Electronically delivered
November 18, 2022

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

RE: CCN: 245530
Cycle Start Date: October 28, 2022

Dear Administrator:

On October 28, 2022, 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 widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 January 28, 2023 (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 April 28, 2023 (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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 10/28/2022

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
E 000	Initial Comments On 10/25/22 through 10/28/22, 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 10/25/22 through 10/28/22, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5530096C (MN80980); H5530098C (MN82154); H55305364C (MN84324 and MN84309); however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5530093C (MN74265); H5530094C (MN78844); H5530095C (MN69457); H5530097C (MN68855); H5530099C (MN70924); H55305361C (MN86360); H55305362C (MN84869); H55305363C (MN86386); H55305365C (MN87525) and H55305366C (MN86762).	F 000		

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

Electronically Signed | 11/28/2022

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 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a	F 585		12/9/22

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F 585	Continued From page 2 grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;	F 585		

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F 585	Continued From page 3 (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to respond to resident concerns in a timely manner for 1 of 1 residents (R69) reviewed for grievances. Furthermore, the facility failed to maintain record of grievances/concerns throughout the facility if such concerns were not provided on a formal grievance form.	F 585	F 585 Samaritan Bethany policies address the residents' right to voice grievances to the facility staff or other agencies/entities that hear grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those regarding care and treatment which have	

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F 585	Continued From page 4 Findings include: According to an admission Minimum Data Set (MDS) assessment dated 10/4/22, R69 was cognitively intact, hospice patient with a diagnosis of Parkinson's disease (a progressive neurological disease). During an interview on 10/25/22, at 3:50 p.m. R69 and family member (FM)-A stated they had concerns with several things that had occurred since R69 was admitted to the facility at the beginning of the month. FM-A said R69 often would not speak up for herself, so FM-A had written an e-mail to a registered nurse (RN)-C who was the "lead staff on the unit" (RN care coordinator). FM-A stated the e-mail detailed a concern with a nursing assistant who was "pressuring" R69 to use a bedpan instead of taking her to the toilet; a concern with a nurse documenting having given a medication (pantoprazole, a medication for acid reflux) that had not yet arrived from the pharmacy; a concern with the same nurse bringing the wrong dose of Tylenol to R69 (bringing two tablets instead of one), and a concern related to one of R69's Parkinson's medications being found on the floor in her room about 8 feet away from the medication storage unit. FM-A stated her concern regarding the medication found on the floor was R69 may not have received a dose which could have caused more difficulty with movement. FM-A and R69 stated they had not heard back from anyone in the facility regarding their concerns. During an interview on 10/25/22, 5:24 p.m. the facility administrator/community leader stated she was unable to provide a list of grievances for the facility as there had been no "formal grievances	F 585	been furnished, care which has not been furnished, the behavior of staff and other residents, as well as any other concerns regarding their facility stay. On 10/27/22, the Care Coordinator was disciplined by the Clinical Mentor (DON) and Assistant Clinical mentor (ADON) regarding the lack of follow up to a medication error that initially occurred on 10/2/22 that R69s daughter brought to the nurse's attention via an email on 10/3/22. During the discipline, discussion on 10/27/22 the care coordinator indicated that she had spoken with R69s daughter in regards to the medication error. The Care coordinator indicated she was planning to review the error with the nurse that made the error during the next shift they were scheduled for, which was on 10/29, however that nurse was absent from that shift. The next time the nurse that made the error was scheduled to work was on 11/4 and the medication error was reviewed with the nurse at that time. The grievance policy was reviewed and updated to include maintaining evidence demonstrating the result of all received by the Community Leader. Neighborhood meetings will be held December 1st and 2nd to review F585 and the POC. An all staff meeting will be held on December 5th and information will be provided to all staff regarding the grievance policy. Additional education will be provided as needed. Neighborhood audits will be conducted by the Community Leader and Clinical Mentor for 3 months and on a random	

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F 585	Continued From page 5 filed for six months." During an interview on 10/27/22, 8:35 a.m. RN-C stated she was aware the facility had a grievance policy and said there were forms that staff and residents could fill out in the case of a grievance. RN-C said the completed forms were then routed to the social worker or to nursing leadership; however, RN-C was not able to clearly state the definition of a grievance. RN-C said, "I don't know 100%, my assumption is if the resident are not getting cared for properly, or if something happens that could harm them." RN-C stated she had received an e-mail from FM-A, but was not able to locate it. RN-C stated she had followed up on that concern by talking with the staff involved in the bedpan concern and training other staff, but was not able to produce any documentation. RN-C stated she did not feel there was an issue with offering a bedpan instead of assisting to the toilet as they didn't "always have 20 minutes to take someone to the bathroom." RN-C was also aware of R69 and FM-A's concerns regarding possible medication errors. RN-C produced a medication error document dating the possible error as having occurred on 10/1/22, but discovered 10/3/22. The form was signed by RN-C, but by no other entities including the contract nurse (CN)-B who was involved. RN-C stated she had not yet talked with CN-B because she did not have his phone number as they were to contact the agency from whom he was hired. RN-C stated she had requested the facility director of nursing (DON) to contact the agency regarding a different nursing concern with a different resident and she had never heard back, so she decided to wait until CN-B was working again. RN-C stated, "unfortunately, we have not been working at the same time, so I thought I	F 585	basis thereafter to ensure that grievances are follow up on in a timely manner according to facility policy. Community Leader and Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 12/9/22	

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F 585	Continued From page 6	F 585		

would have one of the weekend nurses talk with him." RN-C stated a medication error should be followed up on "sooner than later."

During an interview on 10/27/22, 10:57 a.m. a facility social worker (SW)-B stated the facility did have a grievance policy and there was a form available for resident's or families to fill out. SW-B stated a reported concern should always be followed up on by a nurse manager or department leader depending on what the concern was regarding. SW-B stated the grievance form could be offered so it can then go to the appropriate department and then to the facility administrator for tracking. SW-B stated it was important to assess the resident's needs following the report, and to ensure satisfaction with resolution of the reported concern.

During an interview on 10/28/22, 10:26 a.m. the facility clinical mentor/director of nursing (DON) stated concerns from families about how they are treated should be reported to her, but said such a concern was "not necessarily a grievance." DON then stated the unit care coordinator should take care of any reported concern and take care of concerns on the unit, talking with staff and making changes as needed for resident care. DON also stated a medication error should be taken care of as quickly as possible. DON stated she had not previously been made aware of the family concern regarding a possible medication error or their concern with staff. DON stated she was made aware of the medication error on 10/27/22. DON stated she was concerned that the error had not yet been followed up on.

During an interview on 10/28/22, 12:49 p.m. the facility administrator stated a verbal statement of

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F 585	Continued From page 7 concern or e-mail was "just a concern" and not a "formal grievance" since a grievance form had not been initiated. The administrator stated these informal concerns would be talked about during their quality meetings, but mostly they were to be handled at the unit level by the nurse. The administrator stated that leadership would "not even know about most of those" since they were handled by the nurse and everyone was happy. In response to a request for the quality meeting notes, the administrator stated, "I will have to look into that." During an interview on 10/28/22, 3:05 p.m. the facility medical director (MD)-A stated he did attend the quality/quality assurance performance improvement (QAPI) meetings. MD-A stated during the meeting there was a social service report where they would review any concern in the facility that required reporting to the state as a vulnerable adult report; however, MD-A was unable to recall if facility grievances were discussed at the quality meetings. A request was made for a year of QAPI meeting notes, but none were received. A facility provided policy titled Grievance Policy-residents and families, dated as last reviewed August 2022, indicated that for optimal resolution of nursing concerns, residents or families should contact the RN Care Coordinator (lead RN on the unit). If the issue was not resolved, the policy directs for the person having a concern to contact the Clinical Mentor (DON). For other departments, the policy indicated the concern should be taken to the Neighborhood Coordinator or Social Worker. The policy did not indicate for any of these entities to track or	F 585		

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F 585	Continued From page 8 maintain a list of the concerns or grievances. The policy continued, indicating if the resident or family felt their concern was not resolved, they should send a written grievance form to the Community Leader (facility administrator). The administrator was then responsible to follow-up and send a written response within ten days. The policy did not indicate the administrator was to track or maintain a list of concerns or grievances. The policy did not provide definitions or explain how a "concern" might be different than a "grievance."	F 585		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review,the facility failed to provide meaningful activities for 1 of 2 residents (R11) reviewed for activities. Findings include: According to R11's quarterly Minimum Data Set (MDS) assessment dated 8/9/22, R11 had moderately impaired cognition, required extensive	F 679	F679 Samaritan Bethany strives to ensure that we provide based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities. A new activity assessment will be completed and care plan updated with activity preferences for R11. R11 will be	12/9/22

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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 679	Continued From page 9 to total dependence in all activities of daily living, suffered dementia and partial paralysis from a previous stroke. R11's care plan focused problem area related to activities was last revised 6/21/22 and indicated: "My family visits throughout the month and is attentive. I prefer to spend my day in my bed or in my reclining chair, watching TV - ball games or movies or resting. Staff offer frequent visits. I have expressed interest in a few activities such as music and occasionally church services, however, most often I prefer to not attend any programs when invited. I like anything related to sports. I spend much of my day sleeping, which is my preference at this time. I enjoy joking and talking with staff. I am sometimes able to express my preferences." Associated interventions indicated staff should, "offer strong encouragement to attend and participate in programs. I might enjoy music, happy hour and anything sports related. Offer visits throughout the week for solace, TLC, and support. Talk with me about sports or a recent movie I've watched. Please respect my time and privacy when I am with my wife." On 10/25/22, 3:30 p.m. R11 was observed to be asleep in bed with the room darkened and no television or radio turned on. R11 did not respond when approached and name called out. On 10/26/22, 9:17 a.m. R11 was observed to be in bed with eyes closed. R11 did not respond to a knock on the door. A pharmacy nurse entered the room and attempted to waken R11 to give him an immunization. R11 opened his eyes but was not heard to respond to the nurse. A few minutes later, his eyes were again closed.	F 679	provided with weekly 1:1 visits from Life Enrichment staff and be documented. A new activity assessment will be completed for any other residents that experience severe cognitive impairment and total dependence. The activity preferences will be updated on the care plans of those residents. Those identified residents will also receive weekly 1:1 visits from Life Enrichment. Neighborhood meetings will be held on December 1st and 2nd to review F679 and the POC. An all staff meeting will be held on December 5th and information will be provided to all staff regarding residents activities preferences. Additional education will be provided as needed. Audits will be conducted by the Life Enrichment Mentor for 3 months and on a random basis thereafter to ensure that each resident that experience severe cognitive impairment and total dependence are provided preferred choice of activities and 1:1 visits on an ongoing basis. Life Enrichment Mentor and Community Leader will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 12/9/22	

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 _____	C 10/28/2022

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 679	Continued From page 10 On 10/26/22, 11:24 a.m. R11 was observed to remain in bed, appearing to sleep. No television or radio on. R11 did rouse to speech and questions but had limited verbal interaction and did not answer many questions asked, and did not always respond appropriately. On 10/27/22, 11:27 a.m. R11 was observed to be dressed and groomed, but not up out of bed. R11's head of bed was up and the television was going with a game show on, but R11 was napping and did not arouse easily. During an interview on 10/27/22, 2:03 p.m. a nursing assistant (NA)-A stated R11 has episodes where he sleeps a lot, but said he was not always that way. NA-A stated activities for R11 consisted of turning on the television, and NA-A recalled R11 had been receiving music therapy. NA-A stated the care givers would also talk with R11, and said R11 had few visitors outside of occasional visits from his family. On 10/28/22, 8:23 a.m. R11 was observed to be in bed, with the head of the bed slightly elevated and the television on in the room. R11 did not rouse when spoken to. A caregiver was observed to enter the room, look at R11 and then leave without interaction. During an interview on 10/28/22, 10:41 a.m. the facility Life Enrichment Mentor, or head of the activities department (ACT)-A stated it was his philosophy that all persons are sentient beings, and even if mostly bed bound, have a need for life experience. ACT-A stated persons who had cognitive loss, and were isolated should receive one to one (1:1) activity interventions from his	F 679		

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F 679	Continued From page 11 department, providing such things as sensory experiences, reminiscence, music or just visitation for stimulation. ACT-A stated R11 was a difficult case due to communication issues and his cognitive loss. ACT-A said R11 could get overstimulated by group activities, but also stated an expectation to offer assistance to attend those activities if he had an interest. ACT-A stated R11 would infrequently attend group activities so would require 1:1 activities, and those activities should be provided by the Life Enrichment/activities department at least once a week. ACT-A stated activity attendance was to be documented in the resident's chart, but when ACT-A reviewed R11's medical record he found the only documentation was completed by the direct care staff, and not by his department. ACT-A stated this did not constitute therapeutic recreation. ACT-A stated documentation could also be placed in the residents' progress notes, but could see the last note had been written in June of 2022. ACT-A stated he was trying to change the structure of his department to better serve the residents, but was not quite sure how to go about it yet. A policy related to activities was not provided.	F 679		

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	245530	A. BUILDING **02 - NEW** B. WING _____	**10/27/2022**

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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 10/27/2022. At the time of this survey, SAMARITAN BETHANY ON EIGHTH 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, 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.	K 000		

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

Electronically Signed | 11/28/2022

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A 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. SAMARITAN BETHANY ON EIGHTH is a 6 story building with basement with attached 3 story building with basement. The building was constructed at 2 different times. The original building, 3 story with basement, was constructed in 1976 and was determined to be of Type II (222) construction. In 2010, a 6 story building with basement was constructed and was determined to be of Type II (222 construction. In	K 000		

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K 000	Continued From page 2 2012, the original 3 story building with basement was remodel, maintaining its Type II (222) construction. Each floor of the 6 story structure are divided into 2 smoke compartments. Each floor of the 3 story structure are divided into 2 smoke compartments. Because the original building and addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (222). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. There is smoke detection in all resident rooms. The facility has a capacity of 128 beds and had a census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=E	Cooking Facilities 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	K 324		12/9/22

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K 324	Continued From page 3 * 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 and staff interview, the facility failed to install cooking equipment per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.2(9). This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed by observation during the walk-thru of the facility that in the two warming kitchens located on the 3rd FL both were found to be unattended and the keyed shut-offs in the active position. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	K324 Neighborhood meetings will be held on December 1st and 2nd to educate staff on K324 and the POC. Audits will be conducted by Neighborhood Coordinators for 3 months to ensure that the stoves in the neighborhood kitchens if left unattended the keyed shutoff is in the off position. The Building Operations Mentor and Community Leader will monitor to prevent reoccurrence. Date of Completion: 12/9/22	

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K 353	Continued From page 4	K 353		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5, 9.7, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2, 5.2.2.2. These deficient findings could have a widespread impact on the residents within the facility. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 10/27/2022 between 09:00 AM to 02:00 PM, it	K 353	K353 The oxidation on the sprinkler head on 4th floor in the soiled linen room will be replaced. The oxidation and foreign substance on the sprinkler head on 1st floor in the kitchen was removed on 10/27/22. The foreign substance on the sprinkler head on 1st floor in the environmental services storage room was removed on 10/28/22. Audits will be conducted by maintenance quarterly to ensure that all sprinkler heads are free of oxidation and foreign substances.	12/9/22

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K 353	Continued From page 5 was revealed by observation during walk-through of the facility that floor level assessment of sprinkler heads revealed the following: 1. 4th FL in the Soiled Linen Room - exhibited signs of oxidation 2. 1st FL in the Kitchen - exhibited signs of being covered with a foreign substance and signs of oxidation 3. 1st FL in the Environmental Services Storage Room - had items attached to the sprinkler system and sprinkler head(s) exhibited signs of being covered with foreign substance (spray on fireproofing) An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	The Building Operations Mentor will monitor to prevent reoccurrence. Date of Completion: 12/9/22	
K 374 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 374	K374	12/9/22

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K 374	Continued From page 6 facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed by observation during walk-through of the facility that upon testing on the 3rd FL smoke barrier door assembly adjacent to the elevator, the doors did not self-close resist the passage of smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	On 10/28/22 the smoke barrier door assembly on 3rd floor was adjusted by maintenance to ensure self-closing of the doors. Maintenance will continue monthly inspections to ensure smoke barrier doors are self-closing. The Building Operations Mentor will monitor to prevent reoccurrence. Date of Completion: 12/9/22	
K 753 SS=E	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6	K 753		12/9/22

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K 753	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, section 19.7.5.6. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed by observation during the walk-thru of the facility that on the 5th FL in the North sitting area by the elevators, straw bales had been placed as part of seasonal decoration. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 753	K753 On 10/28/22 the straw bales from 5th floor were removed. Neighborhood meetings will be held on December 1st and 2nd to educate staff on the importance of not decorating with a combustible items and the POC related to K753. The Building Operations Mentor and Community Leader will monitor to prevent reoccurrence. Date of Completion: 12/9/22	
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80)	K 761		12/9/22

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K 761	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview the facility failed to inspect and test fire rated doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2, 4.6.12, 7.2.1.15, and NFPA 80 (2010 edition), sections 5.2.1, 6.1, 6.1.4.2 This deficient finding could have an widespread impact on the residents within the facility. Findings include: On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed during documentation review that the last annual door inspection was completed on 04/21/2021. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 761	K761 Maintenance will ensure an annual fire door and assemblies inspection will be completed by 12/9/22. The Building Operations Mentor will monitor to prevent reoccurrence. Date of Completion: 12/9/22	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this	K 914		12/9/22

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

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K 914	Continued From page 9 manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2, 6.3.4, 6.3.4.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed by a review of available documentation that the documentation presented for review identified that the electrical outlet testing was last completed on 10/26/2021. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 914	K914 Maintenance will ensure electrical outlet testing in resident rooms is completed by 12/9/22. The Building Operations Mentor will monitor to prevent reoccurrence. Date of Completion: 12/9/22	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a	K 918		12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING **02 - NEW** B. WING _____	**10/27/2022**

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

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K 918	Continued From page 10 process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to install and test notification devices associated to the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 5.6.5.6, 5.6.6 This deficient condition could have a widespread impact on the residents within the facility.	K 918	K918 The facility is working with Hunt Electric to move the annunciator panel for the emergency generator to 3rd floor where it will be observed and monitored during 3rd shift. Neighborhood meetings will be held on December 1st and 2nd to educate staff on K918 and the POC.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING **02 - NEW** B. WING _____	**10/27/2022**

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

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K 918	Continued From page 11 Findings include: On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed by observation during the walk-through of the facility that the remote annunciator panel for the emergency generator, was located in an area where it would not be observed or monitored during 3rd shift. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	The Building Operations Mentor and Community Leader will monitor to prevent reoccurrence. Date of Completion: 12/9/22	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		12/9/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING **02 - NEW** B. WING _____	**10/27/2022**

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K 920	Continued From page 12 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage the usage of electrical adaptive devices in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient condition could have a patterned impact on the residents within the facility. Findings include: 1. On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed by observation during walk-through of the facility that on the 6th FL in the West sitting area, an extension cord was in use to power holiday lighting 2. On 10/27/2022 between 09:00 AM to 02:00 PM, it was revealed by observation during walk-through of the facility that in office A-328 and extension cord was connected to a power-strip and in use An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920 On 10/28/22 the extension cords were removed from the 6th floor in the west sitting area and the office A-328. Neighborhood meetings will be held on December 1st and 2nd to educate staff on the use of extension cords and the POC regarding K920. The Building Operations Mentor and Community Leader will monitor to prevent reoccurrence. Date of Completion: 12/9/22	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2023

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

RE: CCN: 245530
Cycle Start Date: October 28, 2022

Dear Administrator:

On December 12, 2022 and January 9, 2023, we notified you a remedy was imposed. On March 1, 2023 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 3, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 24, 2023 be discontinued as of February 3, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 12, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 24, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us