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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: K25S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00427

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245530**
2.STATE VENDOR OR MEDICAID NO.
(L2) **851843200**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **182** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	182			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 04/20/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/24/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/23/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245530	A. Building B. Wing	4/20/2015

Name of Facility	Street Address, City, State, Zip Code
SAMARITAN BETHANY HOME ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/10/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/10/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/10/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/10/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/10/2015**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **04/10/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/10/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/10/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	04/20/2015	10160	04/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/5/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K25S

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00427

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(L1) **245530**
2.STATE VENDOR OR MEDICAID NO.
(L2) **851843200**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds **182** (L17)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	182			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Josephine Hassinger, HFE NE II 04/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/23/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
05/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

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

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

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

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

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.

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.

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

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

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	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) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a wheelchair was maintained in good repair so it could be cleaned properly for 1 of 1 resident (R17) whose wheelchair armrests had exposed foam padding. Findings include: On 3/3/15, at 7:05 p.m. R17 was observed seated in her wheelchair (w/c) in her room. There were visible cracks in the vinyl of both armrests and also a hole in the vinyl of each armrest exposing the foam padding beneath. During an observation/interview on 3/05/15, at 2:49 p.m. R17 was observed seated in her w/c in	F 253	approved KMS 4-9-15 **F253** Samaritan Bethany strives to ensure that we provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Resident 17's wheelchair armrests were replaced on 03/05/15. Resident wheelchairs are washed weekly and routine observations to ensure wheelchairs are in good repair. If those areas are found defective, a maintenance work order form will be filled out. An all staff in-service will be held on Tuesday, March 31st to review this POC. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the process for washing wheelchairs and completing routine observations. Additional education will be provided as needed.	

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

Community Leader/Administrator 3/27/15

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.

RECEIVED
MAR 30 2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	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) COMPLETION DATE
F 253	Continued From page 1 her room. The armrest on R17's w/c continued to display the cracks in the vinyl. The left armrest had approximately a quarter size piece of vinyl missing and the right armrest approximately a 2 centimeter (cm) by (x) 1 cm piece of vinyl missing exposing the foam padding beneath. When interviewed R17 stated, "I didn't do it, I got it that way". R17 further stated she would like the armrest fixed as "It might tear my clothes". When interviewed on 3/05/15, at 4:00 p.m. registered nurse (RN)-B stated when there is a maintenance issue with one of the facility w/c's staff will inform maintenance to repair. RN-B further stated maintenance will usually attend to it the next day. RN-B stated that if there is an issue with a resident's private w/c the family is informed and make the decision as to how to proceed. RN-B and surveyor observed R17's w/c in her room. RN-B confirmed the armrests were in need of repair and were no longer a cleanable surface. RN-B further confirmed that the w/c R17 was utilizing was owned by the facility. RN-B confirmed the need for repair of R17's w/c should have been reported to maintenance. When interviewed on 3/5/15, at 4:23 p.m. the maintenance director stated being unaware of a work order being submitted for R17's w/c.	F 253	Neighborhood audits will be conducted by Neighborhood Coordinators for 3 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 the Quality Assurance Committee. Date of Completion: 04/10/15	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	**F282** Samaritan Bethany strives to ensure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	

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	245530	A. BUILDING _____ B. WING _____	03/05/2015

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F 282	Continued From page 2 This 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 grooming and personal 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 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.	F 282	Our facial trimming policy, which was provided to surveyors, states that it is our policy for nursing staff to shave, tweeze, or neatly trim the facial hair of residents during daily cares to maintain dignity. Nail care is provided by nursing staff during daily grooming and as needed to maintain resident dignity. Nail care for residents with diabetes is provided by licensed nursing staff. An all staff in-service will be held on Tuesday, March 31st to review this POC. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the process for facial trimming and nail care. Additional education will be provided as needed. Neighborhood audits will be conducted by Neighborhood Coordinators for 3 months and on a random basis thereafter to ensure that routine facial 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	

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F 282	Continued From page 3 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 their facial hair removed. CM verified R168 was dependent on staff for facial hair removal, verified staff did not follow R168's plan of care to provide assist with personal hygiene. A policy was requested for following a care plan, and was not provided. 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. Observations made on 3/2/15, at 2:28 p.m. and on 3/5/15, at 8:51 a.m. revealed R189 had long finger nails with dry light brown debris build up underneath the nails of the first and second fingers on both hands. The facility admission record indicated R189 was 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	F 282		

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F 282	Continued From page 4 perform hygiene and grooming tasks. 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.	F 282	**F312** Samaritan Bethany strives to ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Our facial trimming policy, which was provided to surveyors, states that it is our policy for nursing staff to shave, tweeze, or neatly trim the facial hair of residents during daily cares to maintain dignity. Nail care is provided by nursing staff during daily grooming and as needed to maintain resident dignity. Nail care for residents with diabetes is provided by licensed nursing staff. An all staff in-service will be held on Tuesday, March 31 to review this POC. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the process for facial trimming and nail care. Additional education will be provided as needed.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents unable to perform personal hygiene were provided 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	F 312		

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F 312	Continued From page 5 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. 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	F 312	Neighborhood audits will be conducted by Neighborhood Coordinators for 3 months and on a random basis thereafter to ensure that routine facial 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	

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F 312	Continued From page 6 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 as part of daily grooming ..." Observations made on 3/2/15, at 2:28 p.m. and on 3/5/15, at 8:51 a.m. revealed R189 had long finger nails with dry light brown debris build up underneath the nails of the first and second fingers on both hands. The facility admission record indicated R189 was 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. A facility policy entitled " bathing ~ bedbath " last reviewed July 2010 included, "Observe resident's nail bed, skin between fingers and provide nail care needed ... " The policy did not give direction on how often nail care should be provided nor by whom for residents who are not diabetic.	F 312		

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop 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 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document 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 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 cm) with no undermining; on 2/10/15 measurements were 1 cm x 1 cm x 0.1 cm with 2 cm of tunneling. R189 subsequently developed an infection in the wound on 3/2/15 and was treated with antibiotics. R189's facility admission record indicated an admission date of 10/2/14, with diagnoses that included but not limited to dementia, anxiety, atrial fibrillation, chronic kidney disease stage 3, osteoporosis, and pressure ulcer on upper back. R189 was enrolled in hospice when admitted on 10/2/14.	F 314	**F314** Samaritan Bethany strives to ensure that based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop 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 prevent new sores from developing. All residents are assessed to determine their individualized plan of care including their specific repositioning schedule to prevent pressure sores and promote 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 condition and concluded that the resident's clinical condition demonstrated that the pressure sore was unavoidable.	

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F 314	Continued From page 8 R189's quarterly Minimum Data Set (MDS) dated 1/6/15, indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3/15 and required extensive assist from two staff members for bed mobility, toileting and personal hygiene and was totally dependent on two staff for transfers between surfaces. The MDS indicated a pressure reducing device for chair, pressure reducing device for bed, and nutrition or hydration intervention were being used to manage skin problems. The hospice enrollment form indicated wound treatment dated 10/2/14 as, "Mepilex border, change every seven days and as needed. " The treatment order conflicted with the facility physician orders in terms of frequency of dressing change (Mepilex border was comparable to Aquacel foam). R189's PU monitoring tool (flow sheet) dated 10/2/14, indicated the wound dressing treatment was Aquacel foam and the measurements of the wound were 1.0 cm x 1.0 x 0.5 cm. The flow sheet documentation dated 11/26/14 indicated 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 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,	F 314	Our current, 3/27/15, documentation of R # 189 's wound is .5 centimeters in length by 1 centimeter in width by .2 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 POC. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the process for the treatment of pressure sores. Additional education will be provided as needed. Neighborhood audits will be conducted by RN Care Coordinators for 3 months 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	

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F 314	Continued From page 9 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 breakdown ....I 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, reposition every 2 hours, observe my skin with 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	F 314		

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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 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. HM-O stated the last time R189 had been repositioned was about 1.5 hours ago. When asked how R189 was repositioned HM-0 stated they had repositioned the pillow from underneath	F 314		

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F 314	Continued From page 11 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 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	F 314		

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F 314	Continued From page 12 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. DME-rep stated that upon delivery 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" 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	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	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) COMPLETION DATE
F 314	Continued From page 13 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. "	F 314	**F329** Samaritan Bethany strives to ensure that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indication for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reason above.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	F 329	Samaritan Bethany strives to ensure that based on a comprehensive assessment of a resident, residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs received gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue those drugs.	

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

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F 329	Continued From page 14 Based on interview and document review the facility failed to ensure each resident's drug regimen is free from unnecessary drugs 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 QD was initiated for appetite stimulant related to depressive disorder. Documented pharmacy recommendations were reviewed from June 2014 until February 2015. The pharmacy review dated 6/4/14, had a recommendation for a gradual dose reduction (GDR) for Remeron 15 mg PO HS for appetite stimulant and depressive disorder. No MD response to this request was documented in the paper or electronic record. The pharmacy review dated 7/9/14, referenced the recommendation of 6/4/14 and indicated: "Will follow up (f/u) [follow up] next month if necessary". Documentation was lacking by MD in response to recommendation. The pharmacy review dated 8/6/14, documented: "This is a duplicate of a previous recommendation with no response.	F 329	The NP reviewed the use of Remeron and concluded that it was appropriate and the benefits outweighed the risks. The consultant pharmacist completes monthly pharmacy recommendations that are addressed by the attending physician or NP/PA. The RN Care Coordinator is responsible for appropriate follow-up on these pharmacy recommendations. An all staff in-service will be held on Tuesday, March 31 to review this POC. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the process for unnecessary drugs. Neighborhood audits will be conducted by RN Care Coordinators for 6 months and on a random basis thereafter to ensure that our process for the use of unnecessary drugs is followed appropriately. RN Care Coordinators will monitor and report their findings to the Quality Assurance Committee. Date of Completion: 04/10/15	

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

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F 329	Continued From page 15 There is a progress note from 6/4/14 which justified no attempt at a GDR on Remeron". The pharmacy reviews dated 9/11/14, 10/9/14, 11/12/14, 12/15/14, 1/15/15 and 2/15/15- lacked physician response to the pharmacist recommendation for GDR for the continued use 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. When interviewed on 03/05/15, at 2:35 p.m. the director of nurses (DON) verified that no further information/documentation was available for review which addressed MD responses to the consultant pharmacist recommendations. The DON further verified that she receives the pharmacist recommendations following the scheduled monthly visits, which are reviewed and faxed to the primary care MD for follow up on the recommendations. :	F 329		

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F 371 F 371 SS=F	Continued From page 16 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This 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	F 371 F 371	**F371** Samaritan Bethany procures food from approved sources and stores, prepares, distributes, and serves food under sanitary conditions. This corrective action will improve food handling for all residents affected by this practice, as well as improve hand hygiene and food safety for all residents through ongoing monitoring and retraining. The policy and procedure on dating and labeling of foods was updated and will be distributed to all dietary and household staff to provide a framework for food safety in this facility. On Tuesday, March 31st an all staff in-service will be held to discuss and demonstrate the importance of dating and labeling food, as well as the food dating and labeling policy, procedure, and regulation. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the importance of dating and labeling food.	

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F 371	Continued From page 17 foods, outdated foods, and foods not dated when opened. CSD stated he expected foods to be dated when opened and sausage links dated 2/17, should be removed. (2) On 3/2/15 at 10:40 a.m., 4th floor--Cascade Creek House neighborhood-four thin slices of ham in plastic bag dated 2/22. During interview at that time, homemaker (HM)-G verified the undated and outdated foods. HM-G stated facility policy to keep foods in refrigerator for one week and then dispose. HM-G verified the ham was outdated. (3) On 3/2/15 at 10:30 a.m.., 3rd floor-- Country Club House neighborhood-three salad dressings including French, thousand island, and Italian, 1/2 to 1/4 remained in each, no date of when opened; 1 opened gallon of milk, 1/2 remained; 4 hard boiled eggs; 12 pasteurized eggs, uncooked in shell; three plastic bags with two uncooked sausage in each; one plastic bag of mixed ham and bacon pieces; all foods with no date when opened. During interview at that time, neighborhood coordinator (NC)-F verified the discolored cheese and undated foods. NC-F verified not aware of what food was in container labeled jelato. (4) On 3/2/15 at 10:35 a.m., 2nd floor--Northgate House neighborhood-4 salad dressings (French, ranch, thousand island, Italian), 1/2 remained; 5 pasteurized eggs, uncooked in hard shell; lettuce in a plastic container with some wilted leaves, all foods without dates when opened. During interview at that time, HM-N verified the foods with no date when opened. (5) On 3/2/15 at 10:40 a.m., 2nd floor--Salem	F 371	The Neighborhood Coordinators will audit food safety in the individual household kitchens weekly for a period of 3 months to ensure compliance and retrain if necessary. Registered Dietitians and Certified Dietary Managers will monitor for compliance and report their findings to the Quality Assurance Committee. Date of Completion: 04/10/15	

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F 371	Continued From page 18 Heights House neighborhood-5 pasteurized eggs, uncooked in hard shell; all foods without dates 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 food borne 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.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 19 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. 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, 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 15	F 428	**F428** Samaritan Bethany strives to ensure that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. The NP reviewed the use of Remeron and concluded that it was appropriate and the benefits outweighed the risks. Pharmacy recommendations are completed on a monthly basis by the consultant pharmacist. The pharmacist's monthly reports will continue to be given to the DON and RN Care Coordinators for appropriate follow-up by the attending physician. All pharmacist recommendations for the physician are reviewed by the attending physician and acted upon. An all staff in-service will be held on Tuesday, March 31 to review this POC. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the process for pharmacy recommendations.	

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F 428	Continued From page 20 mg PO HS for appetite stimulant and depressive disorder. No follow up physician (MD) response to this request was documented in the paper or electronic record. The pharmacy review dated 7/9/14, referenced the recommendation of 6/4/14 and indicated: "Will follow up (f/u) [follow up] next month if necessary". Documentation was lacking by MD in response to recommendation. The pharmacy review dated 8/6/14, documented: "This is a duplicate of a previous recommendation with no response. There is a progress note from 6/4/14 which justified no attempt at a GDR on Remeron". The pharmacy reviews dated 9/11/14, 10/9/14, 11/12/14, 12/15/14, 1/15/15 and 2/15/15 lacked physician response to the pharmacist recommendation for a GDR for the continued use of Remeron. When interviewed on 03/05/15, at 2:35 p.m. the director of nurses (DON) verified that no further information/documentation was available for review which addressed MD responses to the consultant pharmacist recommendations. The DON further verified that she receives the pharmacist recommendations following the scheduled monthly visits, which are reviewed and faxed to the primary care MD for follow up on the recommendations.	F 428	Neighborhood audits will be conducted by RN Care Coordinators for 6 months and on a random basis thereafter to ensure that appropriate follow-up on pharmacy recommendations is completed. RN Care Coordinators will monitor and report their findings to the Quality Assurance Committee. Date of Completion: 04/10/15	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 21 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure a bottle of Aplisol (tuberculin testing solution) was discarded 30 days after being opened. This has the potential to effect newly admitted residents and newly hired employees.	F 431	**F431** Samaritan Bethany ensures that we employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. The medications are dated upon opening. The licensed nurses observe the expiration dates before and after each use, and the medications in the medication room fridge will be audited on a weekly basis. An audit tool will be created to accomplish this objective and audits will be conducted on an ongoing basis to ensure that expired medications are properly disposed of. An all staff in-service will be held on Tuesday, March 31 to review this POC. Neighborhood staff meetings will be held and information will be distributed to all staff regarding the process for proper disposal of expired medications.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 431	Continued From page 22 Findings include: During medication storage review of the third floor medication room on 3/3/15, at 5:58 p.m. an open vial of Aplisol with no open date was observed in the presence of registered nurse (RN)-A. It was noted that solution was missing from the vial as it had been accessed. RN-A verified there was not an open date on the vial and indicated it should have had an open date and once opened and accessed, only good for 30 days. During medication storage review of the third floor rehabilitation medication room an open vial of Aplisol with an expiration date of 3/1/15 (2 days prior) was observed in the presence of RN-B. The vial had been accessed and solution was missing. RN-B verified the date on the vial was past the expiration date, and explained that they did not check for expiration dates on a daily basis but did check dates prior to administration. The facility policy entitled " medication expiration/safe storage ", included "Tuberculin-refrigerate-dispose of 30 days after opening " . The Aplisol package insert read, " Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency " and " Failure to store and handle Aplisol as recommended may result in loss of potency and inaccurate test results. "	F 431	Neighborhood audits will be conducted by RN Care Coordinators on an ongoing basis to ensure that appropriate disposal of expired medications are completed. RN Care Coordinators will monitor and report their findings to the Clinical Mentor/Director of Nursing. Date of Completion: 04/10/15	

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	245530	A. BUILDING **02 - NEW** B. WING _____	**03/04/2015**

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

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 04, 2015. At the time of this survey, Samaritan Bethany Home on 8th, was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. Samaritan Bethany Home on 8th, the original 3-story building with partial basement was completely remodel to meet requirements for new in 2012. The 2012 addition was determined to be of Type II(222) construction. The 2011 addition is a 6-story building with partial basement. The 2011 addition was determined to be of Type 1(332) construction. This facility will be surveyed as 1 building. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, resident rooms and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 182 beds and had a census of 176 beds at the time of the survey.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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

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

(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
2 000	Initial Comments *****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	2 000		

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900 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 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. 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.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with	2 302		

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2 302	Continued From page 2 Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: 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 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	2 302		

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2 302	Continued From page 3 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. 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.	2 302		

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2 302	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use 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	2 565		

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2 565	Continued From page 5 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. 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. Observations made on 3/2/15, at 2:28 p.m. and on 3/5/15, at 8:51 a.m. revealed R189 had long finger nails with dry light brown debris build up underneath the nails of the first and second fingers on both hands. The facility admission record indicated R189 was	2 565		

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2 565	Continued From page 6 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 educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (14) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		

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2 830	Continued From page 7 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. 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.	2 830		

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2 830	Continued From page 8 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	2 830		

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2 830	Continued From page 9 as part of daily grooming ..." SUGGESTED METHOD OF CORRECTION: The director of nursing could implement a policy and procedure that would ensure the facility would provide coordinated care and servies for residents receiving hospice to promote the healing of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (14) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document 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 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	2 905		

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2 905	Continued From page 10 cm) with no undermining; on 2/10/15 measurements were 1 cm x 1 cm x 0.1 cm with 2 cm of tunneling. R189 subsequently developed an infection in the wound on 3/2/15 and was treated with antibiotics. R189's facility admission record indicated an admission date of 10/2/14, with diagnoses that included but not limited to dementia, anxiety, atrial fibrillation, chronic kidney disease stage 3, osteoporosis, and pressure ulcer on upper back. R189 was enrolled in hospice when admitted on 10/2/14. R189's quarterly Minimum Data Set (MDS) dated 1/6/15, indicated severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 3/15 and required extensive assist from two staff members for bed mobility, toileting and personal hygiene and was totally dependent on two staff for transfers between surfaces. The MDS indicated a pressure reducing device for chair, pressure reducing device for bed, and nutrition or hydration intervention were being used to manage skin problems. The hospice enrollment form indicated wound treatment dated 10/2/14 as, "Mepilex border, change every seven days and as needed. " The treatment order conflicted with the facility physician orders in terms of frequency of dressing change (Mepilex border was comparable to Aquacel foam). R189's PU monitoring tool (flow sheet) dated 10/2/14, indicated the wound dressing treatment was Aquacel foam and the measurements of the wound were 1.0 cm x 1.0 x 0.5 cm. The flow sheet documentation dated 11/26/14 indicated 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	2 905		

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2 905	Continued From page 11 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 breakdown ....I 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, reposition every 2 hours, observe my skin with	2 905		

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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 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	2 905		

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2 905	Continued From page 13 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-0 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	2 905		

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2 905	Continued From page 14 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. DME-rep stated that upon delivery 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"	2 905		

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2 905	Continued From page 15 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 (14) days.	2 905		
2 920	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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2 920	Continued From page 16 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.	2 920		

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2 920	Continued From page 17 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 as part of daily grooming ..." Observations made on 3/2/15, at 2:28 p.m. and on 3/5/15, at 8:51 a.m. revealed R189 had long finger nails with dry light brown debris build up underneath the nails of the first and second fingers on both hands. The facility admission record indicated R189 was 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	2 920		

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2 920	Continued From page 18 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. A facility policy entitled " bathing ~ bedbath " last reviewed July 2010 included, "Observe resident's nail bed, skin between fingers and provide nail care needed ... " The policy did not give direction on how often nail care should be provided nor by whom for residents who are not diabetic. 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 adctivities of daily living. The DON or designee (s) could provide training for all appropriate staff on these policies and procedures. The DON or designee (s) could monitor to assure all residents are receiving adequate and appropriate care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored	21095		

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21095	Continued From page 19 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	21095		

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21095	Continued From page 20 opened. CSD stated he expected foods to be dated when opened and sausage links dated 2/17, should be removed. (2) On 3/2/15 at 10:40 a.m., 4th floor--Cascade Creek House neighborhood-four thin slices of ham in plastic bag dated 2/22. During interview at that time, homemaker (HM)-G verified the undated and outdated foods. HM-G stated facility policy to keep foods in refrigerator for one week and then dispose. HM-G verified the ham was outdated. (3) On 3/2/15 at 10:30 a.m., 3rd floor-- Country Club House neighborhood-three salad dressings including French, thousand island, and Italian, 1/2 to 1/4 remained in each, no date of when opened; 1 opened gallon of milk, 1/2 remained; 4 hard boiled eggs; 12 pasteurized eggs, uncooked in shell; three plastic bags with two uncooked sausage in each; one plastic bag of mixed ham and bacon pieces; all foods with no date when opened. During interview at that time, neighborhood coordinator (NC)-F verified the discolored cheese and undated foods. NC-F verified not aware of what food was in container labeled jelato. (4) On 3/2/15 at 10:35 a.m., 2nd floor-- Northgate House neighborhood-4 salad dressings (French, ranch, thousand island, Italian), 1/2 remained; 5 pasteurized eggs, uncooked in hard shell; lettuce in a plastic container with some wilted leaves, all foods without dates when opened. During interview at that time, HM-N verified the foods with no date when opened. (5) On 3/2/15 at 10:40 a.m., 2nd floor--Salem Heights House neighborhood-5 pasteurized eggs, uncooked in hard shell; all foods without dates	21095		

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21095	Continued From page 21 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.	21095		

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21426	Continued From page 22	21426		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (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:	21426		

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21426	Continued From page 23 Review of employee TSTs revealed the following: Personnel records for neighborhood coordinator (NC)-K, with a hire date of 2/3/15, revealed a TB screening was not completed; and the record lacked documentation of the induration of the 2nd step TST. Personnel records for caregiver (C)-B, with a hire date of 12/12/14, revealed a TB screening was not completed; the 2nd step TST was administered on 12/12/14; however, the record lacked evidence the second 2nd step TST was read. On 3/5/15 at 11:43 a.m. clinical mentor (CM) verified the above employees did not have a TB screening documented upon hire, that employee NC-K record lacked documentation of the induration of the 2nd step TST and the record of employee C-B lacked evidence the second 2nd step TST was read to determine the skin response. The Tuberculous Infection Control Program with a review date of 2-13 read, " ...1. To ensure all employees are free from M. tuberculosis all newly hired workers will be tested using the 2 step TST [tuberculin skin test]. They will receive the first step, which must be read negative before beginning work. 2. Current symptoms will be evaluated...4. If the results from the first step is negative the second step will be administered 2-3 weeks later ... " SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff responsible for TB on the most current standards and requirements in regards to TB control. TIME PERIOD FOR CORRECTION: Twenty One	21426		

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21426	Continued From page 24 (21) days. .	21426		
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 justification for the order and if the attending physician does not change the order, the matter	21530		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 25 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 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, 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	21530		

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	00427	A. BUILDING: _____ B. WING _____	03/05/2015

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21530	Continued From page 26 disorder. No follow up physician (MD) response to this request was documented in the paper or electronic record. The pharmacy review dated 7/9/14, referenced the recommendation of 6/4/14 and indicated: "Will follow up (f/u) [follow up] next month if necessary". Documentation was lacking by MD in response to recommendation. The pharmacy review dated 8/6/14, documented: "This is a duplicate of a previous recommendation with no response. There is a progress note from 6/4/14 which justified no attempt at a GDR on Remeron". The pharmacy reviews dated 9/11/14, 10/9/14, 11/12/14, 12/15/14, 1/15/15 and 2/15/15 lacked physician response to the pharmacist recommendation for a GDR for the continued use of Remeron. When interviewed on 03/05/15, at 2:35 p.m. the director of nurses (DON) verified that no further information/documentation was available for review which addressed MD responses to the consultant pharmacist recommendations. The DON further verified that she receives the pharmacist recommendations following the scheduled monthly visits, which are reviewed and faxed to the primary care MD for follow up on the recommendations. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures to ensure proper follow up of pharmacy recommendations. The director of nursing or designee could monitor the follow up of pharmacy recommendations on a regular basis to ensure compliance with state and federal regulations.	21530		

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21530	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, 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 and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure each resident's drug regimen is free from unnecessary drugs for 1 of 5 residents (R 178) reviewed for unnecessary medications.	21535		

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21535	Continued From page 28 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 15mg PO QD was initiated for appetite stimulant related to depressive disorder. Documented pharmacy recommendations were reviewed from June 2014 until February 2015. The pharmacy review dated 6/4/14, had a recommendation for a gradual dose reduction (GDR) for Remeron 15mg PO HS for appetite stimulant and depressive disorder. No MD response to this request was documented in the paper or electronic record. The pharmacy review dated 7/9/14, referenced the recommendation of 6/4/14 and indicated: "Will follow up (f/u) next month if necessary". Documentation was lacking by MD in response to recommendation. The pharmacy review dated 8/6/14, documented: "This is a duplicate of a previous recommendation with no response. There is a progress note from 6/4/14 which justified no attempt at a GDR on Remeron". The pharmacy reviews dated 9/11/14, 10/9/14, 11/12/14, 12/15/14, 1/15/15 and 2/15/15- lacked physician response to the pharmacist recommendation for GDR for the continued use	21535		

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21535	Continued From page 29 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. When interviewed on 03/05/15, at 2:35 p.m. the director of nurses (DON) verified that no further information/documentation was available for review which addressed MD responses to the consultant pharmacist recommendations. The DON further verified that she receives the pharmacist recommendations following the scheduled monthly visits, which are reviewed and faxed to the primary care MD for follow up on the recommendations. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures to ensure proper follow up of pharmacy recommendations. The director of nursing or designee could monitor the follow up of pharmacy recommendations on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation and interview the facility	21620		

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21620	Continued From page 30 failed to ensure a bottle of Aplisol (tuberculin testing solution) was discarded 30 days after being opened. This has the potential to effect newly admitted residents and newly hired employees. Findings include: During medication storage review of the third floor medication room on 3/3/15, at 5:58 p.m. an open vial of Aplisol with no open date was observed in the presence of registered nurse (RN)-A. It was noted that solution was missing from the vial as it had been accessed. RN-A verified there was not an open date on the vial and indicated it should have had an open date and once opened and accessed, only good for 30 days. During medication storage review of the third floor rehabilitation medication room an open vial of Aplisol with an expiration date of 3/1/15 (2 days prior) was observed in the presence of RN-B. The vial had been accessed and solution was missing. RN-B verified the date on the vial was past the expiration date, and explained that they did not check for expiration dates on a daily basis but did check dates prior to administration. The facility policy entitled " medication expiration/safe storage ", included "Tuberculin-refrigerate-dispose of 30 days after opening " . The Aplisol package insert read, " Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency " and " Failure to store and handle Aplisol as recommended may result in loss of potency and inaccurate test results. " SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of	21620		

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21620	Continued From page 31 medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to ensure a wheelchair was maintained in good repair so it could be cleaned properly for 1 of 1 resident (R17) whose wheelchair armrests had exposed foam padding. Findings include: On 3/3/15, at 7:05 p.m. R17 was observed seated in her wheelchair (w/c) in her room. There were visible cracks in the vinyl of both armrests and also a hole in the vinyl of each armrest exposing the foam padding beneath. During an observation/interview on 3/05/15, at 2:49 p.m. R17 was observed seated in her w/c in	21695		

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21695	Continued From page 32 her room. The armrest on R17's w/c continued to display the cracks in the vinyl. The left armrest had approximately a quarter size piece of vinyl missing and the right armrest approximately a 2 centimeter (cm) by (x) 1 cm piece of vinyl missing exposing the foam padding beneath. When interviewed R17 stated, "I didn't do it, I got it that way". R17 further stated she would like the armrest fixed as "It might tear my clothes". When interviewed on 3/05/15, at 4:00 p.m. registered nurse (RN)-B stated when there is a maintenance issue with one of the facility w/c's staff will inform maintenance to repair. RN-B further stated maintenance will usually attend to it the next day. RN-B stated that if there is an issue with a resident's private w/c the family is informed and make the decision as to how to proceed. RN-B and surveyor observed R17's w/c in her room. RN-B confirmed the armrests were in need of repair and were no longer a cleanable surface. RN-B further confirmed that the w/c R17 was utilizing was owned by the facility. RN-B confirmed the need for repair of R17's w/c should have been reported to maintenance. When interviewed on 3/5/15, at 4:23 p.m. the maintenance director stated being unaware of a work order being submitted for R17's w/c. SUGGESTED METHOD OF CORRECTION: The facility administrator could implement policies and procedures to ensure that the wheelchairs have cleanable surfaces. The administrator or designee could perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		