial decubitus ulcer. He was also a paraplegic. R1 presented with decreased dynamic balance, trunk weakness, low activity tolerance, and difficulty with transfers and indicated R1 would benefit from PT to increase safety and independence with transfers. R1's progress note dated 11/19/24 indicated R1 received antibiotics for wound Infection. Incontinence care provided. Unable to visualize wound due to non-removable dressing. R1 turned and repositioned frequently. Positioning devices applied as ordered. Offloading of affected area. R1 displayed difficulty with movement in multiple extremities. Had weakness in bilateral lower extremities. Skilled need: PT, OT, treatment of Stage III or IV pressure ulcer. Management & evaluation of patient care plan. Observation & assessment of resident condition. Teaching & training to manage resident's condition. R1's occupational therapy (OT) Evaluation and Plan of Treatment dated 11/20/24 indicated the following: Toilet transfer = Dependent. (continued on next page)

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

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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on the Lake LLC	1020 Lark Street Alexandria, MN 56308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mobility Function Score (ranges from 0 - 12; 12 being the highest function) = 0 Toileting hygiene = Dependent. Bathing Shower/bathe self = Dependent. Dressing Upper body dressing = Partial/moderate assistance. Lower body dressing = Dependent. Putting on/taking off footwear = Dependent. Self-Care Function Score (score 0 - 12; 12 being the highest function) = 6 R1's base line care plan dated 11/20/24 identified a risk for decline in activities of daily living and mobility related to paraplegia (paralysis of the lower body). The care plan indicated R1 transferred himself. The care plan identified a risk for skin breakdown related to incontinence and directed staff to provide incontinent products and assist to change as needed and indicated R1 was able to manage incontinent products and external catheter independently. Identified a chronic wound on his coccyx and directed staff to provide turn and reposition or reminders to offload every 2-3 hours and as needed. R1's progress note dated 11/20/24 indicated discharge plan to home with homecare services to manage R1's wound. R1 indicated he was able to manage cares and mobility independently and had support from family members. R1 was accepting of homecare services to complete wound care three times a week. R1 stated he felt comfortable with this discharge plan and was willing to discharge tonight or tomorrow. R1 had transportation available by his niece. R1's admission Minimum Data Set, dated dated dated [DATE] indicated intact cognition and indicated he was dependent on staff for toileting hygiene, required partial to moderate assistance for transfers and did not ambulate. R1's progress note dated 11/21/24 indicated social services met with R1 earlier to review discharge plan and complete admission assessments. R1 was accepting of discharge plan and would receive home health services through Homecare and transportation through the facility bus. R1 was from a different county with multiple disciplines involved in his care, both for medical care and for criminal activity. Social services and facility care team members worked with those parties to coordinate return to his apartment and back to an area more familiar to him. R1 scored 15 on the BIMS, indicating his cognition was intact. R1 did not have questions at this time. Social services had called family members to provide updates. Social services will remain available to him throughout stay. R1's progress note dated 11/21/24 indicated R1 was discharged to his home at this time with his medications and all personal items sent with him. Transported by facility bus. Discharge paperwork and instructions completed by nurse manager, signed with copy given to resident. (continued on next page)

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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on the Lake LLC	1020 Lark Street Alexandria, MN 56308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 1:20 p.m., R1's health plan care coordinator (HPCC) stated after R1 was discharged from the facility back to his home, he did not make it very long before returning to the hospital. The HPCC stated prior to his admission to the facility R1 had been hospitalized , then went to a swing bed (A swing-bed is a service that rural hospitals and critical access hospitals provide that allows a patient to transition from acute care to skilled nursing facility care without leaving the hospital. This allows a patient to continue receiving services in the hospital even though acute care is no longer required). The HPCC said the swing bed facility felt he needed more ongoing care, so they discharged him the a skilled nursing facility on 11/19/24. The HPCC stated she spoke to the social services director (SSD) at the facility on 11/20/24, who told her R1 would be there for a few months. She stated the SSD asked her about R1's pending court date and they looked up the information. The HPCC said due to the nature of the charges, the facility told her they were going to discharge R1 immediately and R1 was discharged back home. The HPCC stated R1 went back to the hospital on 11/24/24, because his wound vac (vacuum assisted closure is a therapeutic technique using a suction pump, tubing, and a dressing to remove excess exudate and promote healing in acute or chronic wounds) had come off. She stated R1 was discharged back home again on 12/2/24, and re-hospitalized on [DATE]. The HPCC said R1 was currently in another rehab facility. The HPCC stated she had verbalized to the facility SSD her concerns about the discharge being unsafe and was told the higher-ups had decided to discharge R1. During an interview on 12/10/24 at 2:07 p.m., the SSD stated after R1 admitted to the facility she received a call from R1's HPCC who mentioned R1 needed to speak with a lawyer related to a sexual abuse charge. The SSD stated R1 had sexually harassed someone at the hospital but she was unsure of the circumstances and said R1 had not yet been convicted. The SSD stated she notified the administrator and director of nursing (DON) due to the vulnerability of the facility population. The SSD said they sought consult from the corporate leadership. R1 was independent with therapy so they set up home care services for wound care. R1 was accepting of the discharge. The SSD stated the facility had initiated the discharge. During an interview on 12/10/24 at 2:17 p.m., the administrator stated he had spoken to R1 after he was alerted R1 needed to speak to a lawyer about ongoing legal proceedings. The administrator said he talked to R1 and said we both agreed it would be appropriate for him to go home. The administrator stated he had spoken to an acquaintance with the local police department who said R1 should go back to his county of residence but had not documented the conversation. The administrator stated R1 had not received a discharge notice because he had asked R1 if he wanted to leave and R1 agreed. The administrator further stated the risks and benefits of discharge were not discussed with R1. During an interview on 12/10/24 at 2:39 p.m., R1's family member (FM)-A stated R1 was currently in another rehab facility and said she spoke with R1 frequently. FM-A stated the facility told R1 he could not rehab there because of his sexual abuse charge. FM-A stated they sent him home and R1 was hospitalized again because the wound dressing kept falling off when he got in his wheelchair. FM-A stated I think they ([NAME] on the Lake) violated his rights). During an interview on 12/10/24 at 3:37 p.m., the hospital swing bed social worker (SW) stated R1 had been sent to them following a hospital stay. R1 was discharged to the facility skilled nursing for the wound vac. R1 was able to transfer from the bed to his wheelchair but said every time he self-transferred the wound vac dressing came off. The SW stated home care would have been able to assist with changing the wound vac every three days but could not go to R1's home and replace the wound vac every time it came off, which was why he was referred to the skilled nursing facility. (continued on next page)

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	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany on the Lake LLC	1020 Lark Street Alexandria, MN 56308

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/10/24 at 3:44 p.m., the facility medical director (MD) stated she had done a face-to-face visit for the referral to homecare. The MD said when R1 admitted to the facility she was told he was upset and asking about his court date and his lawyer communication about the pending court date. The medical director stated R1 was at the facility for wound care and was doing well. The MD stated she had not been aware the swing bed facility had sent him to the rehab facility because they had concerns about R1's wound vac coming off when he self-transferred. During an interview on 12/10/24 at 4:24 p.m., the DON stated R1 was admitted to the facility due to a chronic pressure injury that was infected. The DON stated R1 had orders for therapy and a wound vac. The DON said R1 had legal concerns, so the administrator had a conversation with him and discharge had been discussed. She spoke with R1 and he was concerned about his location. The facility had not assessed R1 as no longer having a skilled nursing need and no risk and benefits of leaving had been discussed with R1. The DON said R1 was able to self-transfer, even though therapy assessed R1 to need further rehab, so wound care could be done at home with home health. During an interview on 12/10/24 at 4:45 p.m., the SSD stated the only concern she heard from R1 was he wanted to talk about how to get hold of his lawyer. She had not assisted R1 to reach his lawyer, nor had she offered to assist with transportation to his court appearance. The SSD stated, I just did what was directed by my superiors. During an interview on 12/11/24 at 7:30 p.m., R1 stated he was told by the administrator he could not be at the facility because of his sexual abuse charge and said, I think it sucked actually. R1 stated the administrator had not asked him if he wanted to leave but told him he had to leave. R1 said the facility had not given him a notice nor had they asked him what happened related to the charge and said they more or less just said since the court date was happening, he could not stay. R1 stated after he discharged from the facility his wound did not do well and said the wound vac kept coming off. R1 said he had to have a friend come over and try to help with the wound vac and she had him sent back to the hospital. Facility policy Transfer or Discharge Notice for Facility Initiated Transfers dated 7/2024, indicated a facility initiated discharge referred to a discharge that a resident objects to or did not initiate and did not align with the residents goals for care and preferences. The policy indicated the resident and or family were notified in writing: Specific reason for transfer or discharge, effective date, location and an explanation of their right to appeal.