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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PBFV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00427

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/11/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 5/1/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/07/2014 (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
03/19/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5530

On March 11, 2013, the Minnesota Department of Health and on March 12 and May 5, 2014 the Department of Public Safety completed a Post Certification Revisits (PCR) at this facility. Based on the PCR's, we have determined that the facility has corrected the deficiencies

The temporay waiver request for K18 replacement of corridor doors hardware with a completion date of May 1, 2014 has been completed. Refer to the CMS 2567b for both health and life safety code.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 25, 2014

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

RE: Project Number H5530023, S5530025

Dear Ms. Jacobs:

On February 13, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 12, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter from February 13, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 12, 2014. This was based on the deficiencies cited by this Department for an abbreviated standard completed on December 12, 2013, that included an investigation of complaint number H5530022.

On March 11, 2013, the Minnesota Department of Health and on March 12, 2014 the Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on December 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 13, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on December 12, 2013.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of March 25, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective March 12, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective March 12, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective March 12, 2014, is to be rescinded.

In our letter of February 13, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 12, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on February 13, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Correction of the Life Safety Code deficiencies cited under K18 at the time of the December 12, 2013 standard survey has not yet been verified. Your plan of correction for this deficiency, including your request for a temporary waiver with a date of completion of May 1, 2014, has been approved. Failure to come into substantial compliance with this deficiency by the date indicated in your plan of correction may result in the imposition of enforcement remedies.

Please note it is your responsibility to share the information contained in this letter and the results of this PCR 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
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	3/11/2014

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 **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **02/13/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **02/13/2014**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **02/13/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **02/13/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **02/13/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **02/13/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **02/13/2014**	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/KFD	3/25/2014	31221	03/11/2014
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
12/30/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245530	02 - NEW	5/5/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	05/01/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	05/07/2014	25822	05/05/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 12/27/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245530	02 - NEW	3/12/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**12/30/2013**	ID Prefix Reg. # **NFPA 101** LSC K0033	**12/30/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/kfd	**Date:** 03/25/2014	**Signature of Surveyor:** 03049	**Date:** 03/12/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 12/27/2013		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PBFV

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: **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 **12/30/2013** (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:

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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 03/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/18/2014 (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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN-24-5530

AAt the time of the Standard surveyon December 30, 2013 the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in your facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction. Temporay waiver request for K18 replacement of corridor doors hardware completion date of 5/1/14.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8170

February 13, 2014

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

RE: Project Number S5530025

Dear Ms. Jacobs:

On December 30, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731
Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by January 21, 2014, 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 January 21, 2014 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 March 12, 2014 (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 June 12, 2014 (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
Division of Compliance Monitoring
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.

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
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 _____	12/30/2013

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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post notice of survey results and have accessible to residents. This had the potential to affect 169 of 169 residents residing in the facility. Findings include: During initial tour on 12/26/13, at 11:50 a.m., observation by surveyor revealed survey results had not been posted and accessible to residents. On 12/26/13, at 12:36 p.m., surveyor asked receptionist at front	F 167	F 167 Samaritan Bethany understands the importance of the residents' right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility and that it must be posed in a place that is readily accessible to the residents. On December 26, 2013 the survey results were not posted in a readily accessible area. The most recent Federal and State survey results have been posted in a binder with a visible title page in a readily accessible area for residents to review as of 12/26/13. Observational audits will be conducted for 3 months by the Community Leader and on a random basis thereafter to ensure survey results are posted in a readily accessible area. Community Leader will monitor for compliance. Date of completion: ~~3/7/14~~ 2/13/14	2/24/14 GPN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Community Leader | (X6) DATE: 2/21/14

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 167	Continued From page 1 entrance desk where survey results were posted. Receptionist stated survey results used to be at front desk and had called other staff to inquire where survey results were. During interview on 12/26/13, at 12:36 p.m., office coordinator opened top drawer of wooden cabinet located behind front entrance desk and pulled out survey results. Office coordinator stated residents have to ask for it and verified there was no sign up informing residents of location of survey results. During interview on 12/26/13, at 12:43 p.m., Chief executive officer verified no information had been posted informing residents of location of survey results. On 12/30/13, at 12:40 p.m., clinical mentor stated facility had no written policy regarding posting survey results and stated we follow the regulation.	F 167		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to promote a dignified communication style when staff interact with 1 of 2 residents (R32) reviewed for dignity. Findings include: R32 was interviewed on 12/26/13, at 2:18 p.m. and indicated some staff are "rude" and short when they talk to me. R32 had indicated there had been two nursing assistants in the room when the incident	F 241	**F 241** Samaritan Bethany strives to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. On 12/27/13 a Vulnerable Adult incident report was submitted to Office of Health Facility Complaints (OHFC). The report was made due to R32 reporting that some neighborhood staff	

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F 241	Continued From page 2 occurred. R32 was admitted on 1/31/12. R32's quarterly Minimum Data Set (MDS) dated 10/30/13, revealed R32 had diagnoses of Dementia and Depression. R32 had moderate cognitive impairment with clear speech and no behaviors. R32 required extensive assistance with one staff with bed mobility, transfers, toileting, locomotion and dressing. During interview on 12/27/13, at 1:40 p.m. R32 indicated when the nursing assistant was rude to me it surprised me. R32 revealed they had not known what happened to make the nursing assistant respond rudely to them. R32 indicated there was another nursing assistant (NA)-B in the room at the time and R32 said we talked about the rudeness and why it happened. R32 felt if they had done something wrong they would apologize. R32 said NA-B told her that the other nursing assistant had no right to speak to R32 that way. During interview on 12/27/13, at 1:29 p.m. NA-B indicated a nursing assistant had been a little snippy with R32. NA-B verified they had been in the room when another nursing assistant had made rude comments to R32. NA-B indicated the other nursing assistant had short snippy responses towards R32. NA-B indicated this incident had occurred two weeks ago and had not been reported to anyone. During interview on 12/27/13, at 2:49 p.m. the office coordinator indicated information can be located on each household on how to handle questions and concerns in regards to verbal abuse.	F 241	are rude and short when they talk to her. The VA Committee conducted a complete investigation and submitted a report to OHFC. On 1/16/14, facility received disposition letter from MDH stating no further action necessary at this time. Upon move in, every resident is given a copy of the Resident Bill of Rights. Residents and his or her family are reminded at each resident's care conference about every resident's individual right to be treated with dignity and respect. Care plans are written to reflect the resident's abilities, preferences and needs. All staff receive continuing education about Resident Bill of Rights at the time of hire and annually, on Healthcare Academy educational website. Annually, the Social Service Mentor discusses Resident Bill of Rights at neighborhood Resident Council meetings. At upcoming Resident Council meetings, residents will be reminded about the importance of reporting dignity and respect concerns.	

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F 241	Continued From page 3 During interview on 12/27/13, 2:52 p.m. registered nurse (RN)-B would expect nursing assistants to tell the supervisor at the time of occurrence. RN-B was unaware of any incidents that had occurred with R32. During interview on 12/27/13, a t 3:28 p.m. the director of nursing indicated they would expect staff who may have witnessed rude behavior towards residents to report to supervisor at the time and then the supervisor needs to investigate the concern. The supervisor can make the decision to send the staff home if needed. During review of grievance policy dated July 2013, directed staff the optimum resolution to any nursing related questions or concerns is to immediately contact the RN Care Coordinator that is on duty at the time the question or concern arises. He or she is responsible for meeting these needs in the most expedient and satisfactory way.	F 241	An all staff in-service will be held on 3/5/14 to review this POC. Neighborhood Staff meetings will be held to discuss resident's rights to be treated with dignity and respect. Additional education will be provided as needed. Neighborhood audits will be conducted by the Neighborhood Coordinator for 3 months and on a random basis thereafter to ensure all residents are being treated with dignity and respect. Community Leader and Social Service Mentor will monitor and findings will be reported at Quality Committee meetings. Date of completion: ~~3/7/14~~ 2/13/14 apn	
F 244 SS=D	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure prompt responses related to grievances of call light concerns for 1 of 1	F 244	**F 244** Samaritan Bethany strives to listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.	

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F 244	Continued From page 4 resident (R10) reviewed for resident council. Findings include: R10 The facility did not respond appropriately to R10's concerns related to call light response time as evidenced by resident council meeting minutes and review of call light activation logs between 10/1/13 and 12/30/13. Resident council meeting minutes for fourth floor where R10 resides had been held between 9/25 and 12/30/13, were reviewed and revealed the following: The 9/25/13 resident council minutes indicated R10 had voiced concerns regarding call lights not being responded to. The notes indicated R10 stated he had waited over an hour before his light had been responded to. The council meeting minutes did not reflect whether the facility had responded to the concern or discussed a plan for addressing this issue. The resident council minutes dated 10/31/13 indicated R10 had voiced concerns regarding staff failure to answer call lights. The notes indicated R10 had stated they don't answer call lights at all and at varyied times of the day. The minutes did not address the previous month's concern regarding call lights nor did they reflect whether the facility had responded to R10's concern, or discussed a plan for addressing this issue. On asking the faciltiy for information on resolving R10's greivance, none was provided. Also on requesting resident council minutes from 4/1/13 to 9/25/13 were not provided.	F 244	On 2/24/14, The Care Coordinator and Neighborhood Coordinator for fourth neighborhood will meet with R10 regarding call light response time and create an agreed upon action plan for staff going forward to respond to R10's call light in a timely manner. R10 was also reminded of available resources including weekly companionship visits, conservator/guardian, in-house psychotherapy visits and social service visits as well as all staff members. Information about how to handle questions, concerns, and grievances are posted in every neighborhood and on the main floor of the building. Resident council procedures have been revised to include a Resident Council Action Form to facilitate timely follow up with any resident concern or grievance. An all staff in-service will be held on 3/5/14 to review this POC. Neighborhood Staff meetings will be held to also review this POC. Additional education will be provided as needed.	

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F 244	Continued From page 5 The quarterly Minimum Data Set (MDS) dated 10/14/13, indicated R10 had a Brief Interview for Mental Status (BIMS, a tool used to determine cognitive loss) score of 15 out of 15, which indicated no cognitive impairment. The MDS further indicated R10 had no episodes of hallucinations, delusions or rejection of care, required extensive assist of two staff for bed mobility, transfers and toileting, was frequently incontinent of urine and was not on a toileting program to manage urinary incontinence. R10 was unavailable for interview during the survey. During review of October, November and December 2013 call light audits for R10 the following had been noted: October 2013, R10's call light had been activated 420 times. 148 of the 420 times the response time had been more than five minutes. Review of the 148 times revealed 73 times the response time had been between 5-10 minutes, 44 times the response time had been between 10-20 minutes, 16 times the response time had been between 20-30 minutes, and 15 times the response time had been more than 30 minutes The longest response time had been 1 hour and 11 minutes. November 2013, R10's call light had been activated 296 times. 88 of the 296 times the response time had been more than five minutes. Review of the 88 times revealed 40 times the response time had been between 5-10 minutes, 26 times the response time had been between 10-20 minutes, 11 times the response time had	F 244	Neighborhood audits will be conducted by the Life Enrichment Mentor and Community Leader for 3 months and on a random basis thereafter to ensure on going Neighborhood grievances/concerns are acted upon timely. Community Leader and Life Enrichment Mentor will monitor and findings will be reported at the Quality Committee meetings. Date of completion: ~~3/7/14~~ 2/13/14 sdpn	

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F 244	Continued From page 6 been between 20-30 minutes, and 11 times the response time had been more than 30 minutes The longest response time had been 1 hour. December 2013, R10's call light had been activated 279 times. 97 of the 279 times the response time had been more than five minutes. Review of the 97 times revealed 42 times the response time had been between 5-10 minutes, 41 times the response time had been between 10-20 minutes, 9 times the response time had been between 20-30 minutes, and 5 times the response time had been more than 30 minutes The longest response time had been 37 minutes. Request for call light audits of more than 5 minutes response time for the entire facility were not provided. During interview on 12/30/13, at 9:46 a.m. the clinical mentor (CM) stated the neighborhood coordinator (NC) and care coordinator (CC) for each household had been responsible for the resident council meetings in their unit, and for following up on grievances. The CM indicated if a grievance is related to the nursing department the CC had been expected to address the grievance. The CM indicated she had not received copies of the minutes and stated "If there are nursing concerns the care coordinator would handle the concerns, if they could not handle it they would tell me. I would expect that the care coordinator address concerns and if the concerns are recurring they need to tell me." The CM indicated the meeting minutes should identify the facility had responded to the concern. CM stated "Call lights should be answered in 5 minutes." The CM indicated she did not recall the concern voiced at the 9/25/13, or 10/31/13 meetings regarding the	F 244		

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F 244	Continued From page 7 resident who had voiced specific concerns regarding call light response time. During interview on 12/30/13, at 10:43 a.m. CC-A stated she had not attended all resident council meetings. CC-A indicated if there had been concerns the HC would notify her. CC-A was unable to report if R10's grievances had been addressed. During interview on 12/30/13, at 1:56 p.m. NC-F stated "a couple times his [R10] light has not been working, we could not turn it off." NC-F indicated grievances had been emailed to the CM and CC and he had discussed call light response time concerns with staff. NC-F verified he was unable to provide documentation R10's grievances had been addressed. NC-F further verified the call light response times continued to be a concern. Request for documentation related to R10's call light not working was not provided. During interview on 12/30/13, at 2:09 p.m. the administrator and CM verified R10's call light audit findings. CM further verified the call light response time was not acceptable. CM stated "we reviewed it before we gave it to you and did not expect to find what we found." Request made for policies related to call light response time and grievances were not provided.	F 244		
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	F 282	**F 282** Samaritan Bethany strives to ensure that services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care.	

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F 282	Continued From page 8 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for repositioning for 1 of 3 residents (R270) reviewed for pressure ulcers. Findings include: R270 had not been repositioned "every two hours or more as needed" as directed by the care plan and had been observed to not be repositioned for a total of three hours. R270's signed physician order sheet dated 10/24/13 included diagnoses of delirium, full incontinence of feces, urinary incontinence, senility. R270's significant change Minimum Data Set (MDS) dated 10/31/13 showed a Brief Interview for Mental Status (BIMS) score of 6 (indicating severe cognitive impairment), required extensive assistance with bed mobility and transfers, and was at risk for developing pressure ulcers. R270's care plan initiated on 8/8/13 and revised on 10/31/13 indicated R270 had pressure ulcers and was at risk due to needing help to reposition in bed/chair, urine and bowel incontinency, along with thin fragile skin. R270 had chronic edema to lower extremities, and ulcers on both heels that were currently unstageable. Staff were instructed to help R270 to reposition in bed/chair every 2 hours or more as needed. Also the nursing assignment work sheet dated 11/7/13 instructed staff to reposition R270 every 2 hours in bed and	F 282	All residents are assessed to determine their individualized repositioning schedule to prevent pressure ulcers and promote healing. On January 3, 2014, NA-C was re-educated on the importance of following the plan of care for R270 in regards to her repositioning schedule. An all staff in-service will be held on 3/5/14 to review this POC. Neighborhood Staff meetings will be held to also review this POC. Additional education will be provided as needed. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure repositioning schedules are followed according to each resident's individualized plan of care. Care Coordinators will monitor and findings will be reported at the Quality Committee meetings. Date of completion: ~~3/7/14~~ 2/13/14 MPN	

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F 282	Continued From page 9 chair and noted that R270 had skin breakdown. R270 was observed in R270 's bathroom on 12/30/13 at 7:10 a.m. with the nursing assistant (NA)-C. NA-C stated she was getting R270 up for the morning. During continuous observation on 12/30/13 at 8:15 a.m., R270 had been observed in her wheelchair leaving the dining room table, propelling herself with her feet, to an area at the end of the hallway by her room, looking out of the window. At 8:30 a.m. R270 propelled herself with her feet into her room. At 10:31 a.m. the nursing assistant, (NA)-C, came to R270's room to see if she needed anything. No offer of toileting or repositioning was offered. At 11:07 a.m., R270 propelled herself out of her room to the dining room. No repositioning had occurred for three hours. When interviewed on 12/30/13 at 2:00 p.m., the director of nursing stated that she would expect the nursing assistant to reposition R270 according to what the care plan directed. A facility policy entitled, Skin/Wound Care Policies, dated 01-08, identified residents that were dependent should have their position changed as was consistent with their care plan and that residents having pressure ulcers on seating surfaces should avoid prolonged sitting.			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	F 309	**F 309** Samaritan Bethany strives to ensure that each resident is provided the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment and plan of care. A process for licensed nurses has been developed to follow up on all medications ordered. This process will more efficiently allow all nurses to identify which medications have been ordered, received and which need to be followed up on with the pharmacy. An all staff in-service will be held on 3/5/14 to review this POC. Neighborhood Staff meetings will be held to also review this POC. Additional education will be provided as needed. Neighborhood audits will be conducted by Care Coordinator's for 3 months and on a random basis thereafter to ensure all medications have been received in a timely manner. Care Coordinators will monitor and finding will be reported at the Quality Committee meetings. Date of completion: ~~3/7/14~~ 2/13/14	

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 _____	12/30/2013

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 309	Continued From page 11 received the Biotene from the pharmacy even though the recommendation was made on 12/18/13. During an interview on 12/30/13 at 7:51 a.m. CC-A stated the Biotene was a PRN (as needed) order and staff were relieving R199's complaints of dry mouth with fluids with relief. CC-A stated the Biotene was delivered on 12/27/13 during the evening shift and resident used the Biotene on 12/28/13 and 12/29/13 and had relief. During an interview on 12/30/13 at 8:19 a.m. nursing assistant (NA)-A stated R199 complained of a starchy dry mouth on a daily basis, frequently during the shift she worked and stated she offered fluids during cares. NA-A stated she was unsure if R199 had any medications or sprays to help with her dry mouth. NA-A stated they had not reported the concern of R199 having a dry mouth to the nurse. During an interview on 12/30/13 at 9:04 a.m. CC-A explained if a prescription was not received from the pharmacy during the shift the order was placed, staff must communicate the ordered prescription had not been filled to the next shift for follow-up to obtain the prescription. CC-A verified the staff failed to communicate to the following shift when the Biotene did not arrive at the facility on 12/23/13, and therefore follow-up did not occur with the pharmacy regarding the prescription on 12/24/13. During an interview on 12/30/13 at 9:21 a.m. clinical mentor stated if a PRN order medication was ordered for a resident, her expectation would be the staff would follow through on the order to make sure it was received from the pharmacy so	F 309		

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

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F 309	Continued From page 10 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to meet the needs for 1 of 1 resident (R199) who complained of oral discomfort. Findings Include: R199 complained of dry mouth and the signed order for Biotene (dry mouth symptom relief product) dated 12/23/13 was not obtained from the pharmacy. R199's admission Minimum Data Set (MDS) dated 9/16/13, revealed R199 had diagnoses of Bipolar disorder and Parkinson's disease. R199 had severe cognitive impairment and was admitted to the facility on 9/3/13. R199 had complained of having a dry mouth during all three interviews on 12/26/13 at 7:08 p.m., on 12/27/13 at 3:31 p.m., and also on 12/30/13 at 8:06 a.m. During an interview on 12/26/13 at 7:08 p.m. Family Member-A stated R199 had a dry mouth and it caused her to have pain. R199 was screened by Apple Tree Dental on 12/18/13 and a recommendation was made for Biotene or oasis to help with dry mouth care. During an interview on 12/27/13 at 3:54 p.m. care coordinator (CC)-A verified the Biotene was not in the facility for R199's use as the facility had not	F 309		

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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 309	Continued From page 12 it would be available for the resident to use if needed.	F 309		
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 necessary services to promote healing and prevent pressure ulcers from developing for 1 of 3 residents (R270) reviewed for pressure ulcers. Findings include: R270 had not been repositioned for three hours and had been assessed to be repositioned every two hours and as needed. R270's signed physician order sheet dated 10/24/13 included diagnoses of delirium, full incontinence of feces, urinary incontinence, and senility. R270's significant change Minimum Data Set (MDS) dated 10/31/13 showed a Brief Interview for Mental Status (BIMS) score of 6 (indicating severe cognitive impairment), required extensive	F 314	**F314** Samaritan Bethany strives to ensure that a resident that 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. On 1/9/14 an audit was completed for R270 to determine that the appropriate repositioning schedule was followed according to her plan of care. On January 3, 2014, NA-C was re-educated on the importance of following the plan of care for R270 in regards to her repositioning schedule. All residents are assessed to determine their individualized plan of care including their specific repositioning schedule to prevent pressure ulcers and promote healing.	

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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) COMPLETION DATE
F 314	Continued From page 13 assistance with bed mobility and transfers, and was at risk for developing pressure ulcers. Also R270 was admitted to the facility on 8/08/13. R270's care plan initiated on 8/8/13 and revised on 10/31/13 indicated R270 had pressure ulcers and was at risk for skin breakdown due to needing help to reposition in bed/chair, urine and bowel incontinency, along with thin fragile skin. R270 had chronic edema to lower extremities, and ulcers on both heels that were currently unstageable. Left heel ulcer first noted 9/12/13 and on right heel noted on 10/31/13. Intervention was for staff to reposition R270 when in in either bed or chair every 2 hours or more as needed. Nursing assignment work-sheet dated 11/7/13 instructed staff to reposition R270 every 2 hours in bed and chair and indicated that R270 had skin breakdown. R270's Tissue Tolerance Evaluation form, dated 10/27/13, included that R270 would be repositioned every 2 hours in bed and chair due to high potential and history of skin breakdown. This schedule would provide optimal tissue health for the resident and staff would closely observe. R270 s Pressure Ulcer Monitoring tool indicated that R270 had a stage 2 right buttock pressure ulcer and a left buttock pressure that were identified on 9/23/13 and had healed on 12/05/13. A non-stageable left heel pressure ulcer measured 1.5 centimeters (cm) length by 1.5 cm width and showed slough on 12/26/13. An un-stageable right heal pressure ulcer measured 0.5 cm by 1 cm on 12/26/13. R270 was observed in bathroom on 12/30/13 at	F 314	We are currently working with Stratis Health on a structured pressure ulcer prevention auditing program. This auditing program is completed by the Care Coordinator in each neighborhood. An all staff in-service will be held on 3/5/14 to review this POC. Neighborhood Staff meetings will be held to also review this POC. Additional education will be provided as needed. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure that residents who enter the facility without pressure sores does not develop pressure sores unless clinical condition demonstrates that they were unavoidable. Care Coordinators will monitor and finding will be reported at the Quality Committee meetings. Date of completion: ~~3/7/14~~ 2/13/14 SPN	

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F 314	Continued From page 14 7:10 a.m. with the nursing assistant (NA)-C. NA-C stated she was getting R270 up for the morning. During continuous observation on 12/30/13 at 8:15 a.m., R270 had been observed in her wheelchair leaving the dining room table, propelling herself in the wheelchair and using her feet, to an area at the end of the hallway by her room, looking out of the window. At 8:30 a.m. R270 propelled herself into her room. At 10:31 a.m. NA-C, came to R270's room to see if she needed anything. During the visit by NA-C it was noted that she had not offered to toilet or reposition R270. At 11:07 a.m., R270 propelled herself out of her room to the dining room. From 8:15 a.m. to 11:15 a.m. a total of three hours R270 had not been offered or assisted to reposition while seated in the wheelchair. When interviewed on 12/30/13 at 11:15 a.m., NA-C stated that R270 will tell her if she needs to toilet. NA-C stated that she had not repositioned R270 since she had gotten her up in the morning (observed doing a.m. cares at 7:10 a.m. by surveyor.) When interviewed on 12/30/13 at 11:15 a.m., the registered nurse, (RN)-C stated that she would expect the nursing assistant to follow the resident ' s care plan for repositioning times. RN-C checked the care plan that was located outside of the R270's room in a cupboard and after reading it, stated that R270 needs to be repositioned every 2 hours in bed and chair. When interviewed on 12/30/13 at 2:00 p.m., the director of nursing stated that she would expect the nursing assistant to reposition R270	F 314		

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F 314	Continued From page 15 according to what their care plan directed. A facility policy entitled, Skin/Wound Care Policies, dated 01-08, identified residents that were dependent should have their position changed as was consistent with their care plan and that residents having pressure ulcers on seating surfaces should avoid prolonged sitting. A facility policy entitled, Tissue Tolerance Evaluation, last reviewed 11/12, and directed that staff will reposition the resident within 15 minutes before or after the scheduled time.	F 314		
F 371 SS=F	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 have a system in place to ensure food was prepared and stored under sanitary conditions related to equipment kept in a cleans and sanitary manner. This had the potential to affect 167 residents who received food out of the kitchen. In addition the facility failed to serve food in a sanitary manner during meal service in 2 out of 14 dining rooms	F 371	**F371** Samaritan Bethany Home on Eighth procures, stores, prepares, and serves food in a sanitary manner. Can-opener cleaning procedure located by Nutrition and Wellness Mentor, distributed and demonstrated to Kitchen Manager and kitchen staff. During process of MDH survey, Kitchen Manager updated kitchen cleaning-list to include both can opener and dry storage bins. These items are cleaned on a weekly basis by kitchen staff, monitored by the Kitchen Manager. Cleaning lists are reviewed by the Kitchen Manager and kept on file for audit.	

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F 371	Continued From page 16 observed for meal service. This had the potential to affect 3 out of 19 residents. Findings include: During observation on initial tour of the facility's kitchen on 12/26/13, at 11:40 a.m. a thick layer of sticky, dark brownish colored debris were noted on a can opener cutter blade, base plate and the insert that had been mounted to a countertop. Also during the tour multiple dark drips and splatter marks were located on the lid for a sugar storage bin. The sugar bin had been located below the coffee maker. During interview at that time, kitchen manager (KM) verified the findings. During interview on 12/26/13, at 1:55 p.m. the KM stated that each dietary staff had assigned duties in the kitchen which included cleaning specific pieces of equipment. The KM stated assigned cleaning duties were identified on the daily cleaning checklist which was kept in the kitchen. The KM provided the checklists during interview. During review of the cleaning checklist assignment sheets with the KM it was noted that the checklists had not included cleaning of the can opener or dry storage bins. The KM verified the cleaning of the can opener and dry storage bins was not included on the checklists and therefore was not assigned to a specific discipline. KM was unable to identify when the can opener and sugar bin lid had last been cleaned. On 12/26/13, request was made for copies of policies related to cleaning specific equipment, none were provided. During observation of Northrop House household on 12/26/13, at 4:49 p.m. during the dishing up of food plates, homemaker-A had picked up an	F 371	Glove use review training with written test for understanding held for all staff handling food and Neighborhood Coordinators on 3/5/14. Hand washing policy distributed and reviewed as part of this training. A glove use checklist was given to Neighborhood Coordinators to hold weekly household audits at meal times in their respective neighborhoods for 3 months and on a random basis thereafter. Checklists reviewed by CDM's and kept on file for audit. Neighborhood Staff meetings will be held to also review this POC. Additional education will be provided as needed. Kitchen Manager and Nutrition and Wellness Mentor will monitor and findings will be reported at the Quality Committee meetings. Date of Completion: ~~3/7/14~~ 2/13/14 sfn	

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F 371	Continued From page 17 unwrapped sandwich off of a plate containing multiple sandwiches (sandwiches had not been individually wrapped) with soiled gloves as homemaker-A had touched refrigerator handles with gloves then grabbing sandwiches. During observation on Kutzy Park household on 12/26/13, at 5:08 p.m. during meal set up. homemaker-B had put on gloves then went into forgetter for foods, then wearing the soiled gloves they picked up sandwiches and a cookie off of plates (sandwiches and cookies had not been individually wrapped) with the same pair of soiled gloves. During interview on 12/30/13, at 6:55 a.m., kitchen manager stated if staff touch refrigerator handles with gloves on the gloves are contaminated and the manager would expect the staff person to remove soiled gloves, wash hands and put on clean gloves before touching food. Document review of the facility policy HAND WASHING dated revision date 3/12, read "POLICY: It is Samaritan Bethany Inc. policy to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in the facility. PURPOSE: Recognizing the importance of hand washing and glove use in protecting the transfer of harmful microorganisms during food preparation. PROTOCOL: II WEAR GLOVES PROCEDURE: 4. Examples of times disposable gloves will be worn are: When handling ready to eat food 6. Change gloves between tasks and/or after 2 hours of continuous use preparing the same product. 7. Remove gloves promptly: a. After use. Mb. Before touching non-contaminated items and environmental surfaces. c. Before	F 371		

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F 371	Continued From page 18 preparing other foods. d. Wash hands immediately after removal to avoid transfer of microorganisms from gloves to other food products and surfaces."	F 371		

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

F5530024

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 _____	12/27/2013

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K 000	INITIAL COMMENTS 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Samaritan Bethany Home on 8th, was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000	POC w/ TW for K18 FS 3-11-14 RECEIVED FEB 24 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

De. 1-31-14
Exit: 12-30-13

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

Community Leader 2/21/14

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 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. 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		
K 018 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD	K 018	**K18** All resident pass through cabinets are scheduled for a quarterly PM inspection for positive latching. Work orders will be filled out for immediate attention if repairs are needed. We are working with Nigon Woodworks on replacing the current latch system for all pass through cabinets with a more reliable system. Building Operations Mentor and Community Leader will monitor for compliance. Date of Completion: ~~3/26/14~~ 5-1-14 per T/C w/ Admin	

TW 5-1-14

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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) COMPLETION DATE
K 018	Continued From page 2 Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility had a corridor door which were impeded from fully closing and latching into it's frame in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6.3.2. The deficient practice could affect all 40 out 176 residents. FINDINGS INCLUDE: On facility tour between 8:00 AM and 12 noon on 12/27/2013, observation revealed that the resident pass through cabinets for rooms # 2555 and 2556 from the corridor do not have positive latch. There are others through out the facility that do not positively latch. NOTE: Entire facility needs to be checked for this deficiency These deficient practices were confirmed by the Facility Maintenance Director (TW) and Administrator (KJ) at the time of discovery.	K 018	**K29** The First floor chute room penetration around conduit was sealed with fire rated caulk on 12/30/13. 12-30-13 In Building 1, the 3rd neighborhood laundry door closer was adjusted on 12/30/13 for positive latching. The Building Operations Mentor will monitor for compliance.	
K 029	NFPA 101 LIFE SAFETY CODE STANDARD	K 029	Date of Completion: ~~3/7/14~~	

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 _____	12/27/2013

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 029 SS=D	Continued From page 3 Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 1 hour fire rated wall construction in accordance with the following requirements of 2000 NFPA 101, Section 18.3.2.1. The deficient practice could affect 40 out of 176 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 12/27/2013, observation revealed,that the following was found: 1. 1st floor - chute room - east wall has open penetration around conduit 2. Building 1 - 3rd floor - resident laundry room does not shut and latch These deficient practices were confirmed by the Facility Maintenance Director (TW) and Administrator (KJ) at the time of discovery.	K 029	**K33** The First floor chute room penetration around conduit was sealed with fire rated caulk on 12/30/13. 12-30-13 The Building Operations Mentor will monitor for compliance. Date of Completion: 3/7/14	
K 033 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) in buildings four stories or more are enclosed with construction having fire resistance rating of at	K 033		

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

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 _____	12/27/2013

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 033	Continued From page 4 least two hours, are arranged to provide a continuous path of escape, and provide protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 8.2.5.4, 18.3.1.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a fire resistance rating of at least one hour in the exit component accordance with the following requirements of 2000 NFPA 101, Section 18.3.1.1, 8.2.5.2. The deficient practice could affect 75 out of 176 residents. Findings include: On facility tour between 8:00 AM and 12:00 noon on 12/27/2013, observation revealed that in Stairwell "D" on 3rd floor has open penetration around sprinkler line. This deficient practice was confirmed by the Facility Maintenance Director (TW) and Administrator (KJ) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 033		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Tuesday, March 11, 2014 2:40 PM
To: Jan.Suzuki@cms.hhs.gov
Cc: gary.schroeder@state.mn.us; 'kjacobs@samaritanbethany.com'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Samaritan Bethany Home on Eighth (245530) K18 Temporary Waiver Request

This is to inform you that I am accepting Samaritan Bethany on Eighth's request for a temporary waiver for K18, replacement of corridor doors and door hardware. The exit date was 12-30-13.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

Name of Facility
Samaritan Bethany Home on 8th - 245530 - Rochester, MN

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K18 A temporary waiver is being requested for corridor doors which were impeded from fully closing and latching into it's frame in accordance with the requirements of 2000 NFPA 101, Sections 19.3.6.3.2.	A temporary waiver is being requested for K18 until May 1, 2014. A. Compliance with this provision will cause an unreasonable hardship because: 1. The cost to replace existing latching hardware was not in the 2014 budget. 2. Removing existing hardware could leave holes in the corridor doors which would require placing fire rated caulk. 3. Efforts to obtain a workable replacement plan from our architects has been unsuccessful. 4. The facility is working with Nigon Woodworking to replace all existing hardware that was found to be defective and due to time line delays, replacement is still in process. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13. 2. The existing HVAC system ventilation fans do automatically shut down upon activation of the fire alarm system, or detection of smoke in the HVAC system. 3. Resident sleeping rooms do have smoke detectors and fire sprinklers. 4. The corridors are equipped with a complying smoke detection system. 5. The facility is in compliance with all other fire safety requirements. 6. The facility has obtained an approved plan of correction for any other fire safety deficiencies that were cited.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title: Fire Safety Supervisor	Office: State Fire Marshal	Date: 3-11-14