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	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

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48740 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 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 [DATE], section O100C oxygen therapy had not been checked. In addition, section O100K, Hospice, had not been checked. Review of the quarterly MDS dated [DATE], 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 [NAME] 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. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the review of [NAME] 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 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 [NAME] 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.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 45844 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 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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45844 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 [DATE], 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. 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. 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.