DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: K25S

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00427 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) SAMARITAN BETHANY HOME ON EIGHTH (L1) 245530 1. Initial 2. Recertification (L4) 24 - 8TH STREET NORTHWEST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55901 851843200 (L2)(L5) ROCHESTER, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full Survey After Complaint (1.9)13 PTIP 01 Hospital **05 HHA** 09 ESRD 22 CLIA 6. DATE OF SURVEY 04/20/2015 (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: __ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 09/30 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit То (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 8. Patient Room Size 182 (L18) _1. Acceptable POC __ 9. Beds/Room 5. Life Safety Code Not in Compliance with Program 182 (L17) 13 Total Certified Beds Requirements and/or Applied Waivers: (L12)* Code: A 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)182 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Enforcement Specialist 04/24/2015 (L20) 04/20/2015 Gary Nederhoff, Unit Supervisor PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21)22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 05/01/1988 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (L24)(L41) 03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44)(L27)B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (L31) 31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 04/23/2015

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245530

April 24, 2015

Ms. Kyla Jacobs, Administrator Samaritan Bethany Home On Eighth 24 - 8th Street Northwest Rochester, Minnesota 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 April 10, 2015 the above facility is certified for or recommended 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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

April 24, 2015

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

RE: Project Number S5530026

Dear Ms. Jacobs:

On March 18, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 5, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 20, 2015, 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 March 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 10, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 5, 2015, effective April 10, 2015 and therefore remedies outlined in our letter to you dated March 18, 2015, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure cc: Licensing and Certification File

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245530	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 4/20/2015			
Name of Facility		Street Address, City, State, Zip Code				
SAMARITAN BETHANY HOME ON EIG	ЭНТН	24 - 8TH STREET NORTHWEST				

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).

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5	5) D	ate
		Correction	ı		Correctio	n				Correction
ID Prefix	E0253	Complete 04/10/201		E0282	Complete 04/10/20		ID Prefix	F0312		Completed 04/10/2015
		04/10/201			04/10/20	13		-		_04/10/2013
	483.15(h)(2)			483.20(k)(3)(ii)			•	483.25(a)(3)		=
						<u> </u>				•
		Correction	ı		Correctio	n				Correction
ID Prefix	E0214	Complete 04/10/201		E0220	Complete 04/10/20		ID Profix	F0371		Completed 04/10/2015
	483.25(c)	04/10/201		483.25(I)	04/10/20	13		483.35(i)		_04/10/2013
LSC			LSC				LSC	463.33(1)		-
		Correction	1		Correctio	n				Correction
		Complete			Complete					Completed
ID Prefix	-	04/10/201		-	04/10/20	15				=
Reg. #	483.60(c)		Reg. #	483.60(b), (d), (e)			Reg. #			-
						<u> </u>				
		Correction	ı		Correctio	n				Correction
ID Dog fire		Complete			Complete	ed	ID Dorth			Completed
ID Prefix			ID Prefix							-
Reg. # LSC			Reg. #				Reg. # LSC			-
										-
		Correction	ı		Correctio	n				Correction
ID Prefix		Complete			Complete	ed	ID Profix			Completed
Reg. #			Reg. #				Reg. #			-
							LSC			-
Reviewed I	By Re	viewed By	Date:	Signature	of Surveyor:			D	ate:	
State Agen	cy GI	N/kfd	04/20/20	15		10160)		04/2	4/2015
Reviewed I	Ву Re	viewed By	Date:		of Surveyor:			D	ate:	
CMS RO										
Followup t	to Survey Comple				Uncorrected D			Aba Faailia.o		
	3/5/201	5		uncorrected	l Deficiencies (UNIS-2	oo/) Sent to	tne racility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: K25S

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART	I - TO BE COMPLETED BY T	HE STAT	ΓE SURVEY AGENCY	Facility ID: 00427		
MEDICARE/MEDICAID PROVIDER NO. (L1)	3. NAME AND ADDRESS OF FAC (L3) SAMARITAN BETHANY ((L4) 24 - 8TH STREET NORTH (L5) ROCHESTER, MN	HOME O	N EIGHTH (L6) 55901	4. TYPE OF ACTION:2(L8) 1. Initial		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	7. PROVIDER/SUPPLIER CATEGO 01 Hospital 05 HHA	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 03/05/2015 (L34 8. ACCREDITATION STATUS: (L10 0 Unaccredited 1 TJC 2 AOA 3 Other		10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 182 (L1 13. Total Certified Beds 182 (L1	A D NATIONAL MADE	ram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: B*	7. Medical Director		
14. LTC CERTIFIED BED BREAKDOWN	- 1		15. FACILITY MEETS			
18 SNF 18/19 SNF 19 S 182	NF ICF IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38) (L3	(L42) (L43)					
16. STATE SURVEY AGENCY REMARKS (IF APPL	ICABLE SHOW LTC CANCELLATION E	DATE):				
17. SURVEYOR SIGNATURE	Date :		18. STATE SURVEY AGENCY	APPROVAL Date:		
Josephine Hassinger, HFE NE I	04/09/2015	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 04/23/2015 (L20)		
PART II - TO I	BE COMPLETED BY HCFA RE	GIONAI	L OFFICE OR SINGLE S	TATE AGENCY		
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participate	20. COMPLIANCE WITH RIGHTS ACT:	I CIVIL	 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
2. Facility is not Eligible	1)		3. Both of the 18000	···		
(L2						
22. ORIGINAL DATE 23. LTC AGE OF PARTICIPATION BEGINN 05/01/1988	EEMENT 24. LTC AGREEM ING DATE ENDING DAT		VOLUNTARY 00 01-Merger, Closure 0	` '		
(L24) (L41)	(L25)		02-Dissatisfaction W/ Reimburs			
	ATIVE SANCTIONS usion of Admissions: (L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
(L27) B. Rescii	d Suspension Date:					
	(L45)					
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.		30. REMARKS			
(L28)	03001	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL	DATE				
(L32)		(L33)	DETERMINATION APP	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4417

March 18, 2015

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

RE: Project Number S5530026

Dear Ms. Jacobs:

On March 5, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

<u>Remedies</u> - 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;

Samaritan Bethany Home On Eighth March 18, 2015 Page 2

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

<u>Informal Dispute Resolution</u> - 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:

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Kathryn.serie@state.mn.us Office: (507) 476-4233

Fax: (507) 537-7194

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 April 14, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 14, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

Samaritan Bethany Home On Eighth March 18, 2015 Page 4

VERIFICATION OF SUBSTANTIAL 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. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 27, 2015 (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.

Samaritan Bethany Home On Eighth March 18, 2015 Page 5

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 27, 2015 (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 a PoC 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, Program Specialist

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

Kamala.Fiske-Downing@state.mn.us

Kamara.r iske-Downing @ state.iiii.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 03/18/2015 FORM APPROVED

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245530	B. WING			03/05/2015	
1	PROVIDER OR SUPPLIER	ON EIGHTH		STREET ADDRESS, CITY, ST 24 - 8TH STREET NORTH ROCHESTER, MN 5590	WEST	03/03/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PL X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRIA ICIENCY)	E (X5) COMPLETION DATE	
F 000	INITIAL COMMENT	-S	FO	00			
	as your allegation of Department's accept bottom of the first pube used as verificat. Upon receipt of an a revisit of your facility	acceptable POC an on-site will be conducted to validate		F253 Samaritan Bethany s	trives to ensure		
F 253 SS=D	has been attained ir verification. 483.15(h)(2) HOUS MAINTENANCE SE	RVICES	F 2	that we provide house	sekeeping and s necessary to orderly, and		
	maintenance service	vide housekeeping and es necessary to maintain a dicomfortable interior.	KWR.	Resident 17's wheel replaced on 03/05/1		ere	
	by: Based on observation failed to ensure a what good repair so it cou	T is not met as evidenced on and interview the facility neelchair was maintained in ld be cleaned properly for 1 whose wheelchair armrests adding.	49.	Resident wheelchairs weekly and routine consure wheelchairs a lf those areas are four maintenance work or filled out.	bbservations to are in good repair and defective, a		
	in her wheelchair (w/ visible cracks in the	m. R17 was observed seated (c) in her room. There were vinyl of both armrests and yl of each armrest exposing	•	An all staff in-service Tuesday, March 31 st 1 Neighborhood staff n held and information	to review this PO neetings will be	i l	
1	the foam padding be During an observatio 2:49 p.m. Fx17 was o	neath. n/interview on 3/05/15, at bserved seated in her w/c in	TURE.	to all staff regarding to washing wheelchairs routine observations.	the process for and completing . Additional		
M/11	M/\sim	1 1100 01 +			- 1:1	2/ 11/1	

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 appropriate processing the days following the date these documents are made available to the facility. program participation.

PRINTED: 03/18/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN	UT OF REFIGIENCES	I				<u>MR NO</u>	<u>. 0938-0391</u>
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION		E SURVEY IPLETED
VIII 0		245530	B. WING			03/	05/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		00,2010
SAMAR	IITAN BETHANY HOME	ON EIGHTH			4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BF	(X5) COMPLETION DATE
	her room. The armidisplay the cracks in had approximately a missing and the right centimeter (cm) by (exposing the foam pinterviewed R17 stat way". R17 further stated as "It rown way". R17 further stated as "It rown way". R18 with a maintenance issue way staff will inform mainfurther stated mainted the next day. RN-B with a resident's privand make the decision RN-B and surveyor croom. RN-B confirm need of repair and was utilizing was own confirmed the need for have been reported to when interviewed on maintenance director work order being sub 483.20(k)(3)(ii) SERV PERSONS/PER CAFT he services provided must be provided by continued the reach such as a such as	rest on R17's w/c continued to a the vinyl. The left armrest a quarter size piece of vinyl at armrest approximately a 2 (x) 1 cm piece of vinyl missing padding beneath. When ted, "I didn't do it, I got it that tated she would like the might tear my clothes". In 3/05/15, at 4:00 p.m. In 3/05/15, at 4:0	F 28	S2 F S	Neighborhood audits will be conducted by Neighborhood Coordinators for a months and on a random basis thereafter to ensure that routine washing and observations of resident wheelchairs are completed. Neighborhood Coordinators will monitor and report their findings to Quality Assurance Committee. Date of Completion: 04/10/15	ant the	
	care.	resident's written plan of		q	he facility must be provided by qualified persons in accordance with each resident's written plan of care.		
						1	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K25S11

Facility ID: 00427

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MAR 3 0 2015

PRINTED: 03/18/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION ING	(X3) DA	TE SURVEY MPLETED
		245530	B. WING		03	/05/2015
	PROVIDER OR SUPPLIER	ON EIGHTH	,	STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	1 03	703/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU	DRF	(X5) COMPLETION DATE
	This REQUIREMEN by: Based on observatireview the facility fair related to grooming assistance for 2 of 3 R189) reviewed for a Findings include: R168's quarterly Mir 2/10/15, revealed dineart failure and depognitive impairment assist of one staff for R168's care plan wittevealed R168 requiremental personal hygiene care R168 was observed several facial hairs around he 3/5/15, at 12:30 p.m. remained evident on On 3/5/15 at 2:06 p.m. facial hair removal waday or in the morning in preparation for the resident facial hair greason was missed devening staff would a when needed. C-A voon staff for removal or	on, interview, and record led to follow the plan of care and personal hygiene dependent residents (R168, activities of daily living. dimum Data Set (MDS) dated agnoses including congestive pression, had severe and required extensive repersonal hygiene. In a revision date of 5/23/14, red assist of one staff with red. on 3/3/15, at 5:41 p.m. with posted around the chin and ing afternoon, on 3/4/15 at observed to have several er chin and upper lip. On it was noted that facial hairs R168's chin and upper lip. In. caregiver (C)-A stated as generally done on a bath when staff assist residents day. C-A stated that when owth is noticed or for some uring morning cares, sesist with facial air removal erified R168 was dependent of facial hair, verified her bath and that R168 had facial hair	F2	Our facial trimming policy, which provided to surveyors, states that our policy for nursing staff to shaw tweeze, or neatly trim the facial haresidents during daily cares to ma dignity. Nail care is provided by nustaff during daily grooming and as needed to maintain resident digni Nail care for residents with diabet provided by licensed nursing staff. An all staff in-service will be held of Tuesday, March 31st to review this Neighborhood staff meetings will be held and information will be distril to all staff regarding the process for facial trimming and nail care. Additeducation will be provided as need Neighborhood audits will be conducted by Neighborhood Coordinators for months and on a random basis thereafter to ensure that routine fatrimming and nail care is complete Neighborhood Coordinators and RI Care Coordinators will monitor and report their findings to the Quality Assurance Committee. Date of Completion: 04/10/15	it is e, air of ntain rsing y. es is POC. e outed r ional ed. cted 3 cial	

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Event ID: K25S11

Facility ID: 00427

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PRINTED: 03/18/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DA	ATE SURVEY DMPLETED
		245530	B. WING	i		0:	3/05/2015
ļ	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		24	TREET ADDRESS, CITY, STATE, ZIP CODE 4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETION DATE
F 282	Continued From page On 3/5/15 at 2:13 p. (NN)-D verified R16 across her chin and facial hair was unace R168 was depender and the it should have verified confirmed the required assistance includes facial hair resolutes facial hair resolutes facial hair resolutes facial hair removed. Staff did not follow R assist with personal I requested for following provided. R189's most recent uniformed staff of the dementia, the history admission to hospice anxiety diagnosis. The provide assistance for Observations made con 3/5/15, at 8:51 a.n. finger nails with dry light across her china for the diagnosis with dry light across the control of the diagnosis.	m. neighborhood nurse 8 had several facial hairs upper lip and confirmed the ceptable. NN-D stated that at upon staff for hair removal we been removed. NN-D are plan of care indicated R168 with personal hygiene which emoval. m. the clinical mentor (CM) female residents to be pair removal unless it is care removed unless it is care removed unless it is care removed. Werified R168 was or facial hair removal, verified 168's plan of care to provide the hygiene. A policy was not a care plan on 3/5/15, cognitive deficit related to ref carpal tunnel, the e on 10/2/2014 and the e care plan directed staff to or grooming and hygiene. On 3/2/15, at 2:28 p.m. and n. revealed R189 had long ght brown debris build up of the first and second		282	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
6 k F S	The facility admission admitted on 10/2/14, out not limited to dem R189's quarterly MDS	n record indicated R189 was and included diagnoses of tentia and anxiety. 6 dated 1/6/15, indicated airment with a Brief Interview S) score of 5/15 and					,

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Event ID: K25S11

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245530	B. WING _		03/	05/2015
SAMARI	PROVIDER OR SUPPLIER TAN BETHANY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	1 00/	00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 312 SS=D	perform hygiene and When interviewed o licensed practical nunails were dirty and be provided on bath Mondays by facility so Thursdays by the house of the second of the se	d grooming tasks. n 3/5/15, at 8:56 a.m. urse (LPN)-A verified R189's stated that nail care was to days, which was scheduled staff and provided on spice staff. ARE PROVIDED FOR	F 28	F312 Samaritan Bethany strives to ensure	rry he nd	
	by: Based on observation review, the facility fail unable to perform perform perovided services for R189) reviewed for a Findings Include: R168's quarterly Minipulation 2/10/15, revealed diated the failure and deprocessive impairment assist of one staff for R168's care plan with revealed R168 requires personal hygiene care	a 2 of 3 residents (R168, ctivities of daily living. mum Data Set (MDS) dated agnoses including congestive ression, had severe and required extensive personal hygiene. a revision date of 5/23/14, ed assist of one staff with		provided to surveyors, states that it our policy for nursing staff to shave, tweeze, or neatly trim the facial hair residents during daily cares to maint dignity. Nail care is provided by nursi staff during daily grooming and as needed to maintain resident dignity. Nail care for residents with diabetes provided by licensed nursing staff. An all staff in-service will be held on Tuesday, March 31 to review this POO Neighborhood staff meetings will be held and information will be distribut to all staff regarding the process for facial trimming and nail care. Addition education will be provided as needed	of ain ing is	

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Manestoa Department of Health Marekall

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		245530	B. WING				3/05/2015
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		2	TREET ADDRESS, CITY, STATE, ZIP CODE 4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	, 0	3/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	several facial hairs I upper lip. The follow 3:26 p.m., R168 was facial hairs around h 3/5/15, at 12:30 p.m remained evident on On 3/5/15 at 2:06 p.m facial hair removal way or in the morning in preparation for the resident facial hair greason was missed evening staff would a when needed. C-A won staff for removal day had been today a located on her chin a On 3/5/15 at 2:13 p.m (NN)-D verified R168 across her chin and to facial hair was unacce R168 was dependent and the it should have verified confirmed the required assistance wincludes facial hair removed. CM verified staff for facial hair removed.	ocated around the chin and wing afternoon, on 3/4/15 at so observed to have several her chin and upper lip. On . it was noted that facial hairs in R168's chin and upper lip. The caregiver (C)-A stated was generally done on a bath g when staff assist residents in a caregiver (C)-A stated was generally done on a bath g when staff assist residents in a caregiver (C)-A stated was generally done on a bath g when staff assist residents in a caregiver (C)-A stated was generally done on a bath g when staff assist residents when rowth is noticed or for some during morning cares, assist with facial air removal werified R168 was dependent of facial hair, verified her bath and upper lip. The neighborhood nurse is had several facial hairs upper lip and confirmed the eptable. NN-D stated that it upon staff for hair removal ebeen removed. NN-D eplan of care indicated R168 with personal hygiene which emoval. The clinical mentor (CM) female residents to be air removal unless it is care erence not to have facial hair la R168 was dependent on noval and verified the staff lity policy for facial hair	F3	112	Neighborhood audits will be conducted by Neighborhood Coordinators for a months and on a random basis thereafter to ensure that routine fact trimming and nail care is completed Neighborhood Coordinators and RN Care Coordinators will monitor and report their findings to the Quality Assurance Committee. Date of Completion: 04/10/15	cial	
	i ile Faciai Hair Trimn	ning policy with a review					

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STAT AND	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245530	B. WING				
NAN	E OF PROVIDER OR SUPPLIER				TREET APPRICA CITY OF THE THE	03	3/05/2015
SAI	MARITAN BETHANY HOME			2	STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
PR	EFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
. ·	be shaved, tweezed necessary to mainta We will not shave e facial hair. At times tweezers to remove staff will note and reas part of daily groo Observations made on 3/5/15, at 8:51 a. finger nails with dry underneath the nails fingers on both hand. The facility admissic admitted on 10/2/14 but not limited to del R189's quarterly MD severe cognitive important of Mental status (BIN required extensive a perform hygiene and R189's most recent informed staff of the dementia, the history admission to hospica anxiety diagnosis. The provide assistance for When interviewed or licensed practical nunails were dirty and see provided on bath Mondays by facility so Thursdays by the hose A facility policy entitle reviewed July 2010 in nail bed, skin between care needed " The	Facial hair of all residents will it, or neatly trimmed as ain dignityFemale residents: very female resident with it will be appropriate to use 1 or 2 long hairs. Nursing move facial hair as needed ming" on 3/2/15, at 2:28 p.m. and m. revealed R189 had long light brown debris build up of the first and second dis. In record indicated R189 was and included diagnoses of mentia and anxiety. S dated 1/6/15, indicated pairment with a Brief Interview MS) score of 5/15 and ssist from one staff to a grooming tasks. Supdated care plan on 3/5/15, cognitive deficit related to a of carpal tunnel, the ene care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In 3/5/15, at 8:56 a.m. In the care plan directed staff to or grooming and hygiene. In a state of the provided on the provided on the provided on the provided on the plant of the pla	F	312			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245530	B. WING	3		03	/05/2015
	PROVIDER OR SUPPLIER	ON EIGHTH		2	STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	•	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	PREVENT/HEAL PI Based on the compresident, the facility who enters the facility who enters the facility does not develop prindividual's clinical of they were unavoidal pressure sores receservices to promote prevent new sores for this REQUIREMENT by: Based on observation review the facility faservices to promote ulcer for 1 of 3 reside pressure ulcers. Findings include: Record review reveat (10/2/14) with an unstead (10/2/14) with an unstead 1 centime width by 0.5 cm in decension with no undermine measurements were composed of the promote of tunneling. R18 an infection in the work treated with antibiotic R189's facility admission date of 10 included but not limite atrial fibrillation, chrososteoporosis, and presented to the facility and presented to the facility admission date of 10 included but not limite atrial fibrillation, chrososteoporosis, and presented to the facility admission date of 10 included but not limite atrial fibrillation, chrososteoporosis, and presented to the facility admission date of 10 included but not limite atrial fibrillation, chrososteoporosis, and presented to the facility admission date of 10 included but not limite atrial fibrillation, chrososteoporosis, and presented to the facility admission date of 10 included but not limite atrial fibrillation, chrososteoporosis, and presented to the facility atrial fibrillation, chrososteoporosis, and presented to the facility atrial fibrillation, chrososteoporosis, and presented to the facility atrial fibrillation atrial fibrillation, chrososteoporosis, and presented to the facility atrial fibrillation atrial f	rehensive assessment of a must ensure that a resident ity without pressure sores essure sores unless the condition demonstrates that ole; and a resident having ives necessary treatment and healing, prevent infection and rom developing. T is not met as evidenced on, interview, and document illed to provide care and the healing of a pressure ents (R189) reviewed for stageable pressure ulcer spine (upper back) that ter (cm) in length by 1 cm in epth (1.0 cm x 1.0 cm x 0.5 ning; on 2/10/15 1 cm x 1 cm x 0.1 cm with 2 and subsequently developed bund on 3/2/15 and was	F		Samaritan Bethany strives to ensure that based on the comprehensive assessment of a resident, the facility must ensure that a resident who en the facility without pressure sores on the facility without pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevenew sores from developing. All residents are assessed to determine their individualized plan of care including their specific repositioning schedule to prevent pressure sores appromote healing. The resident's care plan was reviewed and updated to address the pressure sores, treatment and positioning plan. PA-C reviewed documentation and resident's conditional concluded that the resident's clinical condition demonstrated that pressure sore was unavoidable.	y iters loes he ent ine	

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	E SURVEY MPLETED
		245530	B. WING		·	02	/0E/201E
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		2	TREET ADDRESS, CITY, STATE, ZIP CODE 4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	<u> U3/</u>	05/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	R189's quarterly Min 1/6/15, indicated sewith a Brief Interview score of 3/15 and retwo staff members of personal hygiene and two staff for transfer MDS indicated a prechair, pressure redunutrition or hydration used to manage skin The hospice enrollm treatment dated 10/2 change every seven treatment order confing physician orders in the change (Mepilex bor Aquacel foam). R189's PU monitorin 10/2/14, indicated the was Aquacel foam as wound were 1.0 cm where the sheet documentation wound measurement 1.0 cm x 0.7 cm with wound treatment refl. Ag with Aquacel foam on the 2/10/15, flow some as well as the signed physician ord 11/28/15, were "Aquacel Aguacel AG to back well as the staff of the sound care dated 2/14 Aquacel AG to back well as the staff of	nimum Data Set (MDS) dated vere cognitive impairment of for Mental Status (BIMS) quired extensive assist from or bed mobility, toileting and d was totally dependent on selections between surfaces. The ressure reducing device for cing device for bed, and intervention were being in problems. ent form indicated wound 2/14 as, "Mepilex border, days and as needed." The licted with the facility erms of frequency of dressing der was comparable to g tool (flow sheet) dated as wound dressing treatment and the measurements of the x 1.0 x 0.5 cm. The flow dated 11/26/14 indicated as had increased to 1.0 cm x sinus tunneling of 2 cm; exted a change to Aquacel in to cover. Documentation sheet indicated no change in a PU (11/26/14 to 2/10/15), ers for wound care dated acel AG to back wound, ed physician orders for 1/15, remained the same, "vound, change daily".	F3		Our current, 3/27/15, documentation of R # 189 's wound is .5 centimeter length by 1 centimeter in width by centimeters in depth with sinus tunneling of 1 centimeter. These measurements demonstrate an improvement in the condition of the wound. An all staff in-service will be held on Tuesday, March 31 to review this PC Neighborhood staff meetings will be held and information will be distributed all staff regarding the process for treatment of pressure sores. Additionally staff and on a readouted by RN Care Coordinators for 3 month and on a random basis thereafter to ensure that proper documentation for pressure sores, treatment, and positioning is completed. RN Care Coordinators will monitor and report their findings to the Quality Assurance Committee. Date of Completion: 04/10/15	s in 2 DC. tted the onal d. ted	

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING	(X3) DA ⁻	TE SURVEY MPLETED
	•	245530	B. WING	· 3	03	/05/2015
NAME OF	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CO		/05/2015
SAMARI	TAN BETHANY HOME	ON EIGHTH		24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	showed a score of developing pressure tissue tolerance tes "Resident did not shup to 3 hours. Will rhours with lying/sitting with status change of assessment indicate pressure of 3 hours. The repositioning so plan was identified a change. R189's Brauto/12/14, 10/19/14, score of 13 indicating moderate to high ris Subsequently, the caremained the same. R189's care plan datused a Broda chair that it reclined, provide (nutritional supplemental pressure ulcer the included "I am at riscame here with unstated 1/19/15 and held plan instructed staff in prevention/treatment reposition every 2 hocares/baths" and insphysician if pressure healing. Care plan intreatment administrated pressure ulcer treatment administrated and included "I am at riscares/baths" and insphysician if pressure healing. Care plan intreatment administrated pressure ulcer treatment administrated and included "I am at riscares/baths" and insphysician if pressure healing. Care plan intreatment administrated and included "I am at riscare plan in the aling. Care plan in the aling. Care plan in the aling. The I indicated Ag was initiated on 1	It dated 10/2/14 read, now redness while lying/sitting eposition resident every 3 ng at this time. Will change of resident ". The ed R189 could have sustained to the pressure ulcer area. Shedule identified on the care as every 2 hour position den scales performed on and 10/25/14 all revealed a g a borderline score of k for pressure ulcers. are plan and treatments are plan and treatments ted 10/15/14 indicated R189 hat helped with repositioning a 8 ounces of Boost ent) three times a day to help to spine. The care plan also k for skin breakdownI ageable pressure ulcer to my ad one on my coccyx that nealed over 2/2/15. The care to follow facility protocols for to fish breakdown, ours, observe my skin with estructed staff to notify ulcer did not seem to be structed staff to see the tion record (TAR) for nent. If the treatment of Aquacel 1/6/14; the order read wound. Change daily every kin integrity. "	F3	314		

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NAME OF PROVIDER ON BUPPLIER SAMARITAN BETHANY HOME ON EIGHTH O(A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATIONY OR LSC IDENTIFYING INFORMATION) F 314 Continued From page 10 performed daily. A nursing note dated 2/1/15 read "sleep in her Broda chair most nights." A nursing note dated 3/2/15 read, "Resident's wound on mid back has small amount of greenish drainage and foul odor ". A follow up nursing note written on the same day a physician order for Augmentin twice per day for ten days for wound infection. During an observation on 3/3/15, at 2:24 p.m. R189 was sitting in one dated the wall. During an observation on 3/5/15, at 8:35 a.m. R189 was sitting in front of a window in the side of the bed located up against the wall. During an observation on 3/5/15, at 8:51 a.m. R189 was sitting in front of a window in the sunshine. A pillow was placed behind her back. Chair position was leaned back approximately 30 degrees, which would put pressure to the wound on the spine. During an observation on 3/5/15, at 10:41 a.m. R189 was sitting in Broda chair in main lobby area watching the television show MASH. The Broda chair was reclined approximately 30 degrees; a pillow was placed behind the back. During an interview on 3/5/15, at 10:42 a.m. homemaker (Hish) H stated R189 had been in the chair since 7:30 a.m. (over 3 hours). During an interview on 3/5/15, at 10:45 a.m.	STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
SAMARITAN BETHANY HOME ON EIGHTH SUMMAPY STATEMENT OF DEFICIENCIES FROCHESTER, MN 55901 SUMMAPY STATEMENT OF DEFICIENCIES FROCHESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS PLAN OF CORRECTION PROPERTY TAG CROCKESTER, MN 55901 FROUDERS CROCKESTER, MR 55901 FROUDERS CROCKESTER, MN 55901 FROUDERS CROCKESTER, MR 55901 FROUDES PROPERTY TAG CROCKESTER, M			245530	B. WING	à	•		03	/05/2015
PACHESTER, MN 55901 PROVIDENTS PLAN OF CORRECTION PRECIDENCY MUST BE PRECIDED BY FULL PROVIDENTS PLAN OF CORRECTION	NAME OF	PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	1 00/00/2010	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 314 Continued From page 10 performed daily. A nursing note dated 2/1/15 read "sleep in her Broda chair most nights." A nursing note dated 2/2/15 read, "Resident's wound on mid back has small amount of greenish drainage and foul odor ". A follow up nursing note written on the same day a physician order for Augmentin twice per day for ten days for wound infection. During an observation on 3/3/15, at 2:24 p.m. R189 was sitting on the edge of bed. The mattress was not a specialty mattress (air, sand, or alternating air). There was a body pillow on the side of the bed located up against the wall. During an observation on 3/5/15, at 8:35 a.m. R189 was sitting in Broda chair up right at the dining room table. There was a pillow in place under her right arm for positioning. R189 was noted to have curvature of the spine consistent with kyphosis. During an observation on 3/5/15, at 8:51 a.m. R189 was sitting in front of a window in the sunshine. A pillow was placed behind her back. Chair position was leaned back approximately 30 degrees, which would put pressure to the wound on the spine. During an observation on 3/5/15, at 10:41 a.m. R189 was sitting in Broda chair in main lobby area watching the television show MASH. The Broda chair was reclined approximately 30 degrees, a pillow was placed behind the back. During an interview on 3/5/15, at 10:42 a.m. homemaker (HM)-H stated R189 had been in the chair since 7:30 a.m. (over 3 hours). During na interview on 3/5/15, at 10:42 a.m.					1.				
performed daily. A nursing note dated 2/1/15 read "sleep in her Broda chair most nights." A nursing note dated 3/2/15 read, "Resident's wound on mid back has small amount of greenish drainage and foul odor ". A follow up nursing note written on the same day a physician order for Augmentin twice per day for ten days for wound infection. During an observation on 3/3/15, at 2:24 p.m. R189 was sitting on the edge of bed. The mattress was not a specialty mattress (air, sand, or alternating air). There was a body pillow on the side of the bed located up against the wall. During an observation on 3/5/15, at 8:35 a.m. R189 was sitting in Broda chair up right at the dining room table. There was a pillow in place under her right arm for positioning. R189 was noted to have curvature of the spine consistent with kyphosis. During an observation on 3/5/15, at 8:51 a.m. R189 was sitting in front of a window in the sunshine. A pillow was placed behind her back. Chair position was leaned back approximately 30 degrees, which would put pressure to the wound on the spine. During an observation on 3/5/15, at 10:41 a.m. R189 was sitting in Broda chair in main lobby area watching the television show MASH. The Broda chair was reclined approximately 30 degrees; a pillow was placed behind the back. During an interview on 3/5/15, at 10:42 a.m. homemaker (HM)-H stated R189 had been in the chair since 7:30 a.m. (over 3 hours). During an interview on 3/5/15, at 10:45 a.m.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE CROSS-REFERENCE	VE ACTION SHOULD D TO THE APPROPI	BE	COMPLETION
HM-O stated the last time R189 had been repositioned was about 1.5 hours ago. When asked how R189 was repositioned HM-O stated they had repositioned the pillow from underneath		performed daily. A nursing note dated Broda chair most night A nursing note dated wound on mid back drainage and foul of written on the same Augmentin twice perinfection. During an observation R189 was sitting on mattress was not a sor alternating air). The side of the bed located During an observation R189 was sitting in Edining room table. The under her right arm for noted to have curvated with kyphosis. During an observation R189 was sitting in Edining room table. The under her right arm for noted to have curvated with kyphosis. During an observation R189 was sitting in Edining room table and the spine. During an observation R189 was sitting in Edingrees, which would not the spine. During an interview of the spine area watching the telest Broda chair was reclided grees; a pillow was During an interview of the spine and interview of the spine a	d 2/1/15 read "Sleep in her ghts. " d 3/2/15 read, "Resident's has small amount of greenish for ". A follow up nursing note day a physician order for day for ten days for wound on on 3/3/15, at 2:24 p.m. the edge of bed. The specialty mattress (air, sand, nere was a body pillow on the ed up against the wall. on on 3/5/15, at 8:35 a.m. Broda chair up right at the nere was a pillow in place for positioning. R189 was ture of the spine consistent on on 3/5/15, at 8:51 a.m. Font of a window in the as placed behind her back, aned back approximately 30 d put pressure to the wound on on 3/5/15, at 10:41 a.m. Froda chair in main lobby evision show MASH. The ned approximately 30 d put pressure to the wound on 3/5/15, at 10:42 a.m. stated R189 had been in the (over 3 hours). In 3/5/15, at 10:45 a.m. time R189 had been ut 1.5 hours ago. When the repositioned HM-0 stated	F	314				

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Facility ID: 00427

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	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245530	B. WING				/OF /OO 4 =
NAME OF PR	ROVIDER OR SUPPLIER		L		TREET ADDRESS, CITY, STATE, ZIP CODE	03	/05/2015
<u> </u>	AN BETHANY HOME			2	4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBF	(X5) COMPLETION DATE
h with c Rh h h h example of a function of from the indicate of the indicate o	was leaned back. He the Broda chair coulchange resident posense and the pillow as to be reported by the provided by the provid	ind her back and the chair M-O then demonstrated how d be moved up and down to ditions. HM-O also explained esitioned every two hours it ended being every 2.5 is busy. HM-O further provides a reposition change on on 3/5/15, at 11:26 a.m. the dining room. On 3/5/15, at 11:29 a.m. adjusting the Broda chair to r R189 gets laid down. RN-C B9 was repositioned every 2 as R189 is completely checked and changed every ded with repositioning o explained the Broda chairs can just change the position	. F (314			

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		LE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		245530	B. WING				
NAME OF	PROVIDER OR SUPPLIER	2-10000	D. WINC			03/	/05/2015
	ITAN BETHANY HOME			2	STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
	areas. HRN-N stated that of from disease procequestioned what reviewed "she was stated "she was given initiated on 11/13/14 [Broda chair was given believe they have do changes for her back to cover now they are [inconsistent with which will be the pillows underneated leans to one side, are sit up straight ". HR repositioning had no staff should not have When interviewed of medical equipment proposition of the chair of	wound tunneling was likely ss and poor intake. When visions were implemented to prevent further decline, HRN-N arted on a protein shake visian orders, protein shake was [4] and was given a Broda chair ven to R189 on 10/2/14], and I one different dressing sk; they had been using gauze re using opti-foam the orders indicated], I oned more frequently putting ath her arms because she and we are trying to get her to	F	314			

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
	,	245530	B. WING		0:	3/05/2015
	PROVIDER OR SUPPLIER TAN BETHANY HOME	E ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP CO 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		, 00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	tempurpedic mattre and MD/NP will colli for stage II-IV press to conventional ther colonized, minimize cleaning and debrid purulence develops 483.25(I) DRUG RE UNNECESSARY DREACH resident's drug unnecessary drugs. drug when used in eduplicate therapy); owithout adequate moindications for its use adverse consequences should be reduced ocombinations of the Based on a comprehesident, the facility rwho have not used a given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive graduate behavioral interventices.	sses, the clinical supervisor aborate for other modalities are ulcers that don't respond apy, pressure ulcers may be this through effective wound ement, if foul odor or cleanse more frequently. "GIMEN IS FREE FROM RUGS To regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or contoring; or without adequate e; or in the presence of ces which indicate the dose or discontinued; or any reasons above. The residents untipsychotic drug are not alless antipsychotic drug are not occumented in the clinical so who use antipsychotic all dose reductions, and	F 3:	Samaritan Bethany strives to that each resident's drug region be free from unnecessary drug unnecessary drug is any drug used in excessive dose (included uplicate therapy); or for exceduration; or without adequate monitoring; or without adequate indication for its use; or in the of adverse consequences which the dose should be reduced of discontinued; or any combinative reason above. Samaritan Bethany strives to each that based on a comprehensive assessment of a resident, resident and used antipsychotic dinot given these drugs unless antipsychotic drug therapy is resident as pecific condition as diagnosed and documented in clinical record; and residents we antipsychotic drugs received green.	men must ags. An when ling essive e ate presence ch indicate r tions of ensure e dents who rugs are necessary the who use radual	
	This REQUIREMENT by:	「 is not met as evidenced		dose reductions, and behavior interventions, unless clinically contraindicated, in an effort to discontinue those drugs		

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245530	B. WING_			03	/05/2015
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		24	REET ADDRESS, CITY, STATE, ZIP CODE - 8TH STREET NORTHWEST DCHESTER, MN 55901	<u>1 U3/</u>	05/2015
(X4) ID PREFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION	٧	(X5) COMPLETION
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
F 329	Continued From pag	ge 14	F 32		The NP reviewed the use of Remerc		
	Based on interview and document review the facility failed to ensure each resident's drug				and concluded that it was appropria and the benefits outweighed the ris		
	regimen is free from	unnecessary drugs for 1 of 5			The consultant pharmacist complete		
	residents (R 178) re medications.	viewed for unnecessary			monthly pharmacy recommendatio		
			1		that are addressed by the attending	·) ·	
	Findings include:			- 1	physician or NP/PA. The RN Care		
	R178, admitted on 5/30/12 with diagnoses listed				Coordinator is responsible for		
	on the physician pro	gress notes which included:			appropriate follow-up on these		
	hypothyroidism, anxi	umatic fracture lower arm, iety state, depressive		þ	pharmacy recommendations.		
	disorder, and mild co	ognitive impairment from		1	An all staff in-service will be held on		
	electronic progress r	notes.			Tuesday, March 31 to review this PC		
	R178's most recent I			Neighborhood staff meetings will be			
	dated 1/28/15, indica	ated a Brief Interview of b) of 10/15, which indicated			neld and information will be distribu		
	moderate cognitive in	mpairment. Review of the	•		o all staff regarding the process for		
	signed physician ord that Remeron 15 mill	ers dated 3/19/14, indicated ligrams (mg) PO QD was			innecessary drugs.		
	initiated for appetite s depressive disorder.	stimulant related to		N	leighborhood audits will be conduct	ed	
	·				y RN Care Coordinators for 6 month		
	Documented pharma	acy recommendations were			nd on a random basis thereafter to		
	The pharmacy review	2014 until February 2015. v dated 6/4/14, had a		eı	nsure that our process for the use o	f :	
	recommendation for	a gradual dose reduction		uı	nnecessary drugs is followed		
.	(GDR) for Remeron :	15 mg PO HS for appetite sive disorder. No MD			opropriately. RN Care Coordinators		
	response to this requ	est was documented in the			ill monitor and report their findings	to i	
1	paper or electronic re	ecord. The pharmacy review ced the recommendation of		th	e Quality Assurance Committee.		
	6/4/14 and indicated: up] next month if nec	"Will follow up (f/u) [follow essary". Documentation		Da	ate of Completion: 04/10/15		
١,	was lacking by MD in	response to					
8	8/6/14, documented:	he pharmacy review dated "This is a duplicate of a ation with no response.					

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
NAME OF	DROWDED OF CURRY	245530	B. WING			03	/05/2015
SAMAR	PROVIDER OR SUPPLIER		23.000	2	STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	There is a progress justified no attempt The pharmacy reviet 11/12/14, 12/15/14, physician response recommendation for of Remeron. During an interview licensed practical nuhad received Remeron. When interviewed or director of nurses (Dinformation/docume review which address consultant pharmaci DON further verified pharmacist recomme scheduled monthly verified.	note from 6/4/14 which at a GDR on Remeron". ws dated 9/11/14, 10/9/14, 1/15/15 and 2/15/15- lacked	F	329			

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STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TPLE CONSTRUCTION NG		TE SURVEY MPLETED
•		245530	B. WING _		03	/05/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	CODE	03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	483.35(i) FOOD PF STORE/PREPARE The facility must - (1) Procure food from considered satisfact authorities; and (2) Store, prepare, under sanitary conditions and carrots where the facility farefrigerator foods where we way include: During tour of the family following were obsesuith no date; one play and carrots, with resplastic container of the name, undated; one foil with three sausage During interview at the foods, and foods not foods and foods not foods.	ROCURE, (/SERVE - SANITARY) om sources approved or story by Federal, State or local distribute and serve food ditions NT is not met as evidenced ion, interview, and document ailed to ensure kitchenette ere dated when opened and ved from use for 5 of 13 stors reviewed.	F 37	F371	res food from res, prepares, d under mprove food ffected by rove hand r all residents g and n dating and red and will and a framework y. all staff in- res and re of dating the food rocedure, od staff formation ff regarding	

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AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		ATE SURVEY OMPLETED
		245530	B. WING	•		0.	3/05/2015
	PROVIDER OR SUPPLIER ITAN BETHANY HOME	ON EIGHTH		2	TREET ADDRESS, CITY, STATE, ZIP CODE 4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	<u> </u>	3/03/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	opened. CSD stated dated when opened 2/17, should be rem (2) On 3/2/15 at 10: Creek House neight ham in plastic bag dat that time, homem undated and outdate policy to keep foods and then dispose. Hi outdated. (3) On 3/2/15 at 10:: Club House neighbo including French, the to 1/4 remained in eat 1 opened gallon of m boiled eggs; 12 paste shell; three plastic be sausage in each; one and bacon pieces; al opened. During interneighborhood coording discolored cheese ar verified not aware of labeled jelato. (4) On 3/2/15 at 10:3 Northgate House neighborhous eneighborhous ene	ds, and foods not dated when if he expected foods to be and sausage links dated oved. 40 a.m., 4th floorCascade porhood-four thin slices of ated 2/22. During interview aker (HM)-G verified the ed foods. HM-G stated facility in refrigerator for one week M-G verified the ham was 30 a.m, 3rd floor Country rhood-three salad dressings busand island, and Italian, 1/2 ach, no date of when opened; alik, 1/2 remained; 4 hard eurized eggs, uncooked in ags with two uncooked e plastic bag of mixed ham I foods with no date when view at that time, nator (NC)-F verified the ad undated foods. NC-F what food was in container	F3		The Neighborhood Coordinators waudit food safety in the individual household kitchens weekly for a per of 3 months to ensure compliance retrain if necessary. Registered Dietitians and Certified Dietary Managers will monitor for complian and report their findings to the Quarkssurance Committee. Date of Completion: 04/10/15	eriod and	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245530	B. WING	i		03	3/05/2015
	PROVIDER OR SUPPLIER	ON EIGHTH		2	STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	uncooked in hard st when opened. Duri	ge 18 hborhood-5 pasteurized eggs, nell; all foods without dates ng interview at that time, nods with no date when	F	371			
	Labeling Foods, dat following: "Samarita effort to prevent food and labeling of foods household kitchens. labeled and dated w EITHER opened or containers. All lefton thrown away after 5 facility leftovers and residents). Note: The condiments such as These items should first in, first out basis are emptied. It is the chef/supervisor in the cooler weekly for iter away. It is the response	facility policy Dating and ed 3/16/11, revealed the an Bethany will make every do borne illness through dating in both the main kitchen and All containers must be ith contents once items are removed from their original ver refrigerated foods are days. (This applies to both any foods brought in by his does not apply to ketchup, salad dressing, etc. be dated and rotated on a sand thrown away as they be responsibility of the emain kitchen to check the ms that should be thrown ansibility of the homemaker in eack the refrigerator for such					
F 428 SS=D	During interview on 3 services director (CS to be dated when op 483.60(c) DRUG RE IRREGULAR, ACT C	GIMEN REVIEW, REPORT	F 4:	28			

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245530	B. WING			03	/05/2015
l	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP C 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	ÒODE	<u> </u>	05/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO	SHOULD	BE	(X5) COMPLETION DATE
F 428	The pharmacist must the attending physic	ge 19 st report any irregularities to sian, and the director of reports must be acted upon.	F4	F428 Samaritan Bethany strives to that the drug regimen of each must be reviewed at least or by a licensed pharmacist. The pharmacist must report any	ch reside nce a mo	1	
·	This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the physician acted upon the recommendation documented by the consulting pharmacist for 1 of 5 residents (R 178) reviewed for unnecessary medications. Findings include: R178, admitted on 5/30/12 with diagnoses listed on the physician progress notes which included: aftercare healing traumatic fracture lower arm,			irregularities to the attending and the director of nursing, a reports must be acted upon. The NP reviewed the use of F and concluded that it was ap and the benefits outweighed Pharmacy recommendations completed on a monthly basiconsultant pharmacist. The	ding physician, g, and these on. of Remeron appropriate ned the risks. ons are oasis by the		
	hypothyroidism, anxidisorder, and mild coelectronic progress relectronic progress rather than 1/28/15, indicated 1/28/15, indicated 1/28/15, indicated 1/28/15, indicated to depressive that Remeron 15 mill (every day) was initiated to depressive Documented consultated to depressive that February 2015, dated 6/4/14, had a related 6/4/14, had a related 6/4/14, had a related force that the commendations we would be seen that the commendation which the commendations we would be seen that the commendation which the commendation which the commendation was also seen the commendation which the commendation was also seen that the commendation which the commendation was also seen the commendation which the commendation was al	ety state, depressive organitive impairment from notes. Minimal Data Set (MDS) atted a Brief Interview of of 10/15, which indicated impairment. Review of the ers dated 3/19/14, indicated igrams (mg) PO (orally) QD atted for appetite stimulant of disorder.		pharmacist's monthly reports continue to be given to the D Care Coordinators for appropriate follow-up by the attending plant All pharmacist recommendate the physician are reviewed by attending physician and acted An all staff in-service will be Tuesday, March 31 to review Neighborhood staff meetings held and information will be to all staff regarding the procepharmacy recommendations	ON and priate mysician. ions for y the dupon. held on y this PO s will be distributess for	C.	

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Event ID: K25S11

Facility ID: 00427

If continuation sheet Page 20 of 23

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PRINTED: 03/18/2015 FORM APPROVED OMB NO. 0938-0391

STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245530	B. WING	i		03/	05/2015
Ì	PROVIDER OR SUPPLIER	ON EIGHTH		2	STREET ADDRESS, CITY, STATE, ZIP CODE 14 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	1 00/	36/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	mg PO HS for apper disorder. No follow to this request was electronic record. The pharmacy reviet the recommendation "Will follow up (f/u) necessary". Docum in response to record. The pharmacy reviet "This is a duplicate or recommendation with progress note from attempt at a GDR or The pharmacy reviet 11/12/14, 12/15/14, physician response	tite stimulant and depressive up physician (MD) response documented in the paper or w dated 7/9/14, referenced of 6/4/14 and indicated: follow up] next month if tentation was lacking by MD mmendation. W dated 8/6/14, documented: of a previous in no response. There is a 6/4/14 which justified no no Remeron". Ws dated 9/11/14, 10/9/14, 1/15/15 and 2/15/15 lacked	FZ	128	Neighborhood audits will be conduled by RN Care Coordinators for 6 monand on a random basis thereafter to ensure that appropriate follow-up or pharmacy recommendations is completed. RN Care Coordinators with monitor and report their findings to Quality Assurance Committee. Date of Completion: 04/10/15	ths o on vill	
F 431 SS=D	director of nurses (Dinformation/documer review which addres consultant pharmaci. DON further verified pharmacist recommended monthly valued to the primary recommendations. 483.60(b), (d), (e) DELABEL/STORE DRU	GS & BIOLOGICALS bloy or obtain the services of st who establishes a system	F 43	31			·

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K25S11

Facility ID: 00427

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A FORT F. T. BALL

PRINTED: 03/18/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
245530			B. WING			03/05/2015	
NAME OF PROVIDER OR SUPPLIER SAMARITAN BETHANY HOME ON EIGHTH			STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROVIDENCY)			(X5) COMPLETION DATE
F 431	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			31	F431 Samaritan Bethany ensures that we employ or obtain the services of a licensed pharmacist who establishe	-	
	labeled in accordand professional principl appropriate accesso	Is used in the facility must be be with currently accepted es, and include the ry and cautionary expiration date when	·	- 1	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		
	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.				maintained and periodically reconci The medications are dated upon opening. The licensed nurses observathe expiration dates before and after	/e	
					each use, and the medications in the medication room fridge will be audion a weekly basis. An audit tool will be created to accomplish this objective and audits be conducted on an ongoing basis to	e ted will	
					ensure that expired medications are properly disposed of.		
	by: Based on observatio failed to ensure a bot testing solution) was	n and interview the facility tle of Aplisol (tuberculin discarded 30 days after has the potential to effect ents and newly hired			An all staff in-service will be held or Tuesday, March 31 to review this Pone Neighborhood staff meetings will be held and information will be distributed all staff regarding the process for proper disposal of expired medication	OC. e uted	

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Event ID: K25S11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
245530		245530	B. WING			03/05/2015	
NAME OF PROVIDER OR SUPPLIER SAMARITAN BETHANY HOME ON EIGHTH			STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901				703/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)					BE	(X5) COMPLETION DATE
	medication room on vial of Aplisol with not the presence of reginated that solution whad been accessed an open date on the have had an open dacessed, only good During medication sere abilitation medication was observed vial had been access missing. RN-B verifipast the expiration did not check for exput did check dates. The facility policy enexpiration/safe stora "Tuberculin-refrigeration opening". The Aplisol package more than 30 days sepossible oxidation ar affect potency and handle Aplisol as received.	storage review of the third floor 3/3/15, at 5:58 p.m. an open of open date was observed in istered nurse (RN)-A. It was was missing from the vial as it. RN-A verified there was not evial and indicated it should ate and once opened and if for 30 days. It to a company to a compa	F	131	Neighborhood audits will be conduby RN Care Coordinators on an one basis to ensure that appropriate disposal of expired medications are completed. RN Care Coordinators of monitor and report their findings to Clinical Mentor/Director of Nursing Date of Completion: 04/10/15	going e will o the	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: K25S11

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MAR 3 0 2015

Manestoa Department of Health Manekall

DEPARTMENT OF HEALTH AND HUMAN SERVICES F5530025

Printed: 03/06/2015 FORM APPROVED OMB NO. 0938-0391

		(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	02 - NEW		(X3) DATE SURVEY COMPLETED	
		245530)	B. WING		03/	04/2015	
	PROVIDER OR SUPPLIER				TATE, ZIP CODE			
SAMARI	TAN BETHANY HO	ME ON EIGHTH	1	H STREET STER, MN	NORTHWEST 55901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULAT OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	(X5) COMPLETION DATE		
K 000	INITIAL COMMEN	rs		K 000				
	Minnesota Departn Fire Marshal Division time of this survey, 8th, was found to b with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National I	Survey was conductionent of Public Safety on on March 04, 201 Samaritan Bethany e in substantial compats for participation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Associated Care.	, State 5. At the Home on pliance n e 2000 ciation					
	3-story building with completely remode in 2012. The 2012 of Type II(222) cons is a 6-story building 2011 addition was of	Home on 8th, the on partial basement will to meet requirement addition was determined to be of the This facility will be	nts for new nined to be addition nt. The					
	fire alarm system w detection, resident	prinklered. The facilition in the prinklered. The facilition is made spaces on the prinkle for automatical for	e pen to the				Manufacture (Manufacture (Manuf	
		apacity of 182 beds as at the time of the su						

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.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 4417

March 18, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5530026

Dear Ms. Jacobs:

The above facility was surveyed on March 2, 2015 through March 5, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction

Samaritan Bethany Home On Eighth March 18, 2015 Page 2 and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00427 03/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST SAMARITAN BETHANY HOME ON EIGHTH **ROCHESTER, MN 55901** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** On March 2, 3, 4 and 5, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Minnesota Department of Health LABORATØRYDJÁECTÓR'S ØR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE (X6) DATE

Minneso	ota Department of He	ealth			1 Of tivi	ALTROVED
STATEMEN AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION a:	(X3) DATE	SURVEY PLETED
		00427	B. WING		03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	CON EIGHTH	STREET NO TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	Certification Progra MN 55164-0900	m, P.O. Box 64900 St. Paul,				
	the State Licensing federal software. Ta	nent of Health is documenting Correction Orders using ag numbers have been ota state statutes/rules for				
	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.					
	FOURTH COLUMN "PROVIDER'S PLAI	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY.				
	PLAN OF CORREC	UIREMENT TO SUBMIT A TION FOR VIOLATIONS OF E STATUTES/RULES.				
2 302	MN State Statute 14	14.6503 Alzheimer's disease	2 302			

or related disorder train

DISORDER TRAINING: MN St. Statute 144.6503

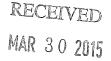
ALZHEIMER'S DISEASE OR RELATED

(a) If a nursing facility serves persons with

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If continuation sheet 2 of 33



Minneso	ota Department of He	ealth			FORM	APPROVED
STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		00427	B. WING		03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SAMARI	ITAN BETHANY HOME	E ON EIGHTH	STREET NO TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 302	a summada i idili pa	ge 2	2 302			
	segregated or generate staff and their supervisor care. (b) Areas of require (1) an explanation or related disorders; (2) assistance with a (3) problem solving and (4) communication s (c) The facility shall written or electronic training program, the trained, the frequency topics covered.	of Alzheimer's disease and activities of daily living; with challenging behaviors;				

facility.

Findings include: Review of the facility information provided from the CMS 672 federal form, it revealed the facility had 60 residents diagnosed with dementia. The director of nurses (DON) provided a list of new employees hired on and after March 12, 2014 and a list of employees hired prior to that

This MN Requirement is not met as evidenced

Based on interview and document review, the facility failed to ensure that the facility 's direct care staff and their supervisors received the required Alzheimer 's disease or related disorder training. This had the potential to affect 60 residents diagnosed with dementia residing in the

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If continuation sheet 3 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	00427	B. WING	03/05/2015	
NAME OF PROVIDER OR SUPPLIER	STDEET AD	DDESS CITY STATE ZID CODE		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

24 - 8TH STREET NORTHWEST

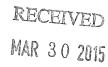
SAMARITAN BETHANY HOME ON EIGHTH 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE			
2 302	Continued From page 3	2 302					
	date. The following is a sample of employees that had not received the dementia training: (1) From list of employees hired since March 12, 2014: Neighborhood Coordinator (NC)-H; Culinary Services Director (CSD)-D; Neighborhood Coordinator (NC)-F; Homemaker (HM)-D; and Homemaker (HM)-B. (2) From list of employees hired prior to March 12, 2014: Caregiver (C)-C; Registered Nurse (RN)-E; Homemaker (HM)-L; Registered Nurse (RN)-F; and Homemaker (HM)-M. During an interview on 3/3/15 at 5:00 p.m. the director of nurses (DON) stated that it was the responsibility of the neighborhood coordinators to monitor/track in-services of their employees. The DON stated that no one person was doing the tracking and that she felt that this needed to change. The DON confirmed that some of the employees had not yet completed the dementia training. The DON provided documentation and stated that 115 employees were hired on or after 3/3/14 and of those employees only 57 had received dementia training. The DON stated there were 229 employees hired prior to 3/3/14 and of those, only 65 had documented dementia training.						
	During an interview on 3/5/15 at 2:53 p.m. the DON stated that they had no policy related to dementia training of their staff.		•				
Winnesota Do	SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review and revise current policies and procedures on dementia training for employees to ensure timely training is accomplished. The administrator, director of nursing or designee could perform audits on dementia training to ensure compliance.						
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00427	B. WING	03/05/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAMARITAN BETHANY HOME ON EIGHTH

24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

	ROCHES	ΓER, MN 55	901	
(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) COMPLETE DATE
2 302	Continued From page 4	2 302		
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use	2 565		
	Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow the plan of care related to the nessassary grooming and hygiene assistance for 2 of 3 dependent residents (R168, R189) reviewed for activities of daily living.			
	Findings include: R168's quarterly Minimum Data Set (MDS) dated 2/10/15, revealed diagnoses including congestive heart failure and depression, had severe cognitive impairment and required extensive assist of one staff for personal hygiene.			
	R168's care plan with a revision date of 5/23/14, revealed R168 required assist of one staff with personal hygiene care.			
	R168 was observed on 3/3/15, at 5:41 p.m. with several facial hairs located around the chin and upper lip. The following afternoon, on 3/4/15 at 3:26 p.m., R168 was observed to have several facial hairs around her chin and upper lip. On			
innesota De	partment of Health			

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If continuation sheet 5 of 33



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION :	1 ' '	E SURVEY PLETED
		00427	B. WING		02/	0E/201E
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	03/0	05/2015
	TAN BETHANY HOME	04 OTH 6	STREET NO			
SAMANI	TAN BETHANT HOWE	ROCHES"	ΓER, MN 55	901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	3/5/15, at 12:30 p.n remained evident of the control of the contro	n. it was noted that facial hairs in R168's chin and upper lip. c.m. caregiver (C)-A stated was generally done on a bathing when staff assist residents he day. C-A stated that when growth is noticed or for some during morning cares, assist with facial air removal verified R168 was dependent of facial hair, verified her bathing and that R168 had facial hair and upper lip. c.m. neighborhood nurse and the coeptable. NN-D stated that the upon staff for hair removal averbable. NN-D stated that the upon staff for hair removal ave been removed. NN-D the plan of care indicated R168 with personal hygiene which removal. c.m. the clinical mentor (CM) defemale residents to be hair removal unless it is care beference not to have facial hair and R168 was dependent on the emoval and verified the staff cility policy for facial hair and revealed R189 had long light brown debris build up sof the first and second	2 565			

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If continuation sheet 6 of 33

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00427	B. WING	03/05/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAMARITAN BETHANY HOME ON FIGHTH

24 - 8TH STREET NORTHWEST

(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) COMPLETE DATE
2 565	Continued From page 6	2 565		
	admitted on 10/2/14, and included diagnoses of but not limited to dementia and anxiety. R189's quarterly MDS dated 1/6/15, indicated severe cognitive impairment with a Brief Interview of Mental status (BIMS) score of 5/15 and required extensive assist from one staff to perform hygiene and grooming tasks. R189's most recent updated care plan on 3/5/15, informed staff of the cognitive deficit related to dementia, the history of carpal tunnel, the admission to hospice on 10/2/2014 and the anxiety diagnosis. The care plan directed staff to provide assistance for grooming and hygiene. When interviewed on 3/5/15, at 8:56 a.m. licensed practical nurse (LPN)-A verified R189's nails were dirty and stated that nail care was to be provided on bath days, which was scheduled Mondays by facility staff and provided on Thursdays by the hospice staff. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure residents receive assistance with activities of daily living as determined necessary by their individualized plan of care. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance.			
2 830	TIME PERIOD FOR CORRECTION: Twenty-one (14) days. MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		
	Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and			

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
·····		00427	B. WING		03/0	05/2015
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON FIGHTH 24 -	ET ADDRESS, CITY, 8TH STREET NC HESTER, MN 5	PRTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	supervision based on d preferences as identified resident assessment and scribed in parts 4658.0400 ing home resident must be possible unless there is a he attending physician that in bed or the resident	and out			
	by: Based on observati review, the facility fa residents received p 2 of 3 residents (R1 activities of daily livi	ent is not met as evidence on, interview and docume ailed to ensure dependent personal hygiene services 68, R189) reviewed for ing.	nt			
	2/10/15, revealed of heart failure and de cognitive impairmer assist of one staff for	nimum Data Set (MDS) da diagnoses including conge- pression, had severe nt and required extensive or personal hygiene.	stive			
	revealed R168 requipersonal hygiene ca R168 was observed several facial hairs lupper lip. The follow 3:26 p.m., R168 was facial hairs around hairs around hairs around hairs around hairs, at 12:30 p.m.	th a revision date of 5/23/ lired assist of one staff with are. If on 3/3/15, at 5:41 p.m. whice are around the chin are wing afternoon, on 3/4/15, sobserved to have severated the chin and upper lip. On the chin and upper lip. It was noted that facial has R168's chin and upper lip.	n ith id at al			

(X2) MULTIPLE CONSTRUCTION

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING 00427 03/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST SAMARITAN BETHANY HOME ON EIGHTH ROCHESTER, MN 55901 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 8 2830 On 3/5/15 at 2:06 p.m. caregiver (C)-A stated facial hair removal was generally done on a bath day or in the morning when staff assist residents in preparation for the day. C-A stated that when resident facial hair growth is noticed or for some reason was missed during morning cares, evening staff would assist with facial air removal when needed. C-A verified R168 was dependent on staff for removal of facial hair, verified her bath day had been today and that R168 had facial hair located on her chin and upper lip.

On 3/5/15 at 2:13 p.m. neighborhood nurse (NN)-D verified R168 had several facial hairs across her chin and upper lip and confirmed the facial hair was unacceptable. NN-D stated that R168 was dependent upon staff for hair removal and the it should have been removed. NN-D verified confirmed the plan of care indicated R168 required assistance with personal hygiene which includes facial hair removal.

On 3/5/15 at 3:41 p.m. the clinical mentor (CM) stated she expected female residents to be assisted with facial hair removal unless it is care planned as their preference not to have facial hair removed, CM verified R168 was dependent on staff for facial hair removal and verified the staff did not follow the facility policy for facial hair trimming.

The Facial Hair Trimming policy with a review date of 3-11 read, "Facial hair of all residents will be shaved, tweezed, or neatly trimmed as necessary to maintain dignity...Female residents: We will not shave every female resident with facial hair. At times it will be appropriate to use tweezers to remove 1 or 2 long hairs. Nursing staff will note and remove facial hair as needed

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00427	B. WING		03/0	5/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	- ()N FIGHTH	STREET NO TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 9	2 830			
	as part of daily groo	oming"				
	The director of nurs and procedure that would provide coord residents receiving healing of pressure	THOD OF CORRECTION: sing could implement a policy would ensure the facility dinated care and servies for hospice to promote the ulcers. R CORRECTION: Twenty-one				
2 905	MN Rule 4658.0525	5 Subp. 4 Rehab - Positioning	2 905			
	positioned in good I of residents unable must be changed a including periods of been put to bed for has documented th hours during this time.	g. Residents must be body alignment. The position to change their own position t least every two hours, it ime after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or rdered a different interval.				
	by:	ent is not met as evidenced				

pressure ulcers.

Findings include:

Record review revealed R189 was admitted (10/2/14) with an unstageable pressure ulcer (PU) on the thoracic spine (upper back) that measured 1 centimeter (cm) in length by 1 cm in width by 0.5 cm in depth (1.0 cm x 1.0 cm x 0.5

review the facility failed to provide care and services to promote the healing of a pressure ulcer for 1 of 3 residents(R189) reviewed for

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AND PLAN OF CORRECTION I IDENTIFICATION NUMBER.		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00427	B. WING		03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CAMAD	ITAN DETUANY HOLE	24 - 8TH 9	STREET NOI			
SAMAR	ITAN BETHANY HOME	ON EIGHTH	TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 905	Continued From pa	age 10	2 905			
	cm) with no undern measurements wer cm of tunneling. R an infection in the v treated with antibior R189's facility admi admission date of 1 included but not lim atrial fibrillation, chrosteoporosis, and pR189 was enrolled 10/2/14. R189's quarterly Mi 1/6/15, indicated sewith a Brief Intervies core of 3/15 and retwo staff members personal hygiene at two staff for transfe MDS indicated a prochair, pressure reduntrition or hydration used to manage skitch The hospice enrolling treatment dated 10/2 change every sever treatment order corphysician orders in change (Mepilex both Aquacel foam). R189's PU monitori 10/2/14, indicated the was Aquacel foam a wound were 1.0 cm	nining; on 2/10/15 e 1 cm x 1 cm x 0.1 cm with 2 189 subsequently developed yound on 3/2/15 and was tics. ssion record indicated an 0/2/14, with diagnoses that ited to dementia, anxiety, onic kidney disease stage 3, pressure ulcer on upper back, in hospice when admitted on nimum Data Set (MDS) dated overe cognitive impairment w for Mental Status (BIMS) equired extensive assist from for bed mobility, toileting and and was totally dependent on ris between surfaces. The essure reducing device for ucing device for bed, and in intervention were being				

wound measurements had increased to 1.0 cm x 1.0 cm x 0.7 cm with sinus tunneling of 2 cm; wound treatment reflected a change to Aquacel Ag with Aquacel foam to cover. Documentation on the 2/10/15, flow sheet indicated no change in

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(***, *********************************		(X3) DATE SURVEY COMPLETED
	00427	B. WING	03/05/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

24 - 8TH STREET NORTHWEST

(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) COMPLETE DATE
2 905	Continued From page 11	2 905		
	measurements of the PU (11/26/14 to 2/10/15). Signed physician orders for wound care dated 11/28/15, were "Aquacel AG to back wound, change daily". Singed physician orders for wound care dated 2/11/15, remained the same, "Aquacel AG to back wound, change daily". Despite lack of improvement in the wound after almost 3 months with the same dressing/treatment, no further changes of dressing treatments were made. R189's initial Braden scale dated 10/2/14, showed a score of 14 indicating moderate risk for developing pressure ulcers. The corresponding tissue tolerance test dated 10/2/14 read, "Resident did not show redness while lying/sitting up to 3 hours. Will reposition resident every 3 hours with lying/sitting at this time. Will change with status change of resident". The assessment indicated R189 could have sustained pressure of 3 hours to the pressure ulcer area. The repositioning schedule identified on the care plan was identified as every 2 hour position change. R189's Braden scales performed on 10/12/14, 10/19/14, and 10/25/14 all revealed a score of 13 indicating a borderline score of moderate to high risk for pressure ulcers. Subsequently, the care plan and treatments remained the same. R189's care plan dated 10/15/14 indicated R189 used a Broda chair that helped with repositioning as it reclined, provide 8 ounces of Boost (nutritional supplement) three times a day to help heal pressure ulcer to spine. The care plan also included "I am at risk for skin breakdownI came here with unstageable pressure ulcer to my thoracic spine and had one on my coccyx that started 1/19/15 and healed over 2/2/15. The care plan instructed staff to follow facility protocols for prevention/treatment of skin breakdown,			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00427	B. WING	03/05/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

24 - 8TH STREET NORTHWEST

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) COMPLETE DATE		
2 905	Continued From page 12	2 905				
	cares/baths " and instructed staff to notify physician if pressure ulcer did not seem to be healing. Care plan instructed staff to see the treatment administration record (TAR) for pressure ulcer treatment. R189's TAR indicated the treatment of Aquacel Ag was initiated on 11/6/14; the order read "Aquacel Ag to back wound. Change daily every day shift for altered skin integrity." Documentation reflected treatment was performed daily. A nursing note dated 2/1/15 read "sleep in her Broda chair most nights." A nursing note dated 3/2/15 read, "Resident's wound on mid back has small amount of greenish drainage and foul odor ". A follow up nursing note written on the same day a physician order for Augmentin twice per day for ten days for wound infection. During an observation on 3/3/15, at 2:24 p.m. R189 was sitting on the edge of bed. The mattress was not a specialty mattress (air, sand, or alternating air). There was a body pillow on the side of the bed located up against the wall. During an observation on 3/5/15, at 8:35 a.m. R189 was sitting in Broda chair up right at the dining room table. There was a pillow in place under her right arm for positioning. R189 was noted to have curvature of the spine consistent with kyphosis. During an observation on 3/5/15, at 8:51 a.m. R189 was sitting in front of a window in the sunshine. A pillow was placed behind her back. Chair position was leaned back approximately 30 degrees, which would put pressure to the wound on the spine. During an observation on 3/5/15, at 10:41 a.m. R189 was sitting in Broda chair in main lobby area watching the television show MASH. The Broda chair was reclined approximately 30					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	00427	B. WING	03/05/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

24 - 8TH STREET NORTHWEST

SAMARI	IAN DETRANT RUME UN EIGHTR	STREET NOF FER, MN 559		
(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) COMPLETE DATE
2 905	Continued From page 13	2 905		
	degrees; a pillow was placed behind the back. During an interview on 3/5/15, at 10:42 a.m. homemaker (HM)-H stated R189 had been in the chair since 7:30 a.m. (over 3 hours). During an interview on 3/5/15, at 10:45 a.m. HM-O stated the last time R189 had been repositioned was about 1.5 hours ago. When asked how R189 was repositioned HM-O stated they had repositioned the pillow from underneath her right arm to behind her back and the chair was leaned back. HM-O then demonstrated how the Broda chair could be moved up and down to change resident positions. HM-O also explained R189 was to be repositioned every two hours however, sometimes it ended being every 2.5 hours when staff was busy. HM-O further explained the pillow provides a reposition change at every meal time. During an observation on 3/5/15, at 11:26 a.m. R189 was sitting in the dining room. During an interview on 3/5/15, at 11:29 a.m. registered nurse (RN)-C explained repositioning of R189 consisted of adjusting the Broda chair to a different degree, or R189 gets laid down. RN-C further explained R189 was repositioned every 2 hours. RN-C stated as R189 is completely incontinent, she was checked and changed every 2 hours which coincided with repositioning schedule. RN-C also explained the Broda chairs made it easy as staff can just change the position to offload the pressure areas. During an interview on 3/5/15, at 2:01 hospice registered nurse (HRN)-N indicated R189 was on an every 2 hours repositioning schedule and as needed. When questioned what constituted repositioning for R189, HRN-N explained the Broda chair had the ability to recline and R189 can be repositioned from side to side with the use of a pillow. When asked how pressure is relieved from the pressure points while the resident is			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAMARI	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) COMPLETE DATE		
2 905	Continued From page 14	2 905				
	located in the chair, HRN-N responded that the Broda chair is a pressure relieving chair. HRN-N stated, "From my understanding she (R189) does not have to be removed from the chair to alleviate pressure on pressure points because of the way the chair [position] can be changed ". HRN-N indicated the DME provider educated staff how to use the chair and offload pressure to pressure areas. HRN-N stated that wound tunneling was likely from disease process and poor intake. When questioned what revisions were implemented to improve the PU to prevent further decline, HRN-N stated "she was started on a protein shake [according to physician orders, protein shake was initiated on 11/13/14] and was given a Broda chair [Broda chair was given to R189 on 10/2/14], and I believe they have done different dressing changes for her back; they had been using gauze to cover now they are using opti-foam [inconsistent with what the orders indicated], I think she is repositioned more frequently putting the pillows underneath her arms because she leans to one side, and we are trying to get her to sit up straight ". HRN-N stated hourly repositioning had not been initiated and indicated staff should not have placed pillows behind back. When interviewed on 3/5/15, at 2:42 p.m. durable medical equipment provider representative (DME-rep) who provided the Broda chair, stated the chair changes to different positions but does not reduce pressure, It can provide pressure relief to a pressure area dependent upon the position of the chair, staff are instructed only on the basic mechanics of the chair. DME-rep verified they do not instruct staff on how to specifically relieve pressure for an individual resident. Facility policy entitled "skin/wound care policies"					
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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
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24 - 8TH STREET NORTHWEST

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2 905	last reviewed January 2008 included, "A clean ulcer should exhibit some evidence of healing within 2 weeks. Consider re-assessment if there is no improvement or an ulcer increases in size, include all preventative measures that involve positioning, avoid positioning residents on pressure ulcers, provide all residents with a tempurpedic mattresses, the clinical supervisor and MD/NP will collaborate for other modalities for stage II-IV pressure ulcers that don't respond to conventional therapy, pressure ulcers may be colonized, minimize this through effective wound cleaning and debridement, if foul odor or purulence develops, cleanse more frequently. "SUGGESTED METHOD OF CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the need for assistance with position related to pressure ulcers. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures and importance of documentation. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one	2 905		
2 920	(14) days. MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	2 920		

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Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:**

(X3) DATE SURVEY COMPLETED

00427

B. WING ___

03/05/2015

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

A. BUILDING: ____

24 - 8TH STREET NORTHWEST

(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) COMPLETE DATE
2 920	Continued From page 16	2 920		
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dependent residents received personal hygiene services for 2 of 3 residents (R168, R189) reviewed for activities of daily living.			
	Findings Include:			
	R168's quarterly Minimum Data Set (MDS) dated 2/10/15, revealed diagnoses including congestive heart failure and depression, had severe cognitive impairment and required extensive assist of one staff for personal hygiene.			
	R168's care plan with a revision date of 5/23/14, revealed R168 required assist of one staff with personal hygiene care.			
	R168 was observed on 3/3/15, at 5:41 p.m. with several facial hairs located around the chin and upper lip. The following afternoon, on 3/4/15 at 3:26 p.m., R168 was observed to have several facial hairs around her chin and upper lip. On 3/5/15, at 12:30 p.m. it was noted that facial hairs remained evident on R168's chin and upper lip.			
	On 3/5/15 at 2:06 p.m. caregiver (C)-A stated facial hair removal was generally done on a bath day or in the morning when staff assist residents in preparation for the day. C-A stated that when resident facial hair growth is noticed or for some reason was missed during morning cares, evening staff would assist with facial air removal when needed. C-A verified R168 was dependent on staff for removal of facial hair, verified her bath day had been today and that R168 had facial hair located on her chin and upper lip.			

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SAMARI	TAN BETHANY HOME	- CNV FIG-BIB	ΓER, MN 55			
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2 920	Continued From pa	ge 17	2 920			
	On 3/5/15 at 2:13 n	.m. neighborhood nurse				
	(NN)-D varified R16	68 had several facial hairs				
	across her chin and	d upper lip and confirmed the				
	facial hair was upon	cceptable. NN-D stated that				
		nt upon staff for hair removal				
		ive been removed. NN-D				
		he plan of care indicated R168				
	required assistance	with personal hygiene which				
	includes facial hair	removal.				
	0-0/5/45 -+0-44					
		.m. the clinical mentor (CM)				
		d female residents to be				
		hair removal unless it is care				
		eference not to have facial hair				
		ed R168 was dependent on				
		emoval and verified the staff				
	did not follow the fa	cility policy for facial hair				
	trimming.					
	The Facial Hair Trin	nming policy with a review				
		Facial hair of all residents will				
		d, or neatly trimmed as				
	necessary to mainta	ain dignityFemale residents:				
	We will not shave e	very female resident with		}		
	facial hair. At times	it will be appropriate to use				
		1 or 2 long hairs. Nursing				
		emove facial hair as needed		·		
	as part of daily groo					
	as pair or daily groo					
	Observations made	on 3/2/15, at 2:28 p.m. and				
		m. revealed R189 had long				
	finger naile with dry	light brown debris build up				
	underneath the polit	s of the first and second			i	
	fingers on both hand				ı	
		on record indicated R189 was			I	
		, and included diagnoses of				
	but not limited to de					
		OS dated 1/6/15, indicated				
		pairment with a Brief Interview				
		MS) score of 5/15 and				

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STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP	E CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMB	BER:	A. BUILDING		COMF	COMPLETED	
		00427		B. WING		03/0	05/2015	
NAME OF	PROVIDER OR SUPPLIER	S	TREET AD	DRESS, CITY,	STATE, ZIP CODE			
SAMARI	TAN BETHANY HOME	E ON EIGHTH		STREET NO				
			ROCHEST	TER, MN 55	901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 920	Continued From pa	age 18		2 920				
	required extensive perform hygiene ar R189's most recent informed staff of the dementia, the histo admission to hospid anxiety diagnosis. It provide assistance When interviewed dicensed practical mails were dirty and be provided on bath Mondays by facility Thursdays by the h A facility policy entit reviewed July 2010 nail bed, skin betwee care needed " Ton how often nail care	assist from one staff to a grooming tasks. It updated care plan on a cognitive deficit related by of carpal tunnel, the care plan directed a for grooming and hygie on 3/5/15, at 8:56 a.m. aurse (LPN)-A verified R I stated that nail care we hays, which was sche staff and provided on	3/5/15, ed to e staff to ene. 1189's vas to duled h " last sident's nail irection	2 320				
	The DON or design as necessary the poregarding the need of daily living. The provide training for policies and proced (s) could monitor to	THOD OF CORRECTIOnee(s) could review and colicies and procedures for assistance with addressistance with addressistance (s) coall appropriate staff on larges. The DON or designates are and appropriate care.	revise tivities ould these gnee					
	TIME PERIOD FOF (21) days.	R CORRECTION: Twen	ity-one					
21095	MN Rule 4658.0650 Storage of Nonperis) Subp. 4 Food Supplie shable food	s;	21095				
		f nonperishable food. erishable food must be	stored					
Ainnocoto Do	enartment of Health							

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03/05/2015

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ____

NAME OF PROVIDER OR SUPPLIER

00427

STREET ADDRESS, CITY, STATE, ZIP CODE

B. WING _

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) COMPLETE DATE				
21095	Continued From page 19	21095						
	a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited.							
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure kitchenette refrigerator foods were dated when opened and expired foods removed from use for 5 of 13 kitchenette refrigerators reviewed.							
	Findings include:							
	During tour of the facility kitchenettes, the following were observed: (1) On 3/2/15 at 9:30 a.m., 6th floor-Quarry Hills neighborhood-one 8 ounce (oz.) glass of shake with no date; one plastic container of mixed peas and carrots, with resident name, undated; one plastic container of beef and gravy, with resident name, undated; one small package of aluminum foil with three sausage links, foil was dated 2/17. During interview at that time, registered nurse (RN)-C verified the undated foods, outdated foods, and foods not dated when opened. During interview on 3/2/15, at 9:50 a.m., culinary services director (CSD) verified the undated foods, outdated foods, and foods not dated when							
innesota De	epartment of Health							

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. BOILBING			
	771	00427	B. WING		03/0	5/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SAMAR	TAN BETHANY HOME	ON EIGHTH	STREET NO TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21095	Continued From pa	ge 20	21095		YYANGATT	
21095	opened. CSD stated dated when opened 2/17, should be rem (2) On 3/2/15 at 10 Creek House neighham in plastic bag of at that time, homen undated and outdat policy to keep foods and then dispose. Foutdated. (3) On 3/2/15 at 10 Club House neighborincluding French, the to 1/4 remained in e1 opened gallon of boiled eggs; 12 passhell; three plastic sausage in each; or and bacon pieces; a opened. During inteneighborhood coord discolored cheese a verified not aware of labeled jelato. (4) On 3/2/15 at 10 Northgate House neighborh, ranch, thou	d he expected foods to be and sausage links dated hoved. :40 a.m., 4th floorCascade borhood-four thin slices of dated 2/22. During interview haker (HM)-G verified the ed foods. HM-G stated facility in refrigerator for one week dM-G verified the ham was :30 a.m., 3rd floor Country perhood-three salad dressings ousand island, and Italian, 1/2 each, no date of when opened; milk, 1/2 remained; 4 hard teurized eggs, uncooked in bags with two uncooked he plastic bag of mixed ham all foods with no date when erview at that time, dinator (NC)-F verified the and undated foods. NC-F f what food was in container	21095			
	shell; lettuce in a pl wilted leaves, all foc opened. During into verified the foods w (5) On 3/2/15 at 10 Heights House neig	astic container with some ods without dates when erview at that time, HM-N ith no date when opened. :40 a.m., 2nd floorSalem hborhood-5 pasteurized eggs, nell; all foods without dates				

(X2) MULTIPLE CONSTRUCTION

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING: B. WING _ 00427 03/05/2015 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) COMPLETI DATE			
21095	Continued From page 21	21095					
	when opened. During interview at that time, HM-N verified the foods with no date when opened.						
	Document review of facility policy Dating and Labeling Foods, dated 3/16/11, revealed the following: "Samaritan Bethany will make every effort to prevent foodborne illness through dating and labeling of foods in both the main kitchen and household kitchens. All containers must be labeled and dated with contents once items are EITHER opened or removed from their original containers. All leftover refrigerated foods are thrown away after 5 days. (This applies to both facility leftovers and any foods brought in by residents). Note: This does not apply to condiments such as ketchup, salad dressing, etc. These items should be dated and rotated on a first in, first out basis and thrown away as they are emptied. It is the responsibility of the chef/supervisor in the main kitchen to check the cooler weekly for items that should be thrown away. It is the responsibility of the homemaker in the household to check the refrigerator for such items."						
	During interview on 3/2/15, at 9:50 a.m., culinary services director (CSD) stated he expected foods to be dated when opened.						
	SUGGESTED METHOD OF CORRECTION: The dietary director could review and revise policies to ensure kitchenette refrigerator foods were dated when opened and expired foods removed from use. Education could be provided and audits performed to ensure compliance.						
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						

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FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: ___ B. WING _ 00427 03/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST SAMARITAN BETHANY HOME ON EIGHTH

(VA) ID	SHMMADY STATEMENT OF DEFICIENCIES		DDOVIDEDIO DI ANI OF CORDECTION	
(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) COMPLETE DATE
21426	Continued From page 22	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		
	 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. 			
	This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to complete a tuberculosis (TB) symptom screening and failed to specify the induration of the results for Tuberculin Skin Tests (TST) for 2 of 5 employees a nursing coordinator (NC)-K and a caregiver (C)-B reviewed and failed to specify the reaction of the results of the TST for 1 of 5 employee, (C)-B reviewed. Findings include:			

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STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOWIDER.	A. BUILDING	:	COMP	LETED
		00427	B. WING		03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH	STREET NO TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 23	21426			
	Review of employed Personnel records to (NC)-K, with a hire screening was not de-	e TSTs revealed the following: for neighborhood coordinator date of 2/3/15, revealed a TB completed; and the record ion of the induration of the 2nd				
	date of 12/12/14, re not completed; the administered on 12/	for caregiver (C)-B, with a hire vealed a TB screening was 2nd step TST was /12/14; however, the record e second 2nd step TST was				
	verified the above e screening documen NC-K record lacked induration of the 2nd employee C-B lacked	a.m. clinical mentor (CM) imployees did not have a TB ited upon hire, that employee I documentation of the d step TST and the record of ed evidence the second 2nd to determine the skin				
	review date of 2-13 employees are free hired workers will be [tuberculin skin test] step, which must be beginning work. 2. C evaluated4. If the	fection Control Program with a read, "1. To ensure all from M. tuberculosis all newly e tested using the 2 step TST . They will receive the first e read negative before Current symptoms will be results from the first step is d step will be administered 2-3				
	director of nursing c responsible for TB c and requirements in	HOD OF CORRECTION: The could inservice all staff on the most current standards regards to TB control.				
	TIME PERIOD FOR	CORRECTION: Twenty One				

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Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAMARITAN BETHANY HOME ON EIGHTH

00427

24 - 8TH STREET NORTHWEST

JAMANI	ROCHEST	TER, MN 55	901	
(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) COMPLETE DATE
21426	Continued From page 24	21426		
	(21) days.			
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate	21530		
	justification for the order and if the attending physician does not change the order, the matter			

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PRINTED: 03/18/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING 00427 03/05/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST SAMARITAN BETHANY HOME ON EIGHTH **ROCHESTER, MN 55901** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) 21530 Continued From page 25 21530 must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced Based on interview and document review the facility failed to ensure the physician acted upon the recommendation documented by the consulting pharmacist for 1 of 5 residents (R 178) reviewed for unnecessary medications.

Findings include:

R178, admitted on 5/30/12 with diagnoses listed on the physician progress notes which included: aftercare healing traumatic fracture lower arm. hypothyroidism, anxiety state, depressive disorder, and mild cognitive impairment from electronic progress notes.

R178's most recent Minimal Data Set (MDS) dated 1/28/15, indicated a Brief Interview of Mental Status (BIMS) of 10/15, which indicated moderate cognitive impairment. Review of the signed physician orders dated 3/19/14, indicated that Remeron 15 milligrams (mg) PO (orally) QD (every day) was initiated for appetite stimulant related to depressive disorder.

Documented consultant pharmacy recommendations were reviewed from June 2014 until February 2015. The pharmacist review dated 6/4/14, had a recommendation for a gradual dose reduction (GDR) for Remeron 15mg PO HS for appetite stimulant and depressive

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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00427		B. WING		03/	05/2015
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH	24 - 8TH S	DRESS, CITY, STREET NO FER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE ' MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21530	disorder. No follow to this request was electronic record. To 7/9/14, referenced and indicated: "Will month if necessary" by MD in response. The pharmacy revies "This is a duplicate recommendation wiprogress note from attempt at a GDR of the pharmacy revies 11/12/14, 12/15/14, physician response recommendation for of Remeron. When interviewed of director of nurses (Einformation/docume review which address consultant pharmacy consultant pharmacy pharmacist recommendations. SUGGESTED MET The administrator, of consulting pharmacy recommended up of pharmacy	up physician (MD) redocumented in the place of the pharmacy review the recommendation follow up (f/u) [follow]. Documentation was to recommendation. Ew dated 8/6/14, doct of a previous ith no response. The 6/4/14 which justified in Remeron. Ews dated 9/11/14, 10 1/15/15 and 2/15/15	aper or a dated of 6/4/14 are up] next as lacking umented: are is a dono 0/9/14, lacked inued use o.m. the ofurther efor to the s. The lacked up on the lack	21530			

(X2) MULTIPLE CONSTRUCTION

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		LIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION	NUMBER:	A. BUILDING	:	COMF	PLETED
		00427		B. WING		03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
CAMADI	TAN BETHANY HOME	ON EIGHTH	24 - 8TH S	STREET NO	RTHWEST		
JAMANI	TAN BETHANT HOWE	ON EIGHTH	ROCHES	ΓER, MN 55	901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCY MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21530	Continued From pa	ige 27		21530		-	
	TIME PERIOD FOR (21) days.	R CORRECTION:	Twenty-one				
21535	MN Rule4658.1315 Drug Usage; Gener		necessary	21535			
	therapy; B. for excessiv C. without adec	unnecessary drugs is any drug when used dose, including due to discuss any drug when used dose, including due to indications for a dose should be reduced a dose should be	. An sed: uplicate drug or its use; or asequences uced or v required in ust comply delines for section State eyors for by the rvices, April 1992. ence. It is ry loan				
	This MN Requirements by: Based on interview facility failed to ensure regimen is free from residents (R 178) remedications.	and document rev ure each resident's n unnecessary dru	iew the drug gs for 1 of 5				

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	OF CORRECTION	(X1) PHOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION ::	(X3) DATE	E SURVEY PLETED
		00427	B. WING		03/0	05/2015
	PROVIDER OR SUPPLIER	ON EIGHTH 24 - 8TH S	DRESS, CITY, STREET NO TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY).	LD BE	(X5) COMPLETE DATE
21535	Findings include: R178, admitted on 8 on the physician proaftercare healing trathypothyroidism, and disorder, and mild delectronic progress R178's most recent dated 1/28/15, indice Mental Status (BIMS moderate cognitive signed physician or that Remeron 15mg appetite stimulant results appetite stimulant results appeared by for Remeron stimulant and depression of the commendation for (GDR) for Remeron stimulant and depression to this require paper or electronic and dated 7/9/14, refere 6/4/14 and indicated month if necessary by MD in response to the pharmacy review da "This is a duplicate of recommendation with progress note from attempt at a GDR of afficiency and the commendation with the comme	5/30/12 with diagnoses listed orgress notes which included: aumatic fracture lower arm, ciety state, depressive cognitive impairment from notes. Minimal Data Set (MDS) atted a Brief Interview of S) of 10/15, which indicated impairment. Review of the ders dated 3/19/14, indicated impairment. Review of the ders dated 3/19/14, indicated in PO QD was initiated for elated to depressive disorder. PO QD was initiated for elated to depressive disorder. PO QD was initiated for elated to depressive disorder. PO QD was initiated for elated to depressive disorder. PO QD was initiated for elated to depressive disorder. PO QD was initiated for elated 6/4/14, had a ra gradual dose reduction 15mg PO HS for appetite essive disorder. No MD puest was documented in the record. The pharmacy review need the recommendation of d: "Will follow up (f/u) next. Documentation was lacking to recommendation. The atted 8/6/14, documented: of a previous the no response. There is a 6/4/14 which justified no no Remeron".	21535			
	The pharmacy revie	ws dated 9/11/14, 10/9/14,				

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11/12/14, 12/15/14, 1/15/15 and 2/15/15- lacked

recommendation for GDR for the continued use

physician response to the pharmacist

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMF	SURVEY
	757	00427	B. WING		03/0	05/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	: ON EIGHTH	STREET NO TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21535	Continued From pa	ge 29	21535			
	of Remeron.					
	During an interview on 03/05/15, at 11:19 a.m. licensed practical nurse (LPN)- A stated R128 had received Remeron for the past year.					
	director of nurses (I information/docume review which addre consultant pharmac DON further verified pharmacist recomm scheduled monthly	on 03/05/15, at 2:35 p.m. the DON) verified that no further entation was available for ssed MD responses to the cist recommendations. The d that she receives the nendations following the visits, which are reviewed and y care MD for follow up on the				
	The administrator, of consulting pharmac policies and proced up of pharmacy rec	THOD OF CORRECTION: director of nursing and sist could review and revise ures to ensure proper follow ommendations. The director nee could monitor the follow up				

by: Based on observation and interview the facility

regulations.

(21) days.

of pharmacy recommendations on a regular basis to ensure compliance with state and federal

TIME PERIOD FOR CORRECTION: Twenty-one

Drugs used in the nursing home must be labeled

This MN Requirement is not met as evidenced

21620 MN Rule 4658.1345 Labeling of Drugs

in accordance with part 6800.6300.

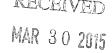
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(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			
		00427	B. WING _		03/	05/2015
NAME OF	PROVIDER OR SUPPLIER		EET ADDRESS, CITY			
SAMARI	ITAN BETHANY HOME	· ()N FIGHTH	8TH STREET N CHESTER, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21620	Continued From pa	ge 30	21620			
	testing solution) wa being opened. This	ottle of Aplisol (tuberculin s discarded 30 days after s has the potential to effec dents and newly hired				
	medication room or vial of Aplisol with n the presence of reg noted that solution whad been accessed an open date on the have had an open of accessed, only good During medication is rehabilitation medical Aplisol with an expiritation was observed vial had been accessing. RN-B verification and the expiration of did not check for expiration/safe stora "Tuberculin-refrigeration/safe stora" Tuberculin-refrigeration of the Aplisol package more than 30 days apossible oxidation and affect potency and SUGGESTED MET The administrator, oconsulting pharmace	storage review of the third ation room an open vial oration date of 3/1/15 (2 dat in the presence of RN-B seed and solution was fied the date on the vial wate, and explained that the prior to administration.	open d in /as as it not uld d floor f tys . The as ney basis			

Minnesota Department of Health

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K25S11

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING:			COMPLETED					
00427		B. WING		03/	03/05/2015							
NAME OF	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	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE						
21620	Continued From page 31			21620								
	medications. Nursir necessary to the im medications proper medications. The D the pharmacist, cou regular basis to ens	portance of labe ly and discarding ON or designee ald audit medicat sure compliance.	eling g expired , along with ions on a									
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.											
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance		21695									
	Subp. 4. Housekee provide housekeepi necessary to mainta comfortable interior ceilings, registers, fi and furnishings.	ng and maintena ain a clean, orde , including walls,	ance services rly, and floors,									
	This MN Requirements by: Based on observation failed to ensure a we good repair so it could follow the second of 1 resident (R17) whad exposed foam page 1.	on and interview heelchair was m uld be cleaned p whose wheelcha	the facility aintained in roperly for 1									
	Findings include:											
	On 3/3/15, at 7:05 p in her wheelchair (w visible cracks in the also a hole in the vii the foam padding be	r/c) in her room. vinyl of both arm nyl of each armre	There were nrests and									
	During an observation 2:49 p.m. R17 was											

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED 03/05/2015						
		00427	B. WING		03/0							
NAME OF	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) COMPLETE DATE						
21695	her room. The arm display the cracks had approximately missing and the rig centimeter (cm) by exposing the foam interviewed R17 staway". R17 further sarmrest fixed as "It When interviewed registered nurse (Fmaintenance issue staff will inform ma further stated main the next day. RN-E with a resident's priand make the decis RN-B and surveyor room. RN-B confirmed of repair and surface. RN-B furtiwas utilizing was on confirmed the need have been reported. When interviewed of maintenance direct work order being sur SUGGESTED MET The facility administ and procedures to have cleanable sur designee could per compliance.	nrest on R17's w/c continued to in the vinyl. The left armrest a quarter size piece of vinyl that armrest approximately a 2 (x) 1 cm piece of vinyl missing padding beneath. When ated, "I didn't do it, I got it that stated she would like the might tear my clothes". On 3/05/15, at 4:00 p.m. RN)-B stated when there is a with one of the facility w/c's intenance to repair. RN-B tenance will usually attend to it 3 stated that if there is an issue ivate w/c the family is informed sion as to how to proceed. To observed R17's w/c in her med the armrests were in were no longer a cleanable her confirmed that the w/c R17 wned by the facility. RN-B If for repair of R17's w/c should	21695									

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