Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 3, 2025

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

RE: CCN: 245530
Cycle Start Date: December 12, 2024

Dear Administrator:

On December 12, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Regional Operations Supervisor
Rochester District Office
Health Regulation Division
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 12, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 12, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	C 12/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/9/24 to 12/12/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/9/24 to 12/12/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55302060C MN108777 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		1/24/25

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

Electronically Signed | 01/10/2025

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

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F 558	Continued From page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate resident needs by ensuring the call light was accessible for 2 of 2 residents (R60, R187) reviewed for call lights. Findings include: R60's annual Minimum Data Set (MDS) dated 11/27/24 identified R60 with cognitive impairment, diagnoses included Parkinson's, heart failure, osteoarthritis, and non-Alzheimer's dementia. R60's care plan with start date of 12/6/23 identified, "Be sure my call light is within reach and encourage me to use it for assistance as needed. I need response to all requests for assistance". R60's kardex (nursing assistant care sheet) printed 12/12/24 at 11:13 a.m., instructed nursing assistants to, "Please remind me to utilize my call light, as I am getting used to my new environment." During observation and interview on 12/9/24 at 3:00 p.m., R60 sitting in wheelchair in his room watching the television set. Call light cord was placed on nightstand behind him out of reach. R60 stated the call light, "[was] not in reach. I	F 558	Samaritan Bethany strives to ensure each resident's right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences. R60 - The care plan identified "be sure my call light is within reach and encourage me to use it for assistance as needed. I need response to all requests for assistance." R60s Kardex instructed the caregivers to "please remind me to use my call light as I am getting used to my environment". During observation on 12/9 R60 was sitting in w/c the call light was out of reach (call cord was on the nightstand) the resident stated, "I don't see it or know where it is but can use it." Upon notification from surveyor on 12/9/24 that the resident's call light was not in reach, staff promptly put call light within resident's reach. R60s care plan was reviewed on 1/6/2025 and remains appropriate. R187 – The care plan/Kardex identified assist of 2 for bed mobility and "I am able to use the call light appropriately". During observation on 12/10/24, R187 was lying in bed, and the call light was out of reach (on top of resident's nightstand). Resident stated, "I can't reach it to ask for help if I	

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F 558	Continued From page 2 don't know where it is. I don't see it." R60 stated he was able to press the call light for assistance but did not know how to ask for help if he did not have it in reach. R187 R187's quarterly MDS dated 10/29/24 identified R187 with limitations in range of motion for both upper and lower extremities, required extensive assist of two or more people for bed mobility and was totally dependent on two or more people to transfer out of bed into wheelchair. Also, R187 with diagnoses of arthritis, heart failure, lung disease, and vision impairment. In addition, R187 on continuous oxygen. R187's care plan with start day of 11/10/21 identified, "BED MOBILITY: Assist of 2" and "I am able to use call light appropriately." R187's kardex printed 12/10/24 identified, "BED MOBILITY: Assist of 2" and "I am able to use call light appropriately". During observation and interview with R187 on 12/10/24 at 8:29 a.m., R187 lying in bed with soft touch call light resting on top of nightstand three feet from the head of her bed. R187 stated, "I should have it on my body so I can use it if I want to. I can't reach it to ask for help if I need it." During interview with nursing assistant (NA)-A on 12/10/24 at 12:26 p.m., NA-A stated she worked full time at facility for five years and was familiar with the residents. NA-A stated call lights "should always be in reach of patients". During interview with NA-B on 12/10/24 at 12:42	F 558	need it". Upon notification from the surveyor on 12/10/24 that the resident's call light was not in reach, staff promptly put call light within resident's reach. R187 passed away on 12/26/24. The Call Light Response policy was reviewed on 1/8/2025 and remains appropriate. Neighborhood meetings will be held with all staff the week of 1/20/2025. Education will be provided during these meetings regarding F558 and the associated plan of correction ensuring that each residents call light is within reach. Call light placement audits will be completed by the Neighborhood Coordinators weekly for three months and on a random basis thereafter to ensure residents have their call light within reach. Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Completion Date: 1/24/25	

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F 558	Continued From page 3 p.m., NA-B stated she had worked at facility "many years" and was familiar with the residents. NA-B stated, call lights, "should always be in reach of the patient. If they can't reach it, then they cannot use it and they may try to get up without help and fall. So, they gotta be in reach." During interview with R187 significant other on 12/11/24 at 2:04 p.m., significant other stated, "[R187] would not be able to reach over and grab the call light thing without someone helping her if she is in bed. [R187] uses it when she needs help". During interview with director of nursing (DON) on 12/12/24 at 10:14 a.m., DON stated expectation call lights should be in reach of all residents. In addition, "[R187] could not reach the call light and ask for help if the call light is not in reach. Same thing goes for [R60]. Facility policy titled Call Light Response with review date of 9/24 identify "Resident's call light must be within reach for the resident to use".	F 558		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/10/2024. At the time of this survey, SAMARITAN BETHANY HOME ON EIGHTH was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. SAMARITAN BETHANY ON EIGHTH is a 6-story building with basement with attached 3-story building with basement. The building was constructed at 2 different times. The original building, 3 story with basement, was constructed in 1976 and was determined to be of Type II (222) construction. In 2010, a 6-story building with basement was constructed and was determined to be of Type II (222 construction. In	K 000		

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K 000	Continued From page 2 2012, the original 3 story building with basement was remodel, maintaining its Type II (222) construction. Each floor of the 6-story structure is divided into 2 smoke compartments. Each floor of the 3-story structure is divided into 2 smoke compartments. Because the original building and addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (222). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 128 beds and had a census of 91 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____	K 353		1/24/25

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K 353	Continued From page 3 b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.1, 5.2, 5.2.1.1.2(2)(6). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/10/2024 between 8:30 AM and 1:30 PM, it was revealed by observation that in the Main Building Basement, outside of the Elevator Pump Room, a sprinkler head exhibited signs of oxidation and paint. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 353	On 12/17/2024 the sprinkler head in the main basement outside of the elevator pump room was replaced. During the week of 1/20/2025 neighborhood meetings will be held to discuss K353 and the POC. Audits will be conducted by maintenance quarterly to ensure that all sprinkler heads are free of oxidation and foreign substances. The Building Operations Mentor will monitor to prevent reoccurrence. Completion Date: 1/24/25	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K 374		1/24/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 374	Continued From page 4 Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 12/10/2024 between 8:30 AM and 1:30 PM, it was revealed by observation that in the Heritage Building that the 3rd and 2nd Floor smoke barrier doors exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke. 2. On 12/10/2024 between 8:30 AM and 1:30 PM, it was revealed by observation that in the Heritage Building that one of the 2nd Floor - Center smoke barrier door assembly was missing operational hardware such that the door would not close and latch properly, which would allow the passage of smoke. An interview with the Maintenance Director	K 374	On 12/19/2024 door astragals were installed on the 2nd and 3rd Heritage doors. On 12/19/2024 operational hardware was installed on the 2nd Heritage door. During the week of 1/20/2025 neighborhood meetings will be held to discuss K374 and the POC. Maintenance will continue monthly inspections to ensure a proper gap for smoke barrier doors and that hardware is operational. The Building Operations Mentor will monitor to prevent reoccurrence. Completion Date: 1/24/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING **02 - NEW** B. WING _____	**12/10/2024**

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
K 374	Continued From page 5 verified these deficient findings at the time of discovery.	K 374		