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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5GHG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00427

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245530**

2. STATE VENDOR OR MEDICAID NO. (L2) **851843200**

3. NAME AND ADDRESS OF FACILITY
(L3) **SAMARITAN BETHANY HOME ON EIGHTH**
(L4) **24 - 8TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

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)

6. DATE OF SURVEY **03/21/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (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) **09/30**

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

12.Total Facility Beds **182** (L18)

13.Total Certified Beds **182** (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
	182			
(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 :
Gary Nederhoff, Unit Supervisor 03/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/22/2016 (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)

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 **05/01/1988** (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. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245530

March 22, 2016

Ms. Kyla Jacobs, Administrator
Samaritan Bethany Home On Eighth
24 - 8th Street Northwest
Rochester, MN 55901

Dear Ms. Jacobs:

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 March 11, 2016 the above facility is certified for:

182 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 182 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 Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
March 22, 2016

Ms. Kyla Jacobs, Administrator
Samaritan Bethany Home On Eighth
24 - 8th Street Northwest
Rochester, MN 55901

RE: Project Number S5530027

Dear Ms. Jacobs:

On February 17, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 4, 2016, effective March 11, 2016 and therefore remedies outlined in our letter to you dated February 17, 2016, will not 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245530 Y1	A. Building B. Wing Y2	3/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN BETHANY HOME ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0329	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(l)	Completed
LSC	03/11/2016	LSC	03/11/2016	LSC	03/11/2016
ID Prefix F0356	Correction	ID Prefix F0431	Correction	ID Prefix	Correction
Reg. # 483.30(e)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. #	Completed
LSC	03/11/2016	LSC	03/11/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	3/22/2016	10160	3/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/4/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5GHG

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(L3) **SAMARITAN BETHANY HOME ON EIGHTH**
(L4) **24 - 8TH STREET NORTHWEST**
(L5) **ROCHESTER, MN** (L6) **55901**

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

6. DATE OF SURVEY **02/04/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (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)
09/30

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From (a) :
To (b) :

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

And/Or Approved Waivers Of The Following Requirements:
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___ 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
	182			
(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 :
Justin Main, HFE NE II 02/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/14/2016 (L20)

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

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

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
05/01/1988
(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
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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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 17, 2016

Ms. Kyla Jacobs, Administrator
Samaritan Bethany Home On Eighth
24 - 8th Street Northwest
Rochester, MN 55901

RE: Project Number S5530027

Dear Ms. Jacobs:

On February 4, 2016, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (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.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 May 4, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

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 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN BETHANY HOME ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

(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 000	INITIAL COMMENTS 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. A recertification survey was conducted and complaint investigation were also completed at the time of the standard survey. An investigation of complaint H5530029 was completed and found not to be substantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan to observe skin with daily cares for 1 of 2 residents (R192) observed to have bruises, reviewed for no pressure related skin conditions.	F 282	F282 Samaritan Bethany strives to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	3/11/16

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

Electronically Signed | 02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMARITAN BETHANY HOME ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

(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 282	Continued From page 1 Findings Include: R192 was observed on 2/1/16, at 12:09 p.m. to have a bruises on the top of his left hand at the base of his pointer finger and the base of his thumb with no documentation of these being found until the staff were informed of them by this surveyor on 2/4/16. R192's signed physician orders dated 1/21/16 included Coumadin (blood thinner) Tablet (Warfarin Sodium) Give 2 mg (milligrams) by mouth one time a day every Tuesday and Thursday until 2/3/16. Coumadin Tablet (Warfarin Sodium) Give 4 mg by mouth one time a day every Sunday, Monday, Wednesday, Friday and Saturday until 2/3/16. R192's plan of care last revised 5/7/2015 instructed staff to, "Observe my skin with daily cares and weekly bathing." On 02/04/2016, 8:45 a.m. registered nurse (RN)-A stated she assessed R192 to have the following bruises: A 2 cm (centimeters) x 2 cm bruise on the back top of left hand pointer finger, a 1 cm x 1 cm bruise located between the pointer finger and the thumb and a 0.5 cm x 1 cm bruise on the base of the thumb. RN-A stated a nurse's note would be completed and stated a green sticker will be placed on R192's chart and weekend staff would check and monitor the bruises until they were resolved. RN-A stated staff should be looking at residents' skin every day with the daily cares and stated skin was also checked on residents' bath days. RN-A stated staff were to report bruises to the RN or licensed practical nurse (LPN) and the nurse would initiate monitoring until the bruising was healed.	F 282	R192 On 2/19/16 RN assessed resident's skin and provided education to the NA/R's about observing and reporting skin issues/bruises in a timely manner to the licensed nurse. Bruise was resolved on 2/22/16. Residents have skin observed by NA/R's daily during cares and report any bruises/skin issues found to a licensed nurse who makes an appropriate assessment of the bruise, documents the bruise, updates the care plan as necessary and observes and documents weekly until resolved. All staff meetings/in-services were held on 2/25 and 2/26/16. Neighborhood staff meetings will be held and information on bruises/skin issues will be provided to all staff. Additional education will be provided as needed. Neighborhood audits will be conducted by Care Coordinators (RN) for 3 months, then on a random basis to ensure appropriate care and services are provided. Care Coordinators (RN) will monitor and report findings to be discussed at the Quality Assurance Committee meetings. Date of completion: 3/11/16	

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F 282	Continued From page 2 On 2/04/2016, 10:22 a.m. the director of nursing (DON) stated nursing assistants caring for residents observed the body every time they helped a resident with bathing or dressing and reported anything they found to their nurse. The DON stated the nurse was to asses and investigate to determine if there was a reason for the bruise and include resident input for the bruise if appropriate. The DON stated if a bruise was less than 3 cm x 3 cm the bruise should be documented in a progress note and stated staff should monitor the bruises for healing until resolved. The DON verified staff did not follow the care plan to monitor skin for bruising. A policy and procedure for following a care plan was requested and none provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow comprehensively assess chronic insomnia and day time sleeping to determine underlying cause to develop interventions to promote quality sleep patterns for 1 of 1 resident (R245) reviewed with	F 309	F309 Samaritan Bethany strives to ensure that each resident receives and must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial	3/11/16

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F 309	Continued From page 3 insomnia. In addition, the facility failed to administer insulin as the doctor ordered or contact the physician to clarify order for 1 of 1 resident (R68) who receives daily insulin dose for diabetes control. Findings include: LACK OF INSOMNIA ASSESSMENT: R245 had been admitted on 11/13/15 and according to their admission form they had a diagnosis including dementia with behavior disturbances, anxiety, restlessness and agitation and malaise. Observations on 02/01/16, at 11:14 a.m., 1:37 p.m. and 2/2/16, at 9:14 a.m. of R245 sleeping in her wheelchair. R245 was observed on 02/03/2016, at 11:54 a.m. sleeping in her wheel chair. The wheelchair was located facing the dining room table. Nursing assistant (NA)-G said, "She was awake a minute ago." She has done this ever since she has been here. NA-G went on to say R245 is awake a lot in the night. NA-G said when we put her to bed at night she talks and talks and doesn't sleep well. She said she sleeps most of the day. NA-G said they had not monitored her sleeping vs. awake time. R245 was observed sleeping on 02/03/2016, until 12:10 p.m. when NA-G awakened her to ask if she wanted to eat. R245 stated she wanted something small to eat. R245 was served her lunch and ate it herself. An observation on 02/03/2016, at 4:09 p.m. NA-G	F 309	well-being, in accordance with the comprehensive assessment and plan of care. R245 Sleep assessment was completed 2/26/16. Based on the sleep assessment, the care plan was updated to include interventions to promote quality sleep. Residents who receive a sleep aide or who have irregular sleep patterns are assessed to determine underlying cause and develop interventions to promote a quality sleep pattern. R68 Insulin is administered according to current physician's order. Residents requiring insulin have their insulin administered according to current physician's orders if necessary to deviate from the order the physician is contacted for further clarification. All staff meetings/in-services were held on 2/25 and 2/26/16. Neighborhood staff meetings will be held and information on sleep/promoting quality sleep and insulin administration/following physician orders will be provided to all staff. Additional education will be provided as needed. Neighborhood audits for those residents receiving a sleep aid or those with irregular sleep patterns will be conducted by Care Coordinators (RN) for 3 months then on a random basis to ensure appropriate care and services are provided.	

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F 309	Continued From page 4 asked R245 if she wanted to go to the music time activity and R245 did not want to so she could sleep. On 02/04/2016, at 8:15 a.m. R245 was observed to have eyes closed and looked to be asleep while in bed. R245 was fully dressed and covered with her blankets. An interview on 02/03/2016, at 3:29 p.m. with NA-H said sometimes she takes a nap and sometime she resists. She resisted today so she didn't take a nap. NA-H is not aware of a sleep assessment being done for her. An interview on 02/03/2016, at 3:33 p.m. with registered nurse (RN)-D said she has not done any sleep assessment for R245. RN-D added that R245 takes dilaudid a pain medication which makes her sleepy. RN-D confirmed R245 does not take any sleep aid before bedtime. RN-D confirmed they do not and have not done any sleep assessment to understand her sleep patterns. RN-D agreed R245 sleeps a lot during the day and is awake a lot at night, and said she would benefit from a sleep assessment. An interview on 02/03/2016, at 3:54 p.m. the director of nurses (DON) said yes, we should have had a sleep assessment completed to understand her sleep patterns. She said we try to meet the residents needs and even provide activities if being awake is their normal at night but we didn't with her. DON said that R245 had a history of being awake all night and then sleeps during the day in the past. A subsequent interview on 02/04/2016, at 8:17 a.m. RN-D stated, It has been R245's pattern to	F 309	Neighborhood audits for resident's insulin administration will be conducted by Care Coordinators (RN) for 3 months then on a random basis to ensure appropriate care and services provided. Care Coordinators (RN) will monitor and report findings to be discussed at the Quality Assurance Committee meetings. Date of completion: 3/11/16	

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awaken during the night, even when she was living in the memory care center. RN-D said R245 would be awake for half the night some times.

R245's care plan indicated she is easily distracted and forgetful. It also read, "I have a potential for a communication problem r/t[related to] dementia with Neuropsychiatric Symptoms, poor vision, nervousness and agitation." There is no mention of R245 being awake during the night.

Nursing progress notes review from 11/24/15 until 2/3/16, did not include any mention of R245 sleeping during the day or lack of sleeping at night as being a concern.

A policy entitled Sleep evaluation dated 8/15 was provided but it did not include a sleep monitoring if sleep awake pattern different from t he norm.
LACK OF FOLLOWING PHYSICIAN'S ORDER FOR INSULIN DOSE:
R68's Move-in Record, dated 7/8/15, indicated that the resident had diagnoses of: type 2 diabetes, long term use of insulin and end stage renal disease.
Review of R68's current physician orders on 2/3/16 stated to administer Insulin NPH (an intermediate acting insulin to help blood sugar level for those with diabetes) suspension 100 unit/milliliter (ml): inject 14 units subcutaneously (under the skin) one time a day. If resident does not eat and blood sugar is below 110, give NPH 5 units. The physician orders also advised to check R68's blood sugar before breakfast and in the evening.

R68's Medication Administration Record (MAR), dated from 11/1/15 through 2/3/16 indicated that the physician's order for insulin had not changed.

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F 309	Continued From page 6 R68's Care Plan, dated 7/17/15, identified that the resident had nutritional problems related to diabetes. It advised to administer medications as ordered. The care plan recommended to monitor and document for effectiveness. R68's meal consumption along with his blood sugars and Medication Administration Record (MAR) were reviewed from 11/1/15 through 2/3/16 as follows: On 11/25/15, R68 did not eat breakfast, his blood sugar was 108 and the MAR indicated that the nurse held R68's insulin; on 11/27/15, the resident was not available for breakfast, his blood sugar was 101 and the MAR indicated that the nurse held R68's insulin; on 1/24/16, R68 did not eat breakfast, his blood sugar was 77 and the MAR indicated that the nurse held his insulin; on 1/25/16, R68 did not eat breakfast, his blood sugar in the morning was 77 and the MAR indicated that the nurse held R68's insulin. Even though the physician's order specified if the resident does not eat and blood sugar is below 100 R68 is to have the 14 units of NPH held and to give 5 units of NPH. R68's Progress Notes, dated 1/29/16, stated, "Resident blood sugar at 116. Resident declined breakfast at this time. Insulin not given at this time." Again the doctors orders were not followed as written. When interviewed on 2/4/16 at 10:50 a.m., the Director of Nursing (DON) stated the nursing staff should have followed the doctor's order regarding the insulin dose to give.	F 309		

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F 309	Continued From page 7 When interviewed on 2/4/16 at 1:11 p.m., the consultant pharmacist stated certainly the nursing staff should follow the physician's order. He stated that if they were to deviate from the order he would have expected the nurses to contact the physician if not following the doctors orders as written. Review of the facility policy titled, Administration of Insulin (last reviewed 9/2015), it stated that the insulin order should be checked in the medication administration record (MAR) carefully. It then further stated to always check the medication record to assure accuracy.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		3/11/16

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F 329	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor specific behaviors and/or mood to justify the use of an antidepressant for for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include: R21's Move-in Record, dated 12/3/13, indicated that the resident had diagnoses of major depressive disorder (single episode) and anxiety disorder. R21's Order Summary Report, dated 11/25/15, indicated that R21 was prescribed Sertraline (an antidepressant medication). She was to take 50 milligrams (mg) by mouth at bedtime. The indication for this medication was for major depressive disorder. R21's Care Plan, dated 11/30/15, stated that the resident scored a 5 on the PHQ-9 (an instrument for screening, diagnosing, monitoring, and measuring the severity of depression) on 11/18/15. The care plan stated that R21 scored a 9 on the previous quarter (8/21/15). Interventions that were put in place were to notify the registered nurse and the social worker if R21 was observed to demonstrate a negative change such as tearfulness, withdrawn behavior, non-social activity or a grumpy mood state.	F 329	F329 Samaritan Bethany strives to ensure that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reason above. R21's irritability, anxiety, and acting out were clearly identified on the resident's care plan on 2/26/16 as to resident specific mood and/or behaviors exhibited. Evidence of resident's behavior/mood symptoms was documented in the progress notes on 2/23/16. Residents with behaviors/mood symptoms are monitored and documented to ensure the process for the use of unnecessary drugs is followed appropriately. All staff meetings/in-services held on 2/25 and 2/26/16. Neighborhood staff meetings will be held and information on behaviors/mood being monitored will be provided to all staff. Additional education	

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F 329	Continued From page 9 R21's Minimum Data Set (MDS), dated 8/21/15 indicated that the resident scored a 9 on the PHQ-9. This identified that the resident had mild depression. When interviewed on 2/4/16 at 8:27 a.m., registered nurse (RN)-D stated that R21 was prescribed Zoloft (an antidepressant medication) for irritability and that the resident would "act out." She stated that the resident was prescribed Zoloft on 11/3/15. A physician's note dated 11/3/15 stated, "Nursing staff report patient [R21] with significant anxiety as of late. She [R21] becomes extremely agitated and anxious if something does not go the way she wants it to go. Patient, will at times become more SOB [short of breath] with the increased anxiety which then leads to chest pain. The weekly shower/bath is always an event patient has increased anxiety over, which tends to build up from the beginning of the day to the time of her shower/bath. Patient does not leave her room, eats all meals in her room. Nursing request PRN [as needed] Ativan." The physician then ordered for increased anxiety, Zoloft, 50 milligrams (mg), which started at one half tablet daily for seven days and then was to increase to one full tablet daily thereafter. Even though R21 was started on Zoloft for "irritability, anxiety, and "act out" were not clearly identified as to resident specific mood and or behaviors exhibited. Review of R21's Progress Notes, dated 11/3/15 through 11/17/15, did not include any information that the resident suffered from any irritability or acting out. A physician's note, dated 11/17/15, stated, "Patient was initiated on Zoloft 50 mg on November 3. Started with 25 mg dose X 1 week,	F 329	will be provided as needed. Neighborhood audits for resident's behaviors/mood symptoms will be conducted by Care Coordinators (RN) for 3 months then on a random basis to ensure appropriate care and services provided. Care Coordinators (RN) will monitor and report findings to be discussed at the Quality Assurance Committee meetings. Date of completion: 3/11/16	

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F 329	Continued From page 10	F 329		

then 50 mg daily thereafter. Nursing reports patient with no noted change. She is still extremely irritable where even small things upset her and 'set her off.' Yesterday, patient's family member bought her a new laptop computer for her birthday and patient exhibited signs of being upset about the gift, complaining she would now have to find someone to give it to when she dies. She is both irritable with staff and family. She does not leave her room except once weekly for her shower, which causes her great anxiety leading up to that event." The physician ordered Zoloft to be increased to 100 mg daily. R21 was to start with 75 mg daily for one week and then 100 mg daily thereafter. The physician recommended that nursing should review R21's behaviors and moods with the Nurse Practitioner in three weeks. If this is ineffective, the physician recommended considering switching to a trial of Buspar (an antianxiety medication).

R21's Minimum Data Set (MDS), dated 11/18/15, indicated that the resident scored a 6 on the PHQ-9. This identified that the resident had mild depression.

Review of the progress notes from 11/19/15 through 11/25/15 did not include any mention of behaviors or moods noted. A note dated 11/25/15 stated that the Zoloft had been reduced to 50 mg daily due to resident's complaints. A note dated 11/25/15 stated that R21 had been complaining of generalized weakness and a feeling of lightheadedness and dizziness.

Review of R21's progress notes, from 11/26/15 through 1/28/16 did not include any mention of behaviors or moods noted.

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F 329	Continued From page 11 When interviewed on 2/4/16 at 8:27 a.m., registered nurse (RN)-D stated that she could not find any documentation that the nursing staff were monitoring the resident's mood. When interviewed on 2/4/16 at 10:43 a.m., the Director of Nursing (DON) stated that if the resident had been given an antidepressant medication then the nursing staff should be documenting the behaviors. Review of the policy titled, Behavior Symptom Tracking (last reviewed on 12-2008), it stated that behavior symptom tracking was initiated when a resident began to demonstrate a destructive or disruptive behavior symptom and when an anti-depressant was used to help manage behavior symptoms. It stated that the behavior symptom tracking form would contain a list of behavior symptoms specific to the resident named. It stated that each shift would document the number of times a behavior symptoms occurred and was redirectable; the number of times a behavior symptoms occurred and was not redirectable; 0 was recorded if the behavior symptom did not occur. Behavior symptom tracking was to be reviewed two times each month by the RN Clinical Supervisor who was to make notes at the bottom of the form.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		3/11/16

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F 356	Continued From page 12 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed prominently post the nurse staffing information for all residents and visitors to view. In addition, the facility failed to consistently post the actual hours worked for nursing staff directly responsible for resident care per shift in a timely manner. This had the potential to affect all 140 residents residing in the facility. Findings include:	F 356	F356 Samaritan Bethany strives to ensure that we provide and ensure accurate nurse staffing information is posted and maintained on a daily basis. The nurse staffing sheet has been changed to meet the requirements as follows: it has been divided into three distinct shifts: 6a-2p, 2p-10p, and 10p-6a by each required shift category. The nurse staffing sheet is posted accurately	

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(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 356	Continued From page 13 During the initial facility tour on 1/4/16, at 7:28 a.m. the nursing staff posting hours were observed on an untitled 8 inch (in) x 11 in. sheet of paper which was facing the receptionist area at the garage entrance, not available for the residents or general public. There was no posting by the front door or on the nursing units. An observation was also made on 2/2/16 at 8 a.m. and 2/3/15 at 1:10 p.m. and the posting information remained the same each time. The posted nursing staff information was dated 1/31/16, and lacked a consistent recording of the total number of hours worked per shift by licensed and unlicensed staff responsible for resident care. An interview with the chief executive officer (CEO) on 2/1/16 at 7:35 a.m. indicated the posting by the receptionist is the only location of the nurse staff posting. An interview on 2/1/2016, at 4:48 p.m. the director of nurses (DON) acknowledged the nurse posting did not meet the requirements at F356. An interview with receptionist (R)-B on 02/03/2016, at 11:43 a.m. stated she was not sure how the public or the residents would be able to see it at the present location by the garage entrance door. A facility's direct care daily staffing policy was requested but not received.	F 356	and timely in a visible location in the main entrance/lobby area where visitor and resident traffic is the most prominent. All staff meetings/in-services held on 2/25 and 2/26/16. Neighborhood staff meetings will be held and information will be provided to all staff. Additional education will be provided as needed. Audits for nurse staffing sheet accuracy and posting timeliness will be conducted by Community Leader for 3 months and then on a random basis thereafter. Community Leader will monitor for compliance and report findings at the Quality Assurance Committee meetings. Date of completion: 3/11/16	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		3/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	02/04/2016

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SAMARITAN BETHANY HOME ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

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F 431	Continued From page 14 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure outdated medication was removed from 2 out of 5 medication storage rooms reviewed which	F 431	F431 Samaritan Bethany strives to ensure that drugs and biologicals used in the facility must be labeled in accordance with	

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F 431	Continued From page 15 resulted in the administration of expired medications, failed to ensure stock medication was appropriately labeled, and failed to ensure time sensitive medication included a use by date on the label. In addition the facility failed to ensure medication labels matched current physician orders for 3 of 6 residents (R171, R166 & R22) observed for medication administration. Findings Include: On 2/1/16 at 8:55 a.m. the 2nd floor medication room was found to have expired standing order medications, resident medication, and refrigerated Aplisol purified protein derivitive (PPD) that were expired. Expired standing order medications included: Expectorant expired 12/2015 with 160 ml (milliliters) remaining, kao-tin bismuth subsalicylate 262 mg expired 12/2015 with 1/4 of the bottle remaining. An opened bottle of acetaminophen 325 mg for a resident who had been discharged several months prior expired 3/2015. Review of the 2nd floor medication room refrigerator revealed an open vial of Aplisol PPD solution, with an open date of 8/6/15, 1/4 of the vial remained. Aplisol package insert reads, "Vials in use for more than 30 days should be discarded." On 11/17/15, 12/8/15, 1/8/16, 1/11/16, and 1/29/16 nursing assistants-D, E, F received a dose of the expired Aplisol PPD solution. On 2/1/16 at 8:55 a.m. trained medication aide-A verified the expired medication in the 2nd floor medication storage room were expired. Licensed	F 431	currently accepted professional principles, and include the appropriate accessory and cautionary instruction, and the expiration date when applicable. R171 On 2/25/16 Advair discus inhaler was checked and found to have appropriate label with “discard unused portion as of 2/27/16.” R166 On 2/1/16 “medication order change sticker” was applied to acetaminophen after verifying physician order. R22 On 2/25/16 “medication order change sticker” was applied to Seroquel after verifying physician order. Employees D, E and F will receive repeat TST to ensure accurate results based on efficacy. All expired medications were disposed of from medication rooms by 2/19/16. All medications will be appropriately labeled according to pharmacy recommendations. All staff meetings/in-services were held on 2/25 and 2/26/16. Neighborhood staff meetings will be held and information on expired medication and labeling will be provided to all staff. Additional education will be provided as needed. Neighborhood audits for expired medication and appropriate labeling will be conducted by Care Coordinators (RN) for 3 months then on a random basis to	

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F 431	Continued From page 16 practical nurse (LPN)-A also verified the medications were expired and then added, "We should be going through the med room monthly." On 2/4/16 at 9:17 a.m. the director of nursing stated, "It's [Aplisol] not good after so long. It should have been removed after 30 days." On 2/4/16 at 1:08 p.m. consultant pharmacist stated, "Aplisol brand vial in use for more than 30 days should be discarded." Facility policy, Medication Expiration/Safe Storage dated 12/05, 10/15, reads, "The following are medications with their "dispose of" dates...Tuberculin, refrigerate, dispose of 30 days after opening." R171's medications in drawer were checked on 2/3/16 at 6:33 p.m. and there was an open and undated Advair Diskus inhaler. LPN-B stated, "We don't date it. It only has 60 tabs in it. She only gets it for 30 days." Advair Diskus package insert reads, "Discard Advair Diskus 1 month after opening the foil pouch or when the counter reads "0" (after all blisters have been used), whichever comes first." On 2/4/16 at 8:59 a.m. the director of nursing stated, "The policy does reflect dispose of after 30 days opened." Facility policy, Medication Expiration/Safe Storage dated 12/05, 10/15, reads "The following are medications with their "dispose of" dates...Inhalers: Advair Diskus, dispose of 30 days after foil pouch is opened even if doses remain."	F 431	ensure appropriate care and services provided. Care Coordinators (RN) will monitor and report findings to be discussed at the Quality Assurance Committee meetings. Date of completion: 3/11/16	

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F 431	Continued From page 17	F 431		

R166's medication storage was checked on 2/3/16 at 12:19 p.m. and a bottle of acetaminophen 500 mg with a pharmacy label that read, "2 tabs by mouth every six hours as needed." Medication administration record (MAR) and physician orders read, "Give 1000 mg by mouth three times a day for pain." LPN-C stated, "They put the little red stickers on the bottle, it must have came off. They come off easily. I'll stick one on there." LPN-C looked in the medication drawer, verified there was not a red sticker [order change sticker] attached to the bottle of acetaminophen.

R22's medication storage was checked on 2/1/16 at 3:46 p.m. and Seroquel (anti-psychotic medication) punch card with a pharmacy label that read, "50 mg give 1 tab by mouth three times a day." MAR and physician orders read, "Seroquel 50 mg by mouth one time a day, arise; Seroquel 50 mg by mouth one time a day, supper; Seroquel 75 mg by mouth at bedtime." The label did not reflect the physicians order.

On 2/3/16 at 3:54 p.m. the DON stated, "The label should match the order. It should be the same or have a sticker on that says order change."

Facility policy, Administration of Medication dated 4/13, reads: "7. Prior to administering the resident's medication the nurse/TMA will compare the drug and dosage schedule on the resident's MAR with the drug label. If there is any discrepancy the physician's order in the residents chart will be reviewed."

A policy entitled medication expiration/safe storage dated 12/15 Medication opened by facility

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F 431	Continued From page 18 staff will be tagged with a 'discard unused portion after the expiration date of _____.' sticker to assure that it is not used beyond the date on which it expires. The staff will fill in the date for disposal."	F 431		

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

F5530026

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	245530	A. BUILDING **02 - NEW** B. WING _____	**02/03/2016**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 3, 2016. At the time of this survey, Samaritan Bethany Home on 8th, was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Samaritan Bethany Home on 8th, the original 3-story building with partial basement was completely remodel to meet requirements for new in 2012. The 2012 addition was determined to be of Type II(222) construction. The 2011 addition is a 6-story building with partial basement. The 2011 addition was determined to be of Type 1(332) construction. This facility will be surveyed as 1 building. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 182 beds and had a census of 145 beds at the time of the survey.	K 000		

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

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.