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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: R2U1

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 **06/13/2018** (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 **155** (L18)

13.Total Certified Beds **155** (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
	155			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Vicki Hamerma, HFE NE II 08/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/03/2018 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245530
August 3, 2018

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

Dear Ms. Berg:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 8, 2018 the above facility is certified for:

155 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 155 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

June 26, 2018

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

RE: Project Number S5530029

Dear Ms. Berg:

On February 22, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

- Civil money penalties. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on February 21, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On April 3, 2018, we informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2018. (42 CFR 488.417 (b))

- Civil money penalties. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by the Minnesota Departments of Health and Public Safety for standard surveys completed on March 13, 2018 and March 16, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 3, 2018, the Minnesota Department of Health and on May 7, 2018 the Department of Public Safety and the Minnesota Department of Health, Office of Health Facility Complaints completed PCR's to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard survey, completed on February 21, 2018 and the standard surveys completed on March 13, 2018 and March 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our visit, we determined that your facility had corrected the deficiencies issued pursuant to the

abbreviated standard survey, completed on February 21, 2018 and the LSC standard survey completed on March 13, 2018. However, the Health survey completed on March 16, 2018 was not corrected as of May 4, 2018. Because of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

We also notified you of the following actions related to the imposed remedies in the letters from February 22, 2018, April 3, 2018 and May 18, 2018:

- Civil money penalty, be imposed. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2018, would remain in effect. (42 CFR 488.417 (b))

On June 13, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 3, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 8, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 13, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 8, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies:

- Civil money penalties, be imposed. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2018 be discontinued effective June 8, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

As we notified you in our letter of February 22, 2018, 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 May 21, 2018.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: R2U1

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 **05/03/2018** (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 **155** (L18)

13.Total Certified Beds **155** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	155			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Stephanie Powers, HFE NE II — 06/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kami Fiske, Enforcement Specialist — 06/26/2018 (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

Electronically delivered
May 18, 2018

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

RE: Project Numbers S5530029, H5530037

Dear Ms. Berg:

On February 22, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

In addition, on February 22, 2018, we recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedy:

- Civil money penalty for the deficiency cited at F224. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by the Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on February 21, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 16, 2018, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The standard survey found that your facility has not achieved substantial compliance with federal certification deficiencies. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy in the letter of February 22, 2018:

- Civil money penalty for the deficiency cited at F224, be imposed. (42 CFR 488.430 through 488.444)

Also, we recommended to the Centers for Medicare and Medicaid Services (CMS) the following enforcement remedies related to the standard survey completed on March 16, 2018:

- Civil money penalty for the deficiency cited at F686. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2018. (42 CFR 488.417 (b))

On May 3, 2018, the Minnesota Department of Health and on May 7, 2018 the department of Public Safety and the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard survey, completed on February 21, 2018 and the standard survey completed on March 16, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to the abbreviated standard survey, completed on February 21, 2018 and the standard survey completed on March 16, 2018. The deficiencies not corrected are as follows:

F0609 -- S/S: D -- 483.12(c)(1)(4) -- Reporting Of Alleged Violations
F0825 -- S/S: D -- 483.65(a)(1)(2) -- Provide/Obtain Specialized Rehab Services

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in the letters dated February 22, 2018 and April 3, 2018:

- Civil money penalty for the deficiency cited at F224, be imposed. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2018. (42 CFR 488.417 (b))

Also, the we notified you in our letter of April 3, 2018, 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 May 21, 2018.

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

• Civil money penalty for the deficiency cited at F686, be imposed. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 from the abbreviated standard survey completed on February 21, 2018 should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction from the standard survey completed on March 16, 2018 should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- 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 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the fourth revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	R 05/03/2018

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 No deficiencies were noted at the time of the survey.	{E 000}		
F 000	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on May 2 & 3, 2018, and found to have NOT corrected all the citations issued on the survey exited March 16, 2018. 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.	F 000		
{F 609} SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.	{F 609}		6/8/18

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

Electronically Signed | 05/29/2018

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.

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 _____	R 05/03/2018

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 609}	Continued From page 1 §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to report an allegation of abuse to the state agency (SA) within two hours after learning of the allegation for 1 of 1 resident (R409) reviewed. This had the potential to affect all 149 residents in the facility. Findings include: R409 ' s nursing Home Incident Reporting-Incident Report Summary dated 5/1/18, at 9:17 p.m. indicated an allegation of abuse for emotional or mental abuse. The description of the incident included: On 5/1/18, a psychotherapist visited R409 for a 1:1 session. R409 reported to the psychotherapist an incident of possible emotional abuse and/or neglect when three black people cared for her and made fun of R409 ' s body and had left R409 uncovered in her room. On 5/3/18, at 2:59 p.m. social worker (SW)-A was interviewed along with social worker (SW)-D who was in training. SW-A stated the psychotherapist reported the allegation of abuse to her after the 1:1 session with R409. SW-A was asked what time the session was with the psychotherapist and she stated it was about 12:30 p.m., on 5/1/18. SW-A stated when the incident was	{F 609}	F609 Samaritan Bethany strives to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. A Vulnerable adult report was made to OHFC on 5/1/18. On 5/9/18 we received the disposition letter from MDH stating that the report had been reviewed and it has been determined that no further action by the office is necessary at this time. The Abuse Prevention Plan of Vulnerable Adults policy was reviewed. Samaritan Bethany staff and our volunteers are instructed to immediately report all witnessed and suspected incidents of mistreatment to a supervisor or member	

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 _____	R 05/03/2018

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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{F 609}	Continued From page 2 reported to her she called the administrator. SW-A said the administrator informed SW-A to revisit R409 with registered nurse (RN)-A to gather further information. SW-A stated the revisit occurred about 3:30 p.m. on 5/1/18. SW-A said R409 had some discrepancies with her stories. SW-A stopped the interview with the surveyor to phone the administrator to get authorization to continue to speak to the surveyor. SW-A had hung up the phone with the administrator and stated, " I want to report more but was told not to. " R409 ' s progress note dated 5/1/18, at 8:27 p.m. included; the allegation was immediately reported to OHFC (Office of Health Facility Complaints), even though the initial SA report was dated 5/1/18, at 9:17 p.m. and the allegation of abuse was reported during the session with the psychotherapist at 12:30 p.m., on 5/1/18. R409 ' s care plan printed 5/4/18 included: Per my preference, I do not want to be cared for by people of color (African American). On 5/3/18, at 3:30 p.m. the administrator stated there was " No bodily injury but possible emotional abuse which is [to be reported] within 24 hours [for reporting to the SA]. " On asking staff when the abuse allegation was reported to the SA, there was no documentation as to when it had been reported. The Abuse Prevention Plan of Vulnerable Adults policy dated February 2018, included the following: IV. Reporting Incidents of Mistreatment: A. Any individual who is aware that mistreatment had occurred or suspected such will IMMEDIATELY report to a supervisor or member	{F 609}	of the Vulnerable Adult Committee. The Abuse Prevention Plan of Vulnerable Adults policy specifically states that supervisory staff is to immediately report the incident to the Community Leader/Administrator and MDH OHFC or MAARC. SW-A was re-educated on F609 and the reporting timeline requirements on 5/25/18. All staff meetings will be held on 6/1/18 and 6/4/18. Neighborhood Nurse (RN) meetings will be held on 5/31/18 and 6/1/18. These meetings will review the Abuse Prevention Policy, specifically reporting requirement timelines. Additional education will be provided as needed. Neighborhood audits will be conducted by Community Leader and Social Services Mentor for 3 months and on a random basis thereafter to ensure that alleged allegations of mistreatments are reported within reporting timeline requirements. Social Services Mentor and Community Leader will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of Completion: 6/8/18	

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{F 609}	Continued From page 3 of Vulnerable Adult Committee. B. Immediate steps will be taken to remove the resident from further harm or danger. A supervisor will immediately assess the resident(s) and collect necessary date for incident reporting. The supervisor will review the initial report and mistreatment and make necessary staffing decisions that could include staff reassignment or sent home pending outcome of the investigations. Staff will not be suspended without notification from a supervisor. D. The supervisor/VA (vulnerable adult) Committee member will IMMEDIATELY contact the Community Leader, MDH-OHFC or MAARC (Minnesota Adult Abuse Reporting Center)...	{F 609}		
{F 825} SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.	{F 825}		6/8/18

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{F 825}	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative services for 1 of 3 residents (R239) who had a limitation in range of motion (ROM). Findings include: R239's most recent face sheet, identified diagnosis including cerebral infarction (stroke), and major depressive disorder. Review of 239's Functional Limitation Assessment dated 3/3/18, identified the treatment diagnosis of muscle wasting of multiple sites. Review of 239's occupational therapy (OT) plan of care (POC) note dated 3/3/18, identified R239's left upper extremity: fine motor control to be moderately impaired, gross motor mobility to be minimally impaired and completes up to 25% of normal range of motion. Left upper extremity sensation is intact, strength is 2+/5, and tone is hypertonic (increased muscle tone, and lack of flexibility). Review of 239's OT Progress and Discharge Summary dated 4/26/18, identified to include a splint schedule for 1-2 hours in the a.m./p.m. Clinical impression identified: "Left resting hand splint orthotic (R239) can wear for up to 2 - 2.5 hours ...extensive OT education has been completed with (R239) and nursing/aides on the floor ...(R239) also knows how to self-range her left hand with her right hand." Review of OT Daily Treatment note dated, 4/26/18, identified recommendations to continue with orthotic on 1 - 2 hours a.m./p.m. with encouragement.	{F 825}	F 825 Samaritan Bethany strives to ensure that if specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at 483.120(c) are required in the residents comprehensive plan of care the facility must provide the required services or obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. On 5/25/18 a clarification of recommendation was completed for C5's orthodic (splint) use stating "resident to wear orthotic 1-2 hours am/pm with encouragement as resident will allow". C5's care plan has been reviewed and updated to ensure the therapy clarification of recommendation is care planned. The clarification of recommendation for the splint has been added to the TAR (treatment administration record) for licensed nurses to ensure use. On 5/30/18 and 6/1/18 5th Neighborhood staff were educated on C5's use of the splint according to her care plan. Each resident is to receive specialized rehabilitative services based on their comprehensive-person centered	

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{F 825}	Continued From page 5 R239's most recent care plan, identified a focus of, "I have limited physical mobility related to debility, history of CVA (cerebral vascular accident) with residual left sided hemiparesis." Interventions included: "I participate in restorative care 2-3 times per week to help decrease contractures. Staff work with resident to wear hand splint on left hand 2-3 hours in the morning and 2-3 hours in the afternoon." R239 was observed and interviewed on 5/3/18, at 1:50 p.m., R239 was seated in her recliner watching television and hand splint was not present to left hand. R239's left hand had the 3rd and 4th finger bent touching the palm of her hand, when asked, R239 is unable to straighten them out, was observed to straighten them with her right hand maneuvering her left fingers when asked to do so. At 1:53 p.m., R239 stated they (therapy) tell her to wear that splint because, "It will help my fingers to straighten out." R239 further stated I do not mind wearing it, "I sometimes remind them [care givers] to put my splint on, but sometimes they don't do it. They forget to do it a lot." During interview on 5/3/18, at 1:55 p.m., nursing assistant (NA)-A stated I don't believe R239 had her splint put on this morning, we do not attempt to put her splint on her, she doesn't like to keep it on. OT usually comes up to do it. Further stated, I looked in point click care (electronic medical record) and it does not say we have to put the splint on her. During observation on 5/3/18, at 2:04 p.m., registered nurse (RN)-A offered to apply R239's left hand splint. R239 agreed and allowed RN-A to apply the left hand splint and R239 stated, "It	{F 825}	assessment completed initially, quarterly, with a significant change and as needed and documented in the care plan. All staff meetings will be held on 6/1/18 and 6/4/18. Neighborhood Nurse (RN) meetings will be held on 5/31/18 and 6/1/18. These meetings will review information regarding the provision of specialized rehabilitative services based on each residents' comprehensive person-centered plan of care. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure that specialized rehabilitative services are provided to residents' based on their comprehensive person-centered plan of care. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 6/8/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 825}	Continued From page 6 feels fine." During interview on 5/3/18, at 2:13 p.m., RN-A verified the nursing assistants should have been assisting R239 with left splint device since 3/22/18, and further verified it was not applied today. Further stated, "I would have expected the caregiver to know to look at the kardex (a summary of a patient's plan of care) and that she would have been responsible to put the hand splint on [R239]. During interview on 5/3/18, at 2:17 p.m., OT-B verified R239 is supposed to have assistance applying her left hand splint daily to prevent a contracture (permanent shortening of a muscle) of the left hand. OT-B said their expectation would be if we order a splint to be used for a resident, nursing staff should at least be offering to put it on the resident. During interview on 5/3/18, at 2:26 p.m., director of nursing (DON) stated, "My expectation would be if there is a recommendation from therapy for someone to wear a hand splint, then I would expect that it would be offered per therapy's recommendation, if the resident cannot tolerate it or if it was refused, it should be documented in the progress notes." A policy for splint services or specialized rehab services was requested but none was provided.	{F 825}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: R2U1

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 **03/16/2018** (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 **155** (L18)

13.Total Certified Beds **155** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	155			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Danette Bakken, HFE NE II — 04/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Amy Johnson, Enforcement Specialist — 04/26/2018 (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

Electronically delivered

April 3, 2018

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

RE: Project Numbers S5530029, H5530037

Dear Ms. Jacobs:

On February 22, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective February 27, 2018. (42 CFR 488.422)

Also, on February 22, 2018, The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F224. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on February 21, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 16, 2018, the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The standard survey found that your facility has not achieved substantial compliance with federal certification deficiencies. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in the letter of February 22, 2018:

- Civil money penalty for the deficiency cited at F224, be imposed. (42 CFR 488.430 through 488.444)

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedies:

- Civil money penalty for the deficiency cited at F686. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 21, 2018. (42 CFR 488.417 (b))

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Specialty Care Community is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 21, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 from the abbreviated standard survey completed on February 21, 2018 should be directed to:

Mike Kaehler, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: mike.kaehler@state.mn.us
Phone: (651) 201-4181
Fax: (651) 281-9796

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction from the standard survey completed on March 16, 2018 should be directed to:

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us
Phone: (507) 206-2731
Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- 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 ePoC 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 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 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 ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronically 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	03/16/2018

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted March 12, 13, 14, 15, and 16, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 12, 13, 14, 15, & 16, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other	F 557		4/25/18

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

Electronically Signed | 04/12/2018

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F 557	Continued From page 1 residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity for 1 of 1 resident (R14), who had soiled shoes and shirt. Findings include: R14's quarterly Minimum Data Set (MDS) an assessment, dated 12/4/17, indicated R14 required one assist for dressing and had moderate cognitive impairment. R14's current care plan, indicated R14 had a self care deficit related to impaired mobility and cognition. R14 required assist of one for dressing. During observation on 3/12/18, at 3:27 p.m., R14 was seated in a wheelchair in the living room area. R14's clothes had visible food on them. During observation on 3/13/18, at 9:34 a.m., R14 was seated in his wheelchair in the dining room area wearing a black t-shirt soiled with food debris and R14's shoes were soiled with food debris. During observation on 3/14/18, at 11:50 a.m., R14 was seated in his wheelchair at a dining room table eating lunch. At 12:17 p.m., R14 was seated in his wheelchair watching television in the living room area. R14's blue t-shirt and shoes were soiled with food debris. At 3:20 p.m., R14's blue t-shirt soiled with food and shoes remained soiled with food. During observation on 3/15/18, at 7:46 a.m., R14's shoes remained soiled with food.	F 557	F 557 Samaritan Bethany strives to ensure that each resident has the right to be treated with respect and dignity, including: the right to retain and use personal possessions, including furnishings and clothing as space permits unless to do so would infringe upon the rights or health and safety of other residents. R14's soiled shoes were cleaned on 3/15/18 and his soiled shirt was changed on 3/15/18. R14's clothing/shoes and personal appearance will be observed during daily cares by the Caregivers in R14's neighborhood. If clothing/shoes or personal appearance needs attention the Caregivers will ensure cleanliness. All residents clothing/shoes and personal appearance is to be observed during daily cares by the Caregivers. If clothing/shoes or personal appearance needs attention the Caregivers will ensure cleanliness All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F557 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding each resident's right to respect and dignity relating to cleanliness. Additional education will be provided as needed. Neighborhood audits will be conducted by Neighborhood Coordinators and Care Coordinators for 3 months and on a random basis thereafter to ensure that	

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F 557	Continued From page 2 During observation on 3/15/18, at 11:10 a.m., nursing assistant (NA)-H confirmed R14's shoes were soiled with food. NA-H stated for shoes normally the night person cleaned once a week and when a shirt is dirty with food, I would change the shirt. During observation on 3/15/18, at 11:10 a.m., licensed practical nurse (LPN)-H confirmed R14's shoes were soiled with food. LPN-H stated when a residents shirt is soiled, would expect the shirt to be changed. Regarding cleaning R14's shoes, LPN-H stated we can do that. During interview on 3/16/18, at 10:12 a.m., the director of nursing (DON) stated R14 was a tough one to take care of. He does not always like to have his shirt changed. The DON stated we should always try to have a clean shirt. Regarding shoes, we would want to clean those. A policy was requested for providing cleanliness, but not provided.	F 557	each resident's right to respect and dignity relating to cleanliness is upheld. Neighborhood Coordinators and Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,	F 561		4/25/18

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F 561	Continued From page 3 assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide bathing preferences for 4 of 4 (R392, R390, R397, and R113,) residents reviewed for choices. Findings include: R392's, Move In Record, document dated 3/15/18, identified an admit date of 3/10/18, and diagnoses of right artificial knee joint and rheumatoid arthritis. R392's care plan dated 3/10/18, identified the focus: "I do not have impaired cognition," intervention: "I am able to make my needs known, please follow my wishes." Further identified the focus: "I have an activity of daily living (ADL) self-care performance deficit related to rheumatoid arthritis and right total knee arthroplasty," intervention: "I require 1 staff	F 561	F561 Samaritan Bethany strives to ensure that each resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions. R392, R390 and R397 moved out prior to receiving the 2567. R113 was interviewed on 4/9/18 to determine bathing preference. R113's care plan was updated to reflect preference in bathing including days and times per week. All residents in Heritage will have a new Resident Personal Care Preference sheet completed to ensure bathing preferences are honored. All resident care plans will	

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F 561	Continued From page 4 participation with bathing." R392's, Follow Up Question Report dated, 3/10/18 - 3/16/18, revealed on 3/13/18, at 1:59 p.m., R392 required physical help in part of bathing activity. R392's unlabeled facility document, dated 3/10/18, identified R392 required 1 assist with a shower every Tuesday morning. R392's facility document, Resident Chosen Bath Day/General Time, printed 3/12/18, identified R392's bath day on Tuesday morning. During observation on 3/12/18, at 4:00 p.m., R392 was lying in her bed, with the head of bed elevated, her left knee was bent and a pillow placed under her right knee, while watching television. During interview on 3/12/18, at 4:26 p.m., R392 stated upon admission the facility had told her she could only have a shower once a week. Further stated, if you were prone to depression, only having 1 shower a week does not help, and its absurd putting on clean clothes when you haven't showered. "I am way not happy knowing I only get a shower once a week and I need help now!" During interview on 3/15/18, at 12:34 p.m., registered nurse (RN)-A verified R392 gets a shower weekly and stated, "My expectation is to offer a resident a shower when they want one." During interview on 3/15/18, at 12:38 p.m. licensed practical nurse (LPN)-A verified R392 gets a bath weekly and stated, "My expectation is	F 561	be updated to reflect any change in bathing preferences. A Bathing Preference Guideline will be created to ensure all staff understand and honor each residents bathing preference. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F561 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding each resident's right to their choice in bathing preferences. Additional education will be provided as needed. Neighborhood audits will be conducted by Neighborhood Coordinators and Care Coordinators for 3 months and on a random basis thereafter to ensure that each resident's bathing preference is upheld and care planned. Neighborhood Coordinators and Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 561	Continued From page 5	F 561		

they should be offering more showers if it is the resident's preference to have more than one a week."

During interview on 3/15/18, at 1:15 p.m., director of nursing (DON) stated, "My expectation for bathing would be for a resident to bathe as often as their preference is."

R390's, Move In Record, document dated 3/15/18, identified an admit date of 2/19/18, and diagnoses of repeated falls, urinary tract infection, major depressive disorder, and fracture of the right humerus and right ulna (fractured bones in the arm).

R390's care plan dated 2/19/18, revised 3/1/18, identified the focus: "I have an ADL self-performance deficit related to falling and fracturing my right humerus." Intervention: "I require 1 assist with bathing."

R390's progress notes revealed R390 had a shower completed on 2/24/18 and 3/10/18.

R390's, Follow Up Question Report dated, 2/19/18 - 3/16/18, revealed a bath on the following days: 2/24/18, at 9:29 p.m., 3/4/18 at 1:59 p.m., and 3/10/18, at 9:29 p.m., R390 required total dependence with bathing.

R390's unlabeled facility document, dated 3/10/18, identified R390 required 1 assist with bathing.

R390's facility document, Resident Chosen Bath Day/General Time, printed 3/12/18, identified R390's bath day on Saturday evening.

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F 561	Continued From page 6 During observation on 3/13/18, at 9:49 a.m., R390 is dressed in a facility gown, sitting on the edge of her bed and occupational therapy is doing passive range of motion (PROM) on her right hand. During observation on 3/14/18, at 11:57 a.m., R390 is dressed lying in bed on her back watching television, and wearing a blue sling on her right arm. During observation on 3/15/18, at 8:24 a.m. R390 is wearing a facility gown lying in her bed on her back watching television. R390's brownish gray hair is noted to be slightly greasy. During interview on 3/13/18, at 10:30 a.m., R390 stated, "So far I have only had 2 showers." Further stated she would like a bath 2-3 times a week. I get my baths on Saturday, I think they just forget about my baths on Thursdays. "I prefer to get a shower 2-3 times a week, I just feel better!" During interview on 3/15/18, at 12:34 p.m., RN-A verified R390 is cognitively intact gets a shower weekly on Saturday evenings and stated, "My expectation is if is the residents preference to take 2-3 showers a week, she should be offered that. During interview on 3/15/18, at 1:15 p.m., director of nursing (DON) stated, "My expectation for bathing would be for a resident to bathe as often as their preference is." R397's, Move In Record, document dated	F 561		

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F 561	Continued From page 7	F 561		

3/15/18, identified an admit date of 3/2/18, and diagnoses of surgical aftercare of a hernia with obstruction, pulmonary fibrosis, osteoporosis, and difficulty walking.

R397's care plan dated 3/2/18, identified the focus: "I do not have impaired cognition," intervention: "I am able to make my needs known, please follow my wishes." Further identified the focus: "I have the following preferences regarding my care," intervention: "Provide a shower when I bathe. I prefer taking a shower on Monday am."

R397's, Follow Up Question Report dated, 3/2/18 - 3/16/18, revealed on 3/13/18, at 10:39 a.m., R397 required supervision with bathing Tuesday morning.

R397's unlabeled facility document, printed 3/15/18, identified R397 required 1 assist with a shower every Tuesday morning.

R397's facility document, Resident Chosen Bath Day/General Time, printed 3/12/18, identified R397's bath day on Tuesday morning.

During interview on 3/13/18, at 8:29 a.m., R397 stated she would be bathing daily if she had the choice, "but you only get one a week." I was supposed to get one yesterday, but I got it today instead.

During observation on 3/14/18, at 11:53 a.m., R397 is dressed in blue jeans and a maroon colored top, walking with a 4 wheeled walker to the dining room.

During interview on 3/15/18, at 10:35 a.m.,

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F 561	Continued From page 8	F 561		

nursing assistant (NA)-A verified R397's bath days are Tuesday mornings, but the care plan stated Monday mornings.

During interview on 3/15/18, at 10:42 a.m., LPN-B verified R397's bath is scheduled for Tuesday morning on the bath sheet and scheduled for Mondays on the care plan. LPN-B stated, upon admission we will ask the resident what day they prefer to shower, and if a resident wants more than one a week, we will try and fit them in. LPN-B verified there is no documentation anywhere regarding a second shower. LPN-B further stated if someone has a preference for a shower every day, they should be getting that.

During interview on 3/15/18, at 1:15 p.m., director of nursing (DON) stated, "My expectation for bathing would be for a resident to bathe as often as their preference is."

R113's, Move In Record, document dated 3/15/18, identified an admit date of 1/23/18, and diagnoses of Sepsis (is a potentially life-threatening complication of an infection), carcinoma (cancer) of the bladder and hydronephrosis (when urine cannot drain out from the kidney to the bladder from a blockage or obstruction).

R113's 30 day Minimum Data Set (MDS) an assessment dated 2/13/18, revealed R113 to be cognitively intact, bathing was not assessed.

R113's care plan dated 1/23/18, identified the focus: "I have an ADL self-performance deficit related to weakness after recent hospitalization for sepsis." Intervention: "I require 1 staff

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F 561	Continued From page 9	F 561		

assistance with bathing. I take a shower on Saturdays in the evening."

R397's, Follow Up Question Report dated, 1/23/18 - 3/16/18, revealed on 2/10/18, at 9:59 p.m., and 3/10/18, at 9:34 p.m., that R113 was independent with bathing. On 2/24/18 and 2/25/18 bathing did not occur.

R113's unlabeled facility document, printed 3/15/18, identified R113, "I require 1 staff participation with bathing. I take a shower on Saturdays in the evening."

R113's facility document, Resident Chosen Bath Day/General Time, printed 3/12/18, identified R113's bath day on Saturday evening.

R113's progress note dated 3/10/18, at 5:12 p.m., revealed R113 needs stand by assist with bathing.

During interview on 3/12/18, at 6:25 p.m., R113 stated it was a least 3 weeks he was here before he even got a bath. Now they tell me I can have one bath every week, "I would rather have one every day." Further stated, I do the best I can, but you can only wash up so good. "Boy, when I got the bath, I sure felt a hell of a lot better!"

During observation on 3/12/18, at 6:37 p.m. R113 was sitting in his chair in his room with the television on. R113 was noted to have long gray hair and long gray beard dressed in clean clothes.

During interview on 3/15/18, at 8:04 a.m., R113 stated, he was supposed to get a shower yesterday, but for some unknown reason he did not get one. "I am a little upset I haven't had a

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F 561	Continued From page 10 shower, especially with my right bag leaking all this urine on me ...this not showering makes me feel like crap!" During interview on 3/15/18, at 10:20 a.m., NA-A stated, one time R113 told me no one gave him a shower yet, so I gave him one, this was back in February, he was pretty upset about it. NA-A verified R113 gets a shower on Saturdays, "I honestly thought he was independent with them though." During interview on 3/15/18, at 12:54 p.m., LPN-A verified R113 gets his showers on Saturday evenings and in the documentation it showed he had a shower on 3/10/18. LPN-A stated, "I know he had a bath at some point, I was here on the weekend, it just wasn't documented." During interview on 3/15/18, at 1:15 p.m., director of nursing (DON) stated, "My expectation for bathing would be for a resident to bathe as often as their preference is." A policy for bathing and resident choices /preferences was requested and was not receive.	F 561		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or	F 578		4/25/18

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F 578	Continued From page 11 inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to respond in a timely manner to change preference for Health Care Directives regarding code status for 1 of 1 resident (R120) reviewed for advanced directives. Findings include:	F 578	F 578 Samaritan Bethany strives to ensure that each resident has the right to request, refuse, and /or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	

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	245530	A. BUILDING _____ B. WING _____	03/16/2018

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F 578	Continued From page 12 R120 was admitted to the facility on 2/14/18, according to the admission form, Also included diagnoses of multiple fractures of ribs, fractured sternum, dementia, hypothyroidism, chronic obstructive pulmonary disease, and atrial fibrillation (irregular, often rapid heartbeat). R120's care area assessment (CAA) indicated R120 had a brief interview for mental status (BIMS) on 2/21/18, which resulted in a score of 6, and indicated R120 had severe cognitive impairment. During a review of R120's code status, the facility's CPR-DNR/DNI consent form identified R120's code status as cardiopulmonary resuscitation (CPR), also known as a full code. Furthermore, the code status was signed by R120 on 2/14/18. The signature of responsible party was unsigned. Review of R120's electronic medical record (EMR) identified a progress note dated 3/6/18, at 3:08 p.m., indicated that a care conference had taken place and the family wished to change the code status to do not resuscitate/do not intubate (DNR/DNI). During an interview on 3/15/18, at 10:58 a.m., regarding code status, registered nurse (RN-E), a manager, stated she had been unaware of the request as she had been on vacation at that time. During an interview with the director of nursing (DON) on 3/15/18 at 11:43 a.m., she stated her expectation would be that RN-E would have checked R120's documentation in the EMR after she returned from vacation and proceeded to	F 578	Care Coordinator spoke with R120's Son, Health Care POA on 3/15/18 in response to request to change code status and son chose to keep code status of full code and not change to DNR/DNI. R120 moved out on 3/27/18. Upon a resident moving in, code status is obtained and wishes care planned. Code status is reviewed quarterly during each resident's care conference and updated as requested or more frequently as resident or resident's representative requests. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F578 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding each resident's right to formulate or change an advance directive/code status in a timely manner. 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 each resident's right to formulate or change an advance directive/code status in a timely manner is upheld. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 578	Continued From page 13 change the code status in a timely manner. A facility policy related to advanced directives was requested but not received.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or	F 580		4/25/18

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F 580	Continued From page 14 State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician and resident responsible party of a change in skin condition for 1 of 3 residents (R69) reviewed for pressure ulcers. Findings include: R69's progress note, dated 3/6/18, a skin/wound note, resident had a shower this a.m. Skin was observed by writer. Small open area to right ankle (a stage 2 pressure ulcer), Avellyn (dressing) applied. R69's record lacked documentation the physician and the responsible party were notified of the newly opened area on R6's right ankle. During observation on 3/15/18, at 8:10 a.m., licensed practical nurse (LPN)-H and registered nurse (RN)-F were observed to provide wound treatment for R69's pressure wound on her right ankle. The right ankle pressure ulcer had intact	F 580	F 580 Samaritan Bethany strives to ensure that we immediately inform the resident; consult with the resident's physician and notify the resident representative when there is a significant change in the resident's physical, mental, or psychosocial status. Care Coordinator notified family and physician of the change in skin condition for R69 on 3/15/18. R69's right ankle ulcer is a healing stage II pressure ulcer measuring 0.3cmx0.3cm. The resident, resident's representative and resident's physician is to be notified by a licensed nurse regarding any significant change in the resident's physical, mental or psychosocial status and documented in resident's medical record. All staff meetings will be held on April 17,	

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F 580	Continued From page 15 skin that was pink in color and measured 1 x 0.5 centimeter. During interview on 3/15/18, at 7:54 a.m., registered nurse (RN)-F stated she was responsible for measuring pressure ulcer wounds then documented the assessment in point click care (computerized charting system) under skin/wound. RN-F stated R69's was found with an open area on her right ankle on 3/6/18 and this was the first RN-F had been aware of the pressure ulcer on R69's ankle. RN-F continued to say that the physician and family had not been contacted when the pressure ulcer first was found on 3/6/18 and will do so today. During interview on 3/16/18, at 10:09 a.m., the director of nursing (DON) stated I would expect the physician and family to be notified when a pressure ulcer has developed. The facility policy Change in Resident Condition Notification, dated review 10/17, indicated Policy: Samaritan Bethany will communicate information regarding resident changes to the resident, family/responsible party, and physician/nurse practitioner in a timely manner. Procedure: 1. Nursing staff will inform the resident, consult with the resident's physician or nurse practitioner, and notify the resident's legal representative or family member when: there is a need to alter the resident's treatment significantly (i.e. need to discontinue an existing form of treatment due to adverse consequences or to commerce a new form of treatment.	F 580	2018 and April 20, 2018 to review F580 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding notification of a change in condition to the resident, resident's representative and physician. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure notification of each residents change in condition to the resident, resident's representative and physician occurs. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609		4/25/18

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F 609	Continued From page 16 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to report an allegation of neglect of care in a timely manner for 1 of 1 resident (R73) who did not receive treatment for a stage 2 pressure ulcer that deteriorated to an unstageable pressure ulcer with malodorous exudate. Findings include:	F 609	F609 Samaritan Bethany strives to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve	

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F 609	Continued From page 17 During an interview with the facility administrator on 3/16/18 at 10:57 a.m., regarding a current stage 4 pressure ulcer R73 had, the administrator stated the facility had reported an allegation of potential neglect of care with the State Agency's Office of Health Facility Complaints (OHFC) when it had been determined the pressure ulcer had deteriorated to a draining, malodorous unstageable pressure ulcer. The administrator then provided a copy of the report the facility had filed: The report to OHFC indicated the facility had submitted it on 1/15/18, at 17:40 (5:40 p.m.). The report alleged neglect of health care for 73 related to pressure ulcers. A Wound Monitoring document indicated R73 had a stage II pressure area monitored duirng her previous and current admission. The document included documentation from 12/6/17 (previous admission), and 1/1/18 (current admission) indicating an area 1 centimeter (cm) x 1 cm with no pain, exudate or odor. The documentation for both dates also described the skin around the area as healthy. The 1/1/18 note on the document indicated an Allyven dressing was in place. On 1/8/18, a Medicare Note indicated R73 had a large blackish/purple wound on her coccyx with foul smelling-blackish-brown drainage coming from the area. Also documented on 1/8/18, a skin/wound note identified presence of a large amount of drainage on the coccyx dressing. The note identified a stage 3 ulcer (decubitus ulcer extends into the underlying subcutaneous tissue layer, but not all the way to the bone) was observed in the gluteal	F 609	abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. A Vulnerable adult report was made to OHFC on 1/15/18 immediately after the Community Leader was notified of the alleged mistreatment. On 1/25/18 we received the disposition letter from MDH stating that the report had been reviewed and it has been determined that no further action by this office is necessary at this time. The Abuse Prevention Plan of Vulnerable Adults policy was reviewed. Samaritan Bethany staff and our volunteers are instructed to immediately report all witnessed and suspected incidents of mistreatment to a supervisor or member of the Vulnerable Adult Committee. The Abuse Prevention Plan of Vulnerable Adults policy specifically states that supervisory staff is to immediately report the incident to the Community Leader/Administrator and MDH OHFC or MAARC. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F609 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding the Abuse Prevention Policy, specifically reporting requirement timelines. Additional education will be provided as needed. Neighborhood audits will be conducted by	

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F 609	Continued From page 18 fold (coccyx/sacrum) region. The immediate surrounding tissue was described as dark purple and intact. Drainage from the ulcer was described as brown and foul smelling. According to the note, the area was cleansed with saline and a new dressing applied. The note also indicated the certified nurse practitioner (CNP)-B was notified of the ulcer. Documentation indicated staff were to continue to offload frequently and observe for signs of systemic infection. A corresponding nursing note indicated the coccyx area was open, about 5 cm x 3 cm with a necrotic area measuring about 3.5 cm x 3 cm and the certified nurse practitioner (CNP) had been notified. On 1/8/18, a clinical note from CNP-B confirmed the CNP-B had received a note from nursing staff that same day regarding R73's wound areas. CNP-B's note indicated "the most worrisome condition" was the sacral wound. CNP-B documented, "it sounds like nursing feels this may have been present prior to patient's return back to facility. Nursing reports include R73 had developed a necrotic area around the sacral wound and very malodorous discharge which is dark to black in color with copious amounts of drainage, enough to saturate the Allevyn dressings applied. Nursing has been cleansing the area with saline and applying Allevyn daily." The CNP-B identified the sacral pressure ulcer area as unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) sacral ulceration indicating, "this lesion [pressure ulcer] is concerning as it could be full thickness given the bogginess noted on exam around the eschar region centrally. This wound probably should be debrided with sharp debridement. Therefore, I	F 609	Community Leader for 3 months and on a random basis thereafter to ensure that alleged allegations of mistreatments are reported within reporting timeline requirements. Community Leader will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of Completion: 4/25/18	

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F 609	Continued From page 19	F 609		

plan to send the patient to the Wound Clinic for this wound... and for recommendations on wound care and also debridement." As a result of the CNP-B's assessment, treatment ordered included 0.25 percent acetic acid soaks for 15-25 minutes, and to follow by cleansing the area with normal saline or clean water/wound cleansing agent, and to apply Santyl to the necrotic areas. CNP-B further indicated staff should proceed to cover the area they used Santyl on with 4 X 4 gauze, and a foam dressing, which should be changed twice daily.

The resident's medical record lacked any assessment or monitoring of the resident's pressure ulcer between 1/1 and 1/8/18.

During interview on 3/16/18, at 9:40 a.m. licensed practical nurse (LPN)-A stated, "I wasn't here as the care coordinator when she came in, I was a floor nurse so I don't know too much about the ulcer." LPN-A attempted to find documentation of any monitoring or interventions from 1/1/17-1/8/18, for R73's coccyx/sacral ulcer. When she was unable to find anything she stated, "the other coordinator left, I don't see anything documented here."

During interview with the neighborhood coordinator (NC)-C on 3/16/18, at 9:50 a.m. she also stated, "I don't see any treatments in the record for that time period." NC-C was asked if there were any nursing assistants working who would have worked with R73 at the time of her admission. However when she checked the schedule, she stated "none of them are here."

During interview with the director of nursing (DON) on 3/16/18, at 10:57 a.m. she stated, "I

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F 609	Continued From page 20 can't tell you anymore than what is in the report. From our investigation of this, staff told us they were doing treatments but there is no documentation of the treatments being completed. I would have expected interventions to have been put into place on admission when she had a current pressure area on her coccyx." Although the facility had made a report to OHFC regarding the allegation of neglect (deterioration of the resident's pressure ulcer to unstageable as of 1/8/18), they did not do so within 24 hours, but waited until 1/15/18.	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the	F 623		4/25/18

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resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and

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F 623	Continued From page 22 telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of facility initiated discharges for 1 of 2 residents (R132) who were discharged to the hospital. Findings include:	F 623	F 623 Samaritan Bethany strives to ensure that before we transfer or discharge a resident, we must notify the resident and the resident's representative of the transfer or discharge and the reasons for	

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F 623	Continued From page 23 R132's Move In Record, dated 3/16/18, identified had diagnoses that included malignant neoplasm of temporal lobe and disorder of brain. Review of R132's resident Progress Notes, identified on 2/13/18, R132 was transported to the emergency room via ambulance. On 2/15/18, social service note read R132 is in the hospital her family member (FM)-F picked up her belongings but is holding her bed here for now, till we hear different. During interview on 3/16/18, at 8:27 a.m., social worker (SW)-A stated (regarding notifying the ombudsman of R132's discharge to the hospital) I did not send notification to the ombudsman. SW-A stated she was not aware she had to do so. During interview on 3/16/18, at 10:00 a.m., the director of nursing stated (regarding notifying the ombudsman), I think there was a misunderstanding as the social worker had not reported it.	F 623	the move in writing and in a language and manner they understand and that we send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. Social Worker notified the ombudsman of the immediate transfer to the hospital on 4/11/18 for R132. The Move out planning policy was reviewed and revised on 3/20/18 to ensure a procedure for notification of the Ombudsman for immediate resident transfers and facility initiated resident transfers. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F623 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided regarding notification of resident transfers or discharges to the Ombudsman. Additional education will be provided as needed. Neighborhood audits will be conducted by Community Leader for 3 months and on a random basis thereafter to ensure that notification of resident transfers or discharges to the Ombudsman occurs according to the move out planning policy. Community Leader will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		4/25/18

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F 656	Continued From page 24 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 656		

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F 656	Continued From page 25 Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 3 residents (R120) reviewed for falls and elopement. Findings include: R120 had been admitted to the facility according to the admission form on 2/14/18. The form also included diagnoses of dementia and repeated falls with fractures. R120's care area assessment (CAA) dated 2/27/18, identified R120 as having altered mental status demonstrated by a brief interview for mental status (BIMS) score of 6 indicating severe impairment. Also identified as a significant risk for falls related to a history of falls, including a fall with injury during a hospital stay on 1/28/18, where it was determined R120 had fractured two ribs and sternum from the fall at the hospital. R120's elopement assessment dated 2/14/18, indicated R120 was not cognitively impaired, did not have poor decision making skills, was alert to person and place and aware of her need for placement and therefore not an elopement risk. According to the facility investigation reports, R120 had sustained a fall on 3/7/18, and 3/11/18. The interventions to continue therapy and remind R120 to use the call light. A progress note dated 3/12/18, at 10:09 p.m., indicated R120 continues to be disoriented to time and place and attempted to leave by opening the stairway door. Continually denies living here and looking for someone to take her home. Able to wheel around in wheelchair. Needs redirection	F 656	F 656 Samaritan Bethany strives to ensure a comprehensive person-centered care plan for each resident is developed and implemented consistent with the resident rights and includes measureable objectives and time frames to meet a residents medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. R120 had no further falls or elopement attempts before moving out of the facility on 3/27/18. A Wandering/Elopement policy has been developed and reviewed to establish a procedure for residents who wander or attempt to elope from the facility. The policy will be provided at the neighborhood meetings. Facility fall protocol was reviewed and revised to ensure residents' comprehensive care plans include interventions related to falls. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F656 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding the wandering/elopement policy and comprehensive care plans implemented related to falls. 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 comprehensive person-centered care plans are created and implemented for each resident related to falls and that the wandering/elopement policy is followed.	

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F 656	Continued From page 26 to return to room. On asking the facility for care plan interventions related to falls and elopement behaviors, none had been found on review of the electronic medical record (EMR). None had been provided. During an interview with nursing assistant (NA)-F, had stated that R120 had not had any falls. NA-F verified there were no fall prevention interventions on the Bedside Kardex Report sheet which is utilized by NA's to provide resident centered care. On asking about elopement history, NA-F stated that to her knowledge, R120 had not tried to leave the unit but NA-F stated she works days and R120 "sundowns [syndrome where a person exhibits confused and restless in the afternoon]." During an interview with registered nurse (RN)-E a manager, on 3/15/18, at 10:58 a.m. she verified that there were no fall prevention interventions developed on R120's comprehensive care plan. RN-E stated that she was unaware that R120 had tried to leave the unit and did not consider R120 to be an elopement risk. Again RN-E verified no interventions were in place to prevent elopement(s) had been developed. During an interview with the director of nursing (DON) on 3/15/18, at 11:43 a.m., she stated it would be her expectation that the unit manager would be aware of R120's wandering and attempt to elope and that R120 would have a wander guard placed, added to the facility wander list, and have an elopement care plan developed. The DON also would expect that R120 would have a fall care plan with interventions to prevent further falls.	F 656	Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 656	Continued From page 27 Facility Policy "Fall Protocol" revised 1/2015 indicate a fall will be investigated to determine the circumstances surrounding the fall, looking for patterns, etc. in an attempt to prevent further falls. In addition, care plan and care sheet are reviewed and updated when changes occur. A policy regarding elopement was requested and not received.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine nail care for 2 of 4 residents (R14 and R340) reviewed for activities of daily living (ADL's), who were assessed to need staff assistance for nail care. Findings include: R14's quarterly Minimum Data Set (MDS) an assessment, dated 12/4/17, indicated R14 required one assist for personal hygiene and had moderate cognitive impairment. R14's current care plan indicated R14 had a self-care deficit related to impaired mobility and cognition. R14 required assist for grooming, was diabetic and the nurse will trim my nails. During observation on 3/12/18, at 3:27 p.m., R14 was seated in a wheelchair in the living room	F 677	F 677 Samaritan Bethany strives to ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R14's nails were trimmed and cleaned on 3/15/18. R340's nails were trimmed and cleaned on 3/15/18. Nail care is provided by nursing staff during daily grooming and as needed to maintain resident dignity. Nail trimming for residents is provided by nursing staff on the day the resident receives a bath or shower and as needed. A resident with diabetes is provided nail trimming by licensed nursing staff on the day the resident receives a bath or shower and as needed. All staff meetings will be held on April 17,	4/25/18

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F 677	Continued From page 28 area. R14's fingernails were long on both hands. During observation on 3/13/18, at 9:34 a.m., R14 was seated in his wheelchair in the dining room area. R14's fingernails were long on both hands. During subsequent observations on 3/14/18, at 11:50 a.m. and 3/15/18, at 7:46 a.m., R14's fingernails remained long on both hands. During observation on 3/15/18, at 11:10 a.m., nursing assistant (NA)-H confirmed R14's fingernails were long. NA-H stated she was unable to provide nail care for R14 due to R14 being diabetic. I have to tell the nurse and the nurse would trim R14's nails on bath days. During observation on 3/15/18, at 11:10 a.m., licensed practical nurse (LPN)-H noted R14's fingernails being long. LPN-H stated maybe two weeks ago I cut them. If a resident needs fingernails trimmed staff should tell the nurse and it was part of the skin check, to check the nails also and if needed trim the nails then. In regards to R14 received a bath on Tuesday evening, LPN-H stated R14's nails should have been done during the bath time. R340's admission MDS an assessment, dated 3/1/18, indicated R340 required limited assist of one for personal hygiene and had moderate cognitive impairment. R340's current care plan indicated R14 needed help with ADL's related to debility and some forgetfulness. R14 required one staff assist with bathing and personal hygiene.	F 677	2018 and April 20, 2018 to review F677 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding necessary services to maintain residents' grooming and personal hygiene related to nail care. Neighborhood audits will be conducted by Neighborhood Coordinators and Care Coordinators for 3 months and on a random basis thereafter to ensure that necessary services to maintain residents' grooming and personal hygiene related to nail care. Neighborhood Coordinators and Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 677	Continued From page 29	F 677		

During observation and interview on 3/13/18, at 10:04 a.m., R340's fingernails on both hands were long, some of them were broken off and had debris underneath the nailbeds. When queried if staff had offered to trim his fingernails, R340 stated no, not since I have been here. R340 stated I would like them trimmed as they are too long and that is why they are breaking off.

During observation on 3/14/18, at 11:53 a.m., R14's fingernails remained long and had debris underneath the nailbeds on both hands.

During interview on 3/14/18, at 1:41 p.m., NA-I stated nail care should be done every bath day and in between baths if needed, unless the resident was diabetic then the nurse would do. We clean underneath the nails using a tool and then trim the nails. NA-I stated R340 received a bath on Wednesday night.

R340's Progress note, dated 3/14/18, at 9:37 p.m., indicated R340 had a shower today. There was no documentation R340 refused nail care.

During observation on 3/15/18, at 11:18 a.m., NA-H looked at R340's fingernails on both hands and stated they were long and dirty.

During observation on 3/15/18, at 11:22 a.m., LPN-H looked at R340's fingernails and stated one is short, the rest are long and dirty. I will clip them. LPN-H stated if a resident refused nail care a note should be made in the progress notes. LPN-H reviewed R340's record and stated no, there was no documentation R340 refused nail care.

During interview on 3/15/18, at 1:08 p.m.,

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F 677	Continued From page 30 registered nurse (RN)-F stated nail care was to be provided on bath days and as needed. During interview on 3/16/18, at 10:12 a.m., the director of nursing (DON) stated she would expect staff to keep fingernails trimmed and clean. A policy was requested for providing nail care, but none provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide proper positioning for 1 of 3 residents (R37) who was reviewed for positioning needs. Findings include: R37's face sheet printed 3/16/18, identified diagnosis including hemiplegia and hemiparesis following cerebral infarction, affecting left non-dominant side. R37 was observed on 3/12/18, at 4:31 p.m. sitting in Broda chair (a tilt and recline repositioning	F 684	F 684 Samaritan Bethany strives to ensure that quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on our comprehensive assessment of a resident we strive to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' choices. An order was obtained on 4/12/18 for R37 to be evaluated and treated by OT/PT for wheelchair positioning.	4/25/18

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F 684	Continued From page 31 chair). R37 was leaning to the right in chair with head resting on right shoulder, no head support on chair. R37's significant change Minimum Data Set (MDS) an assessment dated 12/20/17, identified R37 had moderately impaired cognition, needed extensive assistance of 2 staff with bed mobility and had a functional limitation in the upper and lower extremities on one side. The ADL (activities of daily living)/rehabilitation Care Area Assessment (CAA) dated 12/21/17, identified R37 required the use of the ceiling lift and two staff for all transfers, extensive assist of two staff for bed mobility, dressing, toileting, personal hygiene, locomotion and requires set up assist with eating. The CAA also identified R37 as having left sided hemiparesis that was a result of a CVA (cerebrovascular accident). R37's care plan last reviewed 12/26/17, identified limited physical mobility related to (r/t) cerebrovascular accident (CVA) with left hemiparesis and physical and cognitive impairment. The care plan also identified R37 needs assistance to turn/reposition at least every 2 hours, more often as needed or requested. R37's bedside kardex report printed 3/16/18, identified R37 was dependent on staff for changing positions and repositioning. R37's occupational therapy (OT) note dated 8/9/16, identified OT discussed with nursing staff that current wheel chair not supporting head enough. OT provided patient with tilt in space wheel chair, adjusted arm rests, neck rest and provided patient with left arm trough. Patient reported increased comfort.	F 684	Each resident is to receive treatment and care such as therapy services based on their comprehensive-person centered assessment completed initially, quarterly, with a significant change and as needed. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F684 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff to ensure that residents receive treatment and care in accordance with the comprehensive person-centered care plan. 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' receive treatment and care in accordance with their comprehensive person-centered care plan. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 684	Continued From page 32	F 684		

During observation on 3/12/18, at 5:30 p.m. R37 was observed eating supper. R37 was leaning way to the right in the Broda chair, neck bent, head resting on right shoulder. Had difficult time feeding self in that position.

During observation on 3/14/18, at 10:45 a.m. R37 was observed sleeping reclined back in Broda chair head leaning to the right. Again neck was bent and head resting on right shoulder.

During observation on 3/14/18, at 11:45 a.m. R37 was again observed in the dining room up in Broda chair. R37 leaned to the right with neck bent, head resting on right shoulder and chair reclined back. R37 was observed to have a difficult time getting food to mouth in that position.

During observation on 3/15/18, at 12:55 p.m. staff were going to put resident into bed. R37 was observed in Broda chair leaning to the right with neck bent and head resting on right shoulder.

During observation on 3/16/18, at 9:07 a.m. R37 was observed in Broda chair in the dining room attempting to eat. Continued to lean to the right with neck bent and head resting on right shoulder. R37 had difficult time getting food to his mouth in that position.

During interview on 3/15/18, at 8:37 a.m. certified occupational therapy assistant (COTA)-A when she was observing R37. COTA-A stated the last time anyone worked with R37 had been on 11/10/16. When asked about the chair for positioning she stated he used to be in a tilt and space chair. When R37 was put on hospice they changed the tilt and space chair and replaced it

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F 684	Continued From page 33 with the Broda chair. The tilt and space chair worked very well for him to support him and had a trough for him to elevate his arm. I don't know why you would switch out a chair if it worked well for him. COTA-A then added she had seen a tilt and space chair located in the bathroom. She explained how the tilt and space chair had support for R37's head and shoulders and the trough for his arm. COTA-A added that R37 should use the tilt and space chair. During interview on 3/15/18, at 12:55 p.m. nursing assistant (NA)-F stated he was put in that chair (Broda) when he went on hospice. She stated he sat much better in this other chair (reference to tilt and space chair). NA-F stated he always leans. We can reposition him and put pillows around him when in the Broda chair but it doesn't help. During interview on 3/15/18, at 12:55 p.m. NA-G stated he "flops" around a lot more in that chair (Broda). She stated "that's just his condition." During interview on 3/15/18, at 1:16 p.m. registered nurse (RN)-E stated she didn't know much about the tilt and space chair. She stated he was put in the Broda chair when he went on hospice. She stated I didn't know he had two chairs in his room. RN-E stated I see him sitting like that a lot in regards to the leaning to the right with neck bent and head resting on shoulder. RN-E stated I suppose we should have therapy look at that chair again. A policy on positioning was requested but none was provided.	F 684		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		4/25/18

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F 686 SS=G	Continued From page 34 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and monitor pressure ulcers to determine resident centered treatment(s), and to ensure treatment measures were implemented to promote healing and prevent further pressure ulcer development, for 2 of 3 residents (R73 & R69) reviewed who had current pressure ulcers. R73 sustained harm due to lack of timely treatments/services following identification of coccyx pressure ulcer which deteriorated from a stage II to unstageable in one week. Findings include: R73's readmission Move In Record, indicated she'd been readmitted to the facility on 12/28/17, and included diagnoses of: low back pain, closed fracture of left femur onset 11/2017, a history of falls with fractures prior to this admission, atrial fibrillation and rhabdomyolysis (a condition in	F 686	F 686 Samaritan Bethany strives to ensure that based on the comprehensive assessment of a resident, we must ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable and a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. An order was obtained on 3/15/18 to turn and reposition R69 every 2 hours. R69's care plan was reviewed and updated to reflect the 2 hour repositioning schedule. Physician's dictation on 4/4/18 for R69 states "meticulous wound care continues	

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F 686	Continued From page 35 which damaged skeletal muscle tissue breaks down rapidly). Admission documentation indicated R73 had been a resident at the facility prior to discharge home on 12/22/17, was hospitalized for a brief stay then readmitted to the facility 12/28/17. A PRE MOVE IN Assessment dated 12/27/17, indicated R73 had a stage II pressure area to her coccyx. A Wound Monitoring document indicated R73 had a stage II pressure area monitored duirng her previous admission and 1/1/18. The document had documentation from 12/6/17 (from her previous admission), and 1/1/18 (current admission) indicating an area 1 centimeter (cm) x 1 cm with no pain, exudate or odor. The documentation for both dates also described the skin around the area as healthy. The 1/1/18 note on the document indicated an Allyven dressing was in place. R73's admission Minimum Data Set (MDS) assessment dated 1/4/18, indicated R73 was cognitively intact, had a stage two pressure ulcer and required extensive assist with bed mobility and transfers. The corresponding CAA dated 1/10/18, indicated R73 had been admitted with a stage II sacral ulcer, and indicated R73 was at risk for skin problems due to actual issues, and dependency upon staff for transfers and mobility due to debility. The interventions identified included use of a pressure reducing mattress on R73's bed, and a pressure relieving cushion in the wheelchair. The goal was identified as: "to resolve skin issues and keep skin free of breakdown," and the CAA indicated this would be addressed on the care plan.	F 686	for these chronic wounds. Given her terminal diagnoses and chronic nutritional challenges and mobility issues, wound healing will be compromised despite current excellent wound care measures." Weekly wound assessments were completed on 3/22/18, 3/29/18, 4/3/18, and 4/11/18 for R69. For R73 we failed to ensure treatment measures were implemented timely to promote healing and prevent further pressure ulcer development. A Vulnerable adult report was made to OHFC on 1/15/18 immediately when the Community Leader was notified of the mistreatment. On 1/25/18 we received the disposition letter from MDH stating that the report had been reviewed and it has been determined that no further action by this office is necessary at this time. On 1/8/18 treatment to coccyx ulcer initiated by licensed nurse according to physician orders for R73. Coccyx ulcer is monitored weekly by licensed nurse and wound vac in place as of 3/16/18. Weekly wound assessments were completed on 3/21/18, 3/26/18, 4/6/18, and 4/12/18 for R73. All residents are assessed to determine their individualized plan of care for treatment and services for pressure ulcers including their specific repositioning schedule to prevent pressure ulcers and promote healing. Wound assessments are to be completed weekly by a licensed nurse. On 4/24/18 licensed nurses working in Heritage Rehabilitation will be re-educated	

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F 686	Continued From page 36 Review of R73's December 2017, and January 2018, treatment administration records (TAR) indicated no treatment had been initiated to the coccyx wound until 1/9/18 when Santyl ointment was prescribed. Although the Wound Monitoring document indicated R73 had a 1 cm x 1 cm stage II pressure area on the coccyx on 1/1/18, R73's admission Braden Scale dated 12/28/17, indicated the resident had a 3 cm x 1 cm stage II pressure ulcer to the coccyx area. The Braden score was 20, indicating low risk for pressure ulcers. Also a left heel pressure ulcer "blister area on her heel that is opened." On 12/28/17, the facility had conducted an admission tissue tolerance (an assessment to determine how long skin tissue could tolerate pressure over a bony prominence) which indicated R73 was unable to reposition self independently while in bed, and was unable to stand/off-load independently when sitting. The tissue tolerance summary indicated R73 required staff assist of one to reposition and offload (remove pressure to skin areas over bony prominences) however, no repositioning schedule for sitting/lying was identified to prevent skin damage and allow current pressure ulcers to heal. R73's care plan dated 1/8/18, indicated a problem area of two pressure ulcers related to immobility on sacral/coccyx and heel. Interventions included: provide pressure relieving measures; reposition every two hours; pressure relieving device alternating pressure mattress; supplemental protein to promote wound healing; dry dressing	F 686	on the process and importance of wound care. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F686 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding residents' comprehensive assessments to ensure necessary treatment and services for pressure ulcers. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure that based on residents' comprehensive assessments necessary treatments and services are provided to prevent or promote healing of pressure ulcers. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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changes as ordered for sacral wound; assess/record/monitor wound healing weekly-measure length, width and depth where possible; assess and document status of wound perimeter, wound bed and healing progress; report improvements and declines to the MD (medical doctor); and 4 oz (ounces) mighty shake supplement 1 time per day with midday meal initiated 1/4/18. No previous other care plan or interventions was provided by the facility.

On 12/29/17, a full nutritional assessment completed for R73 indicated the resident had experienced a 4.8 percent (%) weight loss from a prior admission. The assessment indicated a current weight of 111 #(pounds) and indicated the resident's weight was down from 116.2# on 12/6/17. In addition, the nutritional assessment indicated R73 had been started on 4 oz of Mighty Shake one time daily, but did not include any mention of the coccyx pressure ulcer.

On 1/8/18, a Medicare Note indicated R73 had a large blackish/purple wound on her coccyx with foul smelling-blackish-brown drainage coming from the area.

Also documented on 1/8/18, a skin/wound note identified presence of a large amount of drainage on the coccyx dressing. The note identified a stage 3 ulcer (decubitus ulcer extends into the underlying subcutaneous tissue layer, but not all the way to the bone) was observed in the gluteal fold (coccyx/sacrum) region. The immediate surrounding tissue was described as dark purple and intact. Drainage from the ulcer was described as brown and foul smelling. According to the note, the area was cleansed with saline and a new dressing applied. The note also indicated the

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certified nurse practitioner (CNP)-B was notified of the ulcer. Documentation indicated staff were to continue to offload frequently and observe for signs of systemic infection. A corresponding nursing note indicated the coccyx area was open, about 5 cm x 3 cm with a necrotic area measuring about 3.5 cm x 3 cm and the certified nurse practitioner (CNP) had been notified.

On 1/8/18, a clinical note from CNP-B confirmed the CNP-B had received a note from nursing staff that same day regarding R73's wound areas. CNP-B's note indicated "the most worrisome condition" was the sacral wound. CNP-B documented, "it sounds like nursing feels this may have been present prior to patient's return back to facility. Nursing reports include R73 had developed a necrotic area around the sacral wound and very malodorous discharge which is dark to black in color with copious amounts of drainage, enough to saturate the Allevyn dressings applied. Nursing has been cleansing the area with saline and applying Allevyn daily." The CNP-B identified the sacral pressure ulcer area as unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed) sacral ulceration indicating, "this lesion [pressure ulcer] is concerning as it could be full thickness given the bogginess noted on exam around the eschar region centrally. This wound probably should be debrided with sharp debridement. Therefore, I plan to send the patient to the Wound Clinic for this wound... and for recommendations on wound care and also debridement." As a result of the CNP-B's assessment, treatment ordered included 0.25 percent acetic acid soaks for 15-25 minutes, and to follow by cleansing the area with normal

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saline or clean water/wound cleansing agent, and to apply Santyl to the necrotic areas. CNP-B further indicated staff should proceed to cover the area they used Santyl on with 4 X 4 gauze, and a foam dressing, which should be changed twice daily.

On 1/8/18, a progress note indicated an alternating pressure mattress was applied to R73's bed.

On 1/8/18, the physician prescribed a treatment to sacral area; 1/4 strength acetic acid wet to dry dressing, change twice daily or three times daily if needed. ProSource liquid (high protein supplement) 3 times daily at meals due to impaired skin.

On 1/9/18, a progress note indicated the ProSource liquid 30 cc (cubic centimeters) with meals had been added to the resident's nutritional regime for impaired skin, and indicated Santyl ointment daily had been added as an intervention.

On 1/14/18, a nursing progress note included R73's wound on the sacral area was irregular shaped, full thickness area measuring 5.5 cm by 5 cm that is 75% slough and 25 % necrosis. There is a 0.8 cm depth in a small area of the wound. There is a large amount of serosanguinous drainage on the old dressing that is very odorous.

On 1/22/18, nurses note identified the sacral wound as being much deeper measuring 3.5 cm with tunneling at 3 O'clock of 3 cm. The wound was cultured which grew Proteus Mirabilis and R73 was started on the antibiotic Sulfamethoxaxole-Trimethoprim.

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On 1/30/18, a nurses note Identified R73 went to wound clinic. Dressing changes changed to everyday and as needed and included Santyl to wound bed on coccyx as well as packing area with Aquacel AG. Pressure area identified at stage 4 ulcer by the wound clinic.

On 1/31/18, a Clinical document from CNP-B had identified stage IV sacral pressure injury wound, sacral ulcer changed to Aquacel AG daily and as needed (PRN), follow up in wound clinic in 3 weeks.

On 2/5/18, a Skin wound note identified sacral wound as full thickness wound with beefy red wound base. Skin around wound dry and scaly. There is no odor and the wound is clean with a beefy red base. This wound is measuring 3.7 cm by 3.5 cm and 2.4 cm deep. There is tunneling at 6 o'clock measuring 2.5 cm and at 12 o'clock measuring 1.7 cm. The sound base is 25 % epithelial and 75% granulation tissue. Wounds monitored weekly.

On 2/12/18, a Skin wound note identified the sacral wound as a full thickness wound draining a moderate amount of yellowish green drainage, no odor and wound is clean with a beefy red base. Wound measures 5 cm by 3.5 cm. It is 1.5 cm deep. There is tunneling at 6 o'clock measuring 2.8 cm and at 12 o'clock measuring 2.8 cm with the wound base base 55 slough and 95% granulation tissue. 1 cm by 0.1 cm area of maceration at 6 o'clock. Continue to monitor wounds weekly.

On 2/18/18, a Skin wound note identified sacral wound as full thickness and is draining a

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moderate amount of serosanguinous drainage. There is a slight odor but the wound is clean with a shiny beefy red base. This wound measures 5.4 cm by 3.6 cm and 1 cm deep. No longer tunneling at 6 o'clock and 12 o'clock tunneling and decreased to 1 cm. New area of undermining at 9 o"clock measuring 2.5 cm, the wound base remains 5% slough and 95% granulation tissue. A 1 cm by 0.1 cm are maceration at 6 o'clock. Continue to monitor wounds weekly.

On 2/21/18 a wound care clinic care plan report identified treatment as Aquacel AG to ulcer base, moisten slightly with saline, cover with sot dry gauze and secure with cover roll stretch. Change once a day and as needed (PRN) depending on drainage amount. General instruction included, watch for signs of infection, offload pressure areas in prevention of skin breakdown, turn/reposition every 2 hours and PRN to help in prevention of skin breakdown, continue with nutritional support and consider applying wound vac to sacral ulcer.

On 2/26/18, a Skin/wound note identified sacral wound as full thickness and is draining a moderate amount of tan colored drainage, no odor and wound is clean with a shiny beefy red base. Wound measuring 4.4 cm by 3.4 cm and 1.6 cm deep. Tunneling at 12 o"clock is 1.7 cm. New area of undermining at 9 o'clock measuring 2.3 cm. Wound base is 100% granulation tissue. No maceration at this time. Continue to monitor wounds weekly.

On 3/9/18, a Physician order identified to increase frequency of sacral dressing changes to daily.

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On 3/13/18, a Skin/wound note included a dressing changed to sacral ulcer. Upon removing dressing a foul odor noted with brown drainage saturating dressing. Appeared to be bowel movement under the dressing. Area around dressing red and irritated. Full thickness and drainage is difficult to assess as bowel movement had gotten under the dressing creating a foul odor. Wound had shiny beefy red bad, measures 3.6 cm by 3.8 cm and 1.5 cm deep. Tunneling at 12 o'clock is 1.9 cm, with undermining at 9 o'clock measuring 2.5 cm. The wound base is 100% granulation tissue. 0.4 cm of maceration at the distal end of the wound. Periwound is reddened possibly form the irritation of the stool. Continue to monitor wounds weekly.

On 3/15/18, a physician's order for a wound vacuum change 3 times per week was obtained.

The facility's Wound Monitoring document for the coccyx/sacral ulcer, included measurements and interventions including:
-1/1/18: 1 cm length by 1 cm width, no depth, no exudate, no odor. Mattress and cushion in wheelchair, Allevyn dressing on.
-1/14/18: 5.5 cm length by 5 cm width and 0.8 depth and staged as unstageable with 100 percent slough and /or eschar, yellow/green heavy exudate and foul odor. Treatment of acetic acid, ProSource liquid, Santyl ointment, alternating pressure mattress
-1/22/18: length 6 cm by width 4.5 cm and 3.5 cm deep now staged as a IV with foul odor, heavy purulent drainage, pain rated 5 (1 to 10 scale and 10 excruciating). Treatment continued with acetic acid, santyl ointment and started packing wound with Nu-Gauze.
-1/30/18: Aquacel AG, Santyl cover everyday

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F 686	Continued From page 43 -2/5/18: Aquacel AG, Santyl Alt pressure -2/12/18: Santyl, Aquacel AG, alt pressure mattress, cover with border dressing -2/19/18: Aquacel AG, E-stimulation started -2/26/18: Aquacel AG, E-stimulation -3/5/18: Aquacel AG, border dressing, E-stimulation -3/13/18: E stimulation, Aquacel AG Border Dressing During an observation on 3/14/18, at 11:35 a.m. R73 had been moved from her room to the dining room. She had a pressure reducing cushion in her wheel chair (w/c). At 2:38 p.m., R73 was observed sitting up in her wheel chair and stated, "I just got up. They aren't putting that patch on my bottom till 4:30 p.m. and that is way to long for me to be in bed!" At 4:06 p.m. R73 was sitting in the lobby listening to music. During an observation on 3/15/18, at 7:15 a.m. R73 was up in the w/c beside her bed wearing a nightgown. Nursing assistant (NA)-A stated she'd just gotten R73 up and needed the nurse to check R73's wound vac. An alternating air mattress was observed on R73's bed. At 7:55 a.m. R73 was observed lying on her back in bed, with a pillow propped under her left side. At 9:30 a.m. R73 stated she'd just gotten up for breakfast because she'd been in bed because of the new machine (wound vac). At 10:45 a.m. R73 was still sitting in the dining room and was visiting with company. At 11:30 a.m. R73 was seated in a chair in the dining room but stated she'd been back to her room to have a treatment done to her bottom. At 1:05 p.m. R73 was returned to bed and positioned on her right side. On 3/16/18, at 9:00 a.m. R73 was sitting in the	F 686		

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dining room eating breakfast. She stated, "I just have to drink the rest of this then I am going to get my nails done." When asked how her bottom was today, she stated "not too bad, it doesn't hurt a lot, only if I am up too much. I am going to get off it as soon as I'm done with my nails."

During interview on 3/16/18, at 9:40 a.m. licensed practical nurse (LPN)-A stated, "I wasn't here as the care coordinator when she came in, I was a floor nurse so I don't know too much about the ulcer." LPN-A attempted to find documentation of any monitoring or interventions from 1/1/18-1/8/18, for R73's coccyx/sacral ulcer. When she was unable to find anything she stated, "the other coordinator left, I don't see anything documented here."

During interview with the neighborhood coordinator (NC)-C on 3/16/18, at 9:50 a.m. she also stated, "I don't see any treatments in the record for that time period." NC-C was asked if there were any nursing assistants working who would have worked with R73 at the time of her admission. However when she checked the schedule, she stated "none of them are here."

During interview with the director of nursing (DON) on 3/16/18, at 10:57 a.m. she stated, "I can't tell you anymore than what is in the report. From our investigation of this, staff told us they were doing treatments but there is no documentation of the treatments being completed. I would have expected interventions to have been put into place on admission when she had a current pressure area on her coccyx." R69's admission face sheet indicated admission to the facility 12/28/15, with diagnosis including: dementia, depression, end stage renal disease

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and heart failure. Additional medical record review indicated hospice care was initiated for R69 on 1/11/18 due to R69's declining health status and worsening dementia symptoms.

R69's significant change Minimum Data Set (MDS) dated 1/25/18, indicated R69 had moderate cognitive impairment, required extensive assist of one for bed mobility and transfers, was at risk for/currently had pressure ulcers; one stage three pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) measuring 2 cm (centimeter) x 2 cm x 1 cm, and had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough: yellow, tan, gray, green or brown; and/or eschar: tan, brown or black colored in the wound bed). The MDS indicated pressure ulcer interventions included pressure reducing device for bed/chair, nutrition or hydration interventions and pressure ulcer care.

During continuous observation on 3/14/18 beginning at 12:34 p.m., R69 was observed in bed laying on her right side, covered with blankets. At 1:17 p.m., R69 remained the same. At 1:47 p.m., R69 remained on her right side. At 2:23 p.m., R69 remained the same. At 2:42 p.m., R69 remained the same. At 2:56 p.m., R69 remained the same. At 3:10 p.m., nursing assistant (NA)-I entered R69's room with an EZ stand lift (mechanical lift device) and asked R69 if she wanted to get up. During the observation, it was noted R69 had an alternating pressure mattress on her bed, gripper socks on her feet, a

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pillow between her legs and a pillow behind her back. Before transferring R69 from the bed to the wheelchair, NA-I and licensed practical nurse (LPN)-H checked R69's right hip wound and stated the Allevyn (dressing) covering the wound was intact, and the skin surrounding it was normal in color. R69 had remained in bed on her right side for 2 hours and 36 minutes without repositioning.

During interview on 3/14/18 at 3:17 p.m., LPN-H said she was unsure how often R69 was to be repositioned. LPN-H proceeded to look at the care plan (used by the nursing assistants for care delivery) located on the inside of R69's cupboard door, and stated R69 was suppose to be repositioned every one to two hours.

When interviewed at 3:20 p.m. on 3/14/18, NA-I stated R69 was suppose to be repositioned every two hours or so. When NA-I was informed R69 had remained positioned on her right side for 2 hours and 39 minutes, NA-I offered no further information.

A Braden Scale assessment (for predicting pressure sore risk) conducted for R69 on 1/22/18, indicated R69's risk to include: sensory-slightly limited, moisture- rarely moist, activity-chairfast, mobility-slightly limited, nutrition- adequate, and identified friction and shear as potential problems. The Braden Scale assessment indicated R69 was at risk to develop pressure ulcers.

R69's care plan, last reviewed 2/1/18, included: "alteration in skin integrity because I need help with mobility and I am no longer walking. I have depression, hypertension, hyperlipidemia, chronic kidney disease -stage four. I have a stage three

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pressure ulcers to my coccyx and an unstageable pressure ulcer to my left hip." Interventions identified included: administer treatments as ordered and monitor for effectiveness, avoid positioning me on my coccyx, float left foot off the mattress while in bed, follow my elimination and mobility care plans, I use an alternating pressure mattress on bed and tempurpedic cushion in my w/c (wheelchair), observe my skin with daily cares and weekly bathing, use house products to protect my skin, obtain and monitor lab/diagnostic work as ordered, report results to MD (medical doctor) and follow up as indicated. I have a terminal prognosis related to CVA (cerebral vascular accident) and vascular dementia. I am on Hospice care. I need help with ADL's (activities of daily living) and mobility because I have limited mobility." Interventions were identified as "Repositioning: I need 1 staff to reposition in bed and chair every 2 hours. I am able to use assist rails properly to help with my repositioning."

R69's currently has the following pressure ulcers in various stages of healing. Each pressure ulcer that follows includes, observation, interviews and record reviews as follows:

COCCYX PRESSURE ULCER:

On 9/28/17, first developed sacral pressure ulcer stage III, according to RN-F during interview on 3/15/18 at 7:54 p.m.

From 9/28/17 to 3/6/18, the facility missed weekly wound assessments on several occasions, although the treatments were completed as ordered.

On 3/15/18, observed with LPN-A during wound

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care to be 2.4 X 2.5 X 1.3 cm (slight deterioration from 2/27/18 measurements) with red wound base, foul smell (this is new finding).

LEFT HIP PRESSURE ULCER:
On 11/21/17, skin/wound note, skin was observed, quarter size red area left hip. Skin protectant and Allevyn applied.

From 11/21/17 to 3/6/18, weekly documentation of wound status was missed on several weeks. Wound was noted to show slow healing, treatments given as ordered.

On 3/15/18, at 8:10 a.m. observed left hip pressure ulcer when LPN-H completed wound treatment. Observed wound to be white/yellow tissue around base and measure 2 X 1.8 X 0.8 cm with some improvement since last measurement on 2/27/18 or seventeen days ago.

RIGHT HIP PRESSURE ULCER:
On 2/6/18, a physician's progress note indicated right lateral hip/greater trochanter region stage one/unstageable wound. Though the skin is intact, there are discolored punctuated areas at the central region of this skin discoloration concerning for unstageable wound. Nursing has been covering this with a foam border protective dressing for a time but when I examined the area today there was no dressing present. Asked nursing to continue to dress with productive foam border dressing moving forward. We will have to monitor this closely for eschar and development of ulceration. Goals of care are aimed towards comfort, continues to work with hospice.

From 2/6/18 to 2/27/18, the ulcer deteriorated in status, continued hospice services due to decline

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in health and nutritional intake.

On 3/15/18, at 8:10 a.m. observation along with LPN-H and registered nurse (RN)-F provided wound care to pressure ulcer on right hip. Wound base had black and white tissue with red surrounding skin, measures 1.2 X 0.9 cm. RN-F said the wound had opened today.

RIGHT LATERAL (OUTSIDE) FOOT BY THE FIFTH TOE PRESSURE ULCER:

On 2/27/18, a skin/wound note, Right lateral foot next to 5th toe (little toe) had a large intact blister with purple center. Blister measured 1.8 x 1.5 cm. Cover with Allevyn to relieve pressure.

From 2/27/18 to 3/6/18 the weekly wound assessment had not been completed each week.

On 3/15/18, at 8:10 a.m. LPN-H and RN-F were observed to complete wound treatment for R69. Noted wound measures 1.2 X 1.8 cm with black eschar tissue. The last wound assessment was on 2/27/18 or sixteen days ago.

RIGHT LATERAL (OUTSIDE) ANKLE PRESSURE ULCER:

On 3/15/18, at 8:10 a.m. (nine days after stage II pressure ulcer was discovered by facility) during an observation of wound treatment with LPN-H and RN-F. The stage II ankle ulcer measured 1 X 1.5 cm with intact pink skin. RN-F said before the treatment was completed she had not been aware of this pressure ulcer. Also the ankle pressure ulcer discovered on 3/6/18 had not been comprehensively assessed nor had the physician been notified of its development. RN-F said that

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she would complete the comprehensive wound assessment today as well as notify the physician of its development.

During interview on 3/15/18, at 10:54 a.m.., RN-F had reviewed the information regarding the pressure ulcers located on R69's coccyx, left hip, right hip, right foot and right ankle. RN-F confirmed weekly measurements and complete wound assessments had not been done consistently. The left hip pressure ulcer was first noted on 11/21/17 and had not been comprehensively assessed until 12/21/17 a month later.

During interview on 3/16/18, at 10:09 a.m., the director of nursing (DON) stated she would expect staff to measure/document description of wounds weekly in the resident progress notes. I would expect newly identified pressure areas to be assessed and interventions developed timely to prevent the area from opening. I would expect all areas of wound treatment to be on the current physician orders. The DON also stated she would expect the resident to be repositioned per the plan of care.

The policy SKIN/WOUND CARE TREATMENT AND HEALING PROGRAM: last reviewed 11/2017, identified it is the policy of the facility to identify and assess residents whose clinical conditions increase the risk for development of skin issues and pressure ulcers, to implement preventative measures, and to provide appropriate treatment measures for pressure ulcers.

1. Assessment
A. Each resident who develops a Stage I, II,

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III, IV ulcer, deep tissue injury, and stasis ulcer will be evaluated. The nurse making the initial evaluation will initiate the wound monitoring tool.

B. For development of a Stage II, III, IV pressure ulcer a MDS may be generated per significant change criteria.

C. Document weekly on Wound Monitoring Tool. Do not down stage a pressure ulcer.

Criteria to be included in an assessment:

1. Location of wound(s)
2. Stage of pressure ulcer
3. Size including length, width, and depth measured in centimeters
4. Appearance of the wound bed including a description of the type of tissue present. When there is a combination of tissue types each type should be identified by the percentage present - i.e. 50% granulation and 50% fibrous slough
5. Undermining can be assessed by gently probing the wound base with a cotton swab. Measure depth in centimeters and describe location in relation to the face of a clock.
6. Drainage/exudate should be described using amount, color or type, consistency, odor of exudate.
7. Periwound tissue should be palpated and described if erythematous, indurate, edematous, macerated.
8. Pain and tenderness should be evaluated.

D. A clean ulcer should exhibit some evidence of healing within 2 weeks. Consider reassessment if there is no improvement or an ulcer increases in size.

E. Every effort will be made to set treatment goals consistent with the values and lifestyle of the resident, and family.

2. Managing Tissue Load - refers to the

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distribution of pressure, friction, and shear on the tissue.

A. Include all preventative measures that involve positioning.

B. Avoid positioning residents on pressure ulcers.

C. Residents at risk and those who have a pressure ulcer are at risk for developing further ulcers.

D. Provide all residents with Tempurpedic mattresses.

E. Residents who have pressure ulcers on seating surfaces should avoid prolonged sitting.

F. Reposition and use of devices should be individualized on care plan. Tempurpedic cushions are available.

3. Ulcer Care per MD, NP or Wound Clinic recommendations

A. Follow facility Wound and Skin Formulary for all wound care.

B. The Clinical Supervisor and MD/NP will collaborate for other modalities for Stage II-IV pressure ulcers that

don't respond to conventional therapy.

4. Managing Bacteria Colonization and Infection

A. Pressure ulcers may be colononized. Minimize this through effective wound cleaning and debridement. If foul odor or purulence develops, cleanse more frequently.

B. Protect pressure ulcers from urine, feces or other contamination.

C. Always follow Universal Precautions.

D. If a resident has multiple pressure areas attend to the most contaminated on last.

5. Quality Improvement

A. Wound will be assessed weekly to monitor prevention, healing and treatment of wounds.

B. A report identifying any notable trends will be presented by the Clinical Supervisor at the

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F 686	Continued From page 53 monthly CQI Committee Meeting.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and implement interventions to prevent reoccurring falls for 2 of 5 residents (R97 & R10) reviewed for accidents. Finding include: R97 was admitted to the facility on 10/18/18, with diagnosis identified on the admission diagnosis report sheet as including: fractured left femur, repeated falls, dysphasia, chronic kidney disease and cerebral vascular accident (CVA). Review of the significant change Minimum Data Set (MDS) an assessment dated 1/22/18, identified R97's Brief Interview for Mental Status (BIMS) score of "14" (meaning intact cognition). Requires extensive assistance with dressing, toileting, bed mobility and transfers. Has an unsteady balance during transitions and walking. Utilizes a wheelchair for mobility. R97 was identified as having a fall since the last assessment with no injury.	F 689	F 689 Samaritan Bethany strives to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents. Care Coordinator reviewed R97's and R10's fall history for possible contributing factors and interventions and care plan was updated after review. After each fall for a resident, contributing factors are identified and interventions are implemented and care planned in attempt to prevent further falls. Facility fall protocol reviewed and revised. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F689 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding contributing factors and interventions related to falls. Neighborhood audits will be conducted by	4/25/18

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F 689	Continued From page 54 Review of the Care Area Assessment (CAA) dated 1/22/18, identified R97 as triggering for falls and referred to the plan of care. R97's current plan of care identified the resident as being at risk for falls related to CVA, dementia and lower left sided weakness. The resident had a fall on 1/12/18, which resulted in a left displaced femoral neck fracture. Interventions listed: observe for change in cognition, assist with activities of daily living (ADL's), toileting plan, provide a safe environment free of clutter, call light in reach, redirect and remind, occupational therapy (OT) and physical therapy (PT) as ordered, mechanical stand with transfers, edge defining mattress and recliner. Review of the current fall risk assessment dated 1/20/18, identified R97 as having a history of falls and being at high risk for falls. R97 sustained a left femoral neck fracture after a fall on 1/12/18. Review of a fall incident report dated 1/12/18, at 6:30 p.m. indicated R97 was found on the floor in her room by another residents family member. The resident was observed laying on her right side next to her bed. The resident stated she had been trying to put her clothes away in her closet and fell on her way back to the chair. Upon examination the resident complained of severe left hip pain and range of motion was severely limited in her left leg/hip. The resident was sent to the emergency room for further evaluation at 7:10 p.m. and was admitted to the hospital after confirming a fracture of the left femur. Review of the incident reports/progress notes for falls revealed R97 experienced repeat falls on	F 689	Care Coordinators for 3 months and on a random basis thereafter to ensure that contributing factors are identified and interventions are implemented after resident falls in attempt to prevent further falls. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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12/11/17, 12/26/17, 1/2/18, 1/8/18, 1/12/18, 1/17/18 1/29/18, 2/3/18, 2/24/18 and 3/14/18. The incident/progress reports included the following information:

(1) dated 12/11/17, R97 fell at 4:28 a.m. in her room. The staff responded to the residents call light and found her on her left knee next to her bed hanging onto the side rail. R97 complained of left knee pain and obtained an abrasion to her left knee. The resident indicated she was getting out of bed to use the bathroom and slid off the mattress. Causal factors: none identified. Interventions: continue care plan interventions of placing call lite in reach and has a low bed.

(2) dated 12/26/17, R97 fell at 3:00 a.m. in her room. The resident was found on the floor in her room near her recliner. The resident indicated she was trying to get up and couldn't put the footrest down on her recliner and slid to the floor. No injuries. Causal factors: none identified. Intervention: no new interventions other than to continue to check on resident frequently.

(3) dated 1/2/18, R97 fell at 4:00 a.m. in her room. The staff found the resident kneeling on the floor next to her bed when answering her call light. The resident indicated she was sitting on the edge of her recliner and slid to her knees. No injuries. Causal factors: none identified. Interventions: no new interventions other than continue to monitor.

Review of the interdisciplinary team meeting note dated 1/3/18, indicated R97's falls have been related to self transfers to and from the recliner and chair in the middle of the night between the hours of 3-4:00 a.m. A 4 day sleep study ordered

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to identify patterns. A discussion with the residents family regarding a different type of recliner as the resident can no longer manage the side lever to let down the foot portion of the chair.

(4) dated 1/8/18, R97 fell at (unknown) time in the bathroom. The residents daughter informed the facility staff that in the "middle of the night" around 4:00 a.m.. the resident called her daughter and informed her she had just fallen in the bathroom and hit her head when she was getting dressed for the day. The resident had gotten herself up without notifying staff. The resident obtained a small bruise on the back of her head. Causal factors: none identified. Interventions: lift chair was unplugged.

Review of a progress note dated 1/12/18 at 9:09 a.m., indicated OT unplugged R97'S lift recliner on 1/8/18, for safety purposes. The note further included OT currently trained R97 with the use of the lift chair and the plan is to leave the chair plugged in for use. The resident was able to demonstrate safe use of the chair as well as the foot rise mode

(5) dated 1/12/18, fell at 6:30 p.m. in her room. The resident was found on the floor in her room by another residents family member. The resident was observed laying on her right side next to her bed. The resident stated she had been trying to put her clothes away in her closet and fell on her way back to the chair. Upon examination the resident complained of severe left hip pain and range of motion was severely limited in her left leg/hip. The resident was sent to the emergency room for further evaluation at 7:10 p.m. and was admitted to the hospital after confirming a fracture of the left femur

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R97 was re-admitted to the facility from the hospital on 1/16/18, after a surgical repair of a fractured left femur.

(6) dated 1/17/18, fell at 7:15 a.m. in her room. The resident was getting up to use the bathroom and fell. Injuries: none noted. Causal factors: none identified. Interventions: PT/OT to evaluate and treat. Toileting plan.

(7) dated 1/29/18, fell at 8:05 a.m. in her room. The resident indicated she was getting up to check on some furniture. Injuries: none noted. Causal factors: none identified. Interventions: added a edge defining mattress.

Review of the interdisciplinary note dated 1/30/18, indicated R97's falls were reviewed and determined to have been falling more early in the morning. Interventions: assist the resident with getting up for the day at to include at 6:30 a. m. instead of 7:00 a.m.

(8) dated 2/3/18, fell at 11:30 p.m. in her room. The resident was getting up from her recliner and slid off. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(9) dated 2/24/18, fell at 6:35 a.m. in her room. The resident was found sitting on the floor in front of her bed. The resident stated she was trying to get from her bed to her recliner. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(10) dated 3/14/18, fell at 3:00 a.m. in her room. The resident was found laying on the floor on her left side with a pillow underneath her head at the

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bedside in front of her recliner. The resident stated she was trying to get into her chair. The resident was incontinent of urine. Injuries: none noted. Causal factor: none identified. Interventions: no new interventions.

Although, interventions had been identified following some of the resident's falls, a comprehensive assessment of causal factors, and review of effectiveness of interventions had not been routinely conducted to reduce the risk of further falls.

Review of the OT/PT notes indicated R97 received therapy treatment/services during these times:

PT services:
dated 10/19/17-11/22/17, due to reduced functional capacity and safe transfers and ambulation related to a possible CVA.
dated 1/2/18-1/12/18, due to falls and sliding from her recliner
dated 1/17/18-current, treatment after a post hip fracture

OT services:
dated 10/19/17-11/22/17, due to decline in ADL's due to weakness and falls.
dated 12/31/17-1/12/18, due to decline in ADL's
dated 1/17/18-2/19/18, due to post treatment of a hip fracture

Interview with nursing assistant (NA)-L on 3/14/18, at 12:55 p.m. indicated R97 makes attempts to transfer self independently without using the call light for assistance or waiting long enough for staff to assist her. NA-L further included the resident becomes confused and

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thinks she is able to transfer and walk independently even though she requires 1 assistance and a mechanical standing lift.

Interview and observation of the resident on 3/14/18, at 2:30 p.m. R97 was observed resting in her remote recliner. The call light was in place. The residents daughter was visiting. The residents daughter indicated R97 had a history of falls. The daughter further included R97 forgets to use the call light for assistance due to her dementia, as well as wanting to be more independent. R97 confirmed the above statement.

Observation of the resident on 3/15/18, at 10:30 a.m. R97 was resting in her recliner with the call light in place. No attempts to transfer self. Observation during this time, R97 was assisted to the toilet with the use of a mechanical stand and 1 assistance per the plan of care. The resident is not able to bear full weight bearing at this time due to recent hip fracture.

Interview with registered nurse (RN)-H on 3/15/18, at 11:00 a.m. indicated R97 is forgetful and will transfer self without assistance. RN-H further included R97's falls had been reviewed and felt interventions had been exhausted to prevent the resident from further transferring independently and falling. RN-H further verified possible causal factors related to the residents falls were not always investigated and new interventions implemented.

R10 was admitted to the facility on 4/4/14, with diagnosis identified on the admission diagnosis report sheet as including: osteoporosis,

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peripheral vascular disease (PVD), dementia, Alzheimer's disease, bipolar disease and chronic kidney disease.

Review of the annual MDS assessment dated 6/22/17, identified R10 as requiring extensive assistance with dressing, toileting, bed mobility and transfers. Has an unsteady balance during transitions and walking. Utilizes a wheelchair for mobility. R10 was identified as having 2 or more falls since the last assessment with no injury.

Review of the CAA dated 6/22/17, identified R10 as triggering for falls and referred to the plan of care.

Review of the quarterly MDS assessment dated 12/6/17, identified R10's BIM's score of "9" (meaning impairment in cognition). Requires extensive assistance with dressing, toileting, bed mobility and transfers. Has an unsteady balance during transitions and walking. Utilizes a wheelchair for mobility. R10 was identified as having 2 or more falls since the last assessment with no injury.

R10's current plan of care identified the resident as being at risk for falls and having a history of fractures/dislocations. R10 was identified as having poor balance and being forgetful and impulsive related to diagnosis of Alzheimer's, memory impairment and anxiety. The care plan identified the resident as having an ADL self care performance deficit and limited mobility. Interventions: anti-lock brakes to wheelchair, call light to wheelchair, staff assistance and mechanical stand with toileting and transfers, staff assist with positioning, edge-defining mattress and remind and encourage the resident

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to use the call light.

Review of the current fall risk assessment dated 3/6/18, identified R10 as having a history of falls and being at high risk for falls.

Review of the incident reports/progress notes for falls revealed R10 experienced repeat falls over the past year on 4/2/17, 4/9/17, 4/26/17 (2), 4/28/17, 5/13/17 (2), 5/15/17, 5/20/17, 5/26/17, 6/23/17, 7/29/17, 7/30/17, 8/5/17, 8/14/17, 9/28/17, 10/26/17, 11/1/17, 11/2/17, 11/15/17, 11/28/17, 12/18/17, 12/28/17, 12/31/17, 1/21/18, 2/2/18, 2/8/18, 2/10/18, 2/11/18, 2/14/18, 2/18/18 and 2/24/18. The incident/progress reports indicated the following information:

(1) dated 4/2/17, R10 fell at 1:12 p.m. in her room. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions included.

(2) dated 4/9/17, R10 fell at 9:13 p.m. in her room. The resident indicated she was transferring self to the toilet when staff found her. R10 had hit her head on the toilet stool and obtained a bump to the back of her head. Causal factors: none identified. Interventions: no new interventions included.

(3) dated 4/26/17, R10 fell at 4:34 p.m. in her room. The resident had fallen forward from her wheelchair on to the floor. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions included.

Review of the interdisciplinary team progress note dated 4/28/17, identified R10 as having 3 falls in the month of April. No patterns to the falls

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were identified. The plan is to monitor the resident for her sleep preferences and initiate a bladder screening assessment on 5/1/17.

(4) dated 5/13/17, R10 fell at 1:24 p.m. and again at 8:50 p.m. The resident was found sitting on the floor next to her bed at 1:24 p.m. and at 8:50 p.m. the resident was found on the floor in the dining room trying to transfer self from the dining room chair to her wheelchair. Injuries: no injuries noted from either fall. Causal factors: none identified for either fall. Interventions: no new interventions for either fall.

(5) dated 5/15/17, R10 fell at 2:26 a.m. in her room. The resident was found on the floor next to her bed. The resident was confused and unsure to why she fell. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions included.

(6) dated 5/20/17, R10 fell at 6:44 p.m. in her room. The resident was found on the bathroom floor. The resident was confused and hallucinating. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions included.

(7) dated 5/26/17, R10 fell at 9:06 a.m. in her room. The resident indicated she was transferring self into her wheelchair. Call light was in reach. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions included.

(8) dated 6/23/17, R10 fell at 5:40 p.m. in her room. The resident was found sitting on the floor next to her bed. The resident indicated she was trying to transfer to her wheelchair from her bed.

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Injuries: none noted. Causal factors: none identified. Interventions: no new interventions included.

(9) dated 7/29/17, R10 fell at 10:20 a.m. in her room. The resident indicated she was transferring herself to her wheelchair so she could go to the bathroom and also brush her teeth. Injuries: obtained a small scrape on her left hip. Causal factors: none identified. Interventions: no new interventions included.

(10) dated 7/30/17, R10 fell at 11:50 p.m. in her room. The resident indicated she was trying to to go to the bathroom. The resident obtained a laceration to the back of her head. Causal factors: none identified. Interventions: no new interventions included.

Review of the interdisciplinary team progress note dated 8/4/17, indicated falls were reviewed for R10 with no pattern to her falls regarding the time of day or incontinence of bowel and bladder. Interventions to change toileting plan to every 3 hours during the day until a pattern can be identified. Vitamin D3 supplement changed to daily from weekly to aid in the prevention of falls.

(11) dated 8/5/17, R10 fell at 12:30 p.m. in her room. The resident had indicated she was attempting to go to the bathroom when she fell. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(12) dated 8/14/17, R10 fell at 8:30 a.m. in her room. The resident indicated she was walking to her closet to find something and lost her balance. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

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(13) dated 9/28/17, R10 fell at 5:55 p.m. in her room. The resident was found next to her dresser with her wheelchair beside her. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(14) dated 10/26/17, R10 fell at 9:05 p.m. in her room. The resident was found on the floor next to her bed. The resident told staff she was trying to get from her wheelchair to her chair by the window and lost her balance. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(15) dated 11/1/17, R10 fell at 1:26 a.m. in her room. The resident indicated she was getting up to go cook something to eat. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(16) dated 11/2/17, R10 fell at 9:30 p.m. in her room. The resident was found on the bathroom floor. The resident obtained a bruise on her coccyx and a reddened area on the back of her head. The resident indicated she was attempting to go to the bathroom. Causal factors: none identified. Interventions: no new interventions.

Review of the interdisciplinary team progress note dated 11/6/17, identified R10 as having 3 falls within the month. Discussed evening activities the resident may enjoy. Interventions include to plan to involve the resident in activities and to involve her husband as well.

(17) dated 11/15/17, R10 fell at 6:00 p.m. in her room. The resident was observed to be walking behind her wheelchair from her recliner and fell.

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Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(18) dated 11/28/17, R10 fell at 7:10 p.m. in her room. The resident indicated she was walking over to her phone to pay some bills. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(19) dated 12/18/17, R10 fell at 9:10 p.m. in her room. The resident was found on the floor next to her bed yelling for help. The resident indicated she was trying to reach for something by the window. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(20) dated 12/28/17, R10 fell at 5:35 p.m. in her room. The resident indicated she was trying to transfer to her wheelchair from her bed. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(21) dated 12/31/17, R10 fell at 1:55 p.m. in her room. The resident was found on the bathroom floor and had been incontinent of bowel. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

Review of the interdisciplinary team progress note dated 1/3/18, included suggestions regarding wheelchair brakes that would auto break with weight when the resident attempts to stand. A call light will be attached to the residents wheelchair.

Review of the progress note dated 1/4/18, indicated brake stops were installed on R10's wheelchair.

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Review of the OT progress note dated 1/12/18, included a recommendation to offer activities for the resident to engage in to include folding napkins/towels in the dining/TV area after the residents husband leaves for the day. Check on resident in her room before supper meal and remind the resident that her call light is on her wheelchair.

(22) dated 1/21/18, R10 fell at 11:31 p.m. in her room. The resident was found on the floor next to her wheelchair by the doorway of her room. The resident stated she was getting out of bed and fell. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(23) dated 2/2/18, R10 fell at 12:45 p.m. in her room. The resident was found on the bathroom floor. The resident had taken her clothes off to go to the bathroom. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(24) dated 2/8/18, R10 fell at 5:00 p.m. in her room. The resident was found on the bathroom floor and had been attempting to transfer self to the toilet. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(25) dated 2/10/18, R10 fell at 7:24 p.m. in her room. The resident was found on the floor in front of her bed. The resident had attempted to transfer herself to bed. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

(26) dated 2/11/18, R10 fell at 11:05 a.m. in her

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room. The resident was found on the bathroom floor. The resident fell after trying to transfer self from the toilet into her wheelchair. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

Review of the interdisciplinary team progress note dated 2/13/18, indicated fall prevention was reviewed for R10. The resident has an edge defining mattress, wheelchair stops and a call light place on wheelchair. R10 still chooses to self-transfer causing falls. The resident has Alzheimer's disease that causes forgetfulness, poor judgement and impulsive behaviors. The team suggests a sign for her room for reminders to call for staff assistance with transfers. Time patterns were reviewed and determined not to be a factor for her falls. No changes to toileting schedule at this time.

(27) dated 2/14/18, R10 fell at 7:45 p.m. in her room. The resident was found on the floor between her bed and wheelchair. The resident obtained a bruise on the right side of her back and back of her right arm. Causal factors: none identified. Interventions: have the resident read the newspaper in the main lounge for increased monitoring.

(28) dated 2/18/18, R10 fell at 6:00 p.m. in her room. The resident was found on the bathroom floor under the sink. The resident indicated she was attempting to go to the bathroom and fell. The resident hit her head on the toilet. The resident obtained a bump on the back of her head. Causal factors: none identified. Interventions: frequent checks

(29) dated 2/24/18, R10 fell at 5:15 p.m. in her

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room. Injuries: none noted. Causal factors: none identified. Interventions: no new interventions.

Although, interventions had been identified following some of the resident's falls, there were many that did not include new interventions to prevent further falls. Many falls did not include a comprehensive assessment of causal factors, and a review of the effectiveness of interventions had not been routinely conducted to reduce the risk of further falls.

Review of the physician visit progress notes dated 12/22/17 and 2/23/18, did note address R10's re-current falls.

Review of the OT/PT notes indicated R97 received therapy treatment/services during these times:

PT services:
dated 12/20/17-1/12/18, due to weakness contributing to a decline in ADL's and falls.

OT services:
dated 12/20/17-1/11/18, due to a decline in ADL's and a history of fall patterns and self-transferring.

Observation and interview with R10's husband on 3/14/18, at 2:14 p.m. the resident and her husband were visiting in her room. R10 was resting in bed with the wheelchair placed next to her bed. Ant-lock breaks were on the wheelchair and the call lite was in reach of the resident. R10's husband indicated the resident becomes anxious easily when he leaves for the day because she does not understand why he is leaving. The residents husband further indicated R10 becomes more confused and will often then

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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 689	Continued From page 69	F 689		

transfer self and fall. R10's husband felt the staff were doing the best they could to prevent the resident from falling after he leaves for the day.

Interview with NA-L on 3/14/18, at 12:48 p.m. indicated R10 frequently transfers self and has a history of falls. NA-L indicated the resident often transfers herself when in her stationary chair to her wheelchair. NA-L was aware of R10's plan of care interventions to prevent falls. NA-L indicated R10's husband visits daily and when he leaves in the afternoon the resident becomes very anxious and will attempt to transfer more during that time. Observation of the resident transfer to the toilet at 1:00 p.m. with assistance of NA-L and a mechanical stand. The resident was able to bear weight and participate with the transfer.

Observation and interview with R10 on 3/15/18, at 10:55 a.m. the resident was in the dining room eating a snack and visiting with another resident. The resident was pleasant but confused. Call light attached to her wheelchair and anti-lock brakes on. The resident was in sight of staff during this time. Made no attempts to transfer self.

Interview with registered nurse (RN)-H on 3/15/18, at 11:00 a..m. indicated R10 has dementia and is forgetful causing her to self-transfer without assistance. RN-H further included R10's falls had been reviewed and felt interventions had been exhausted to prevent the resident from further transferring independently and falling. RN-H further verified possible causal factors related to the residents falls were not always investigated and new interventions implemented.

The facility policy, entitled Fall Protocol, last

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F 689	Continued From page 70 revised 1/15, indicated when a fall occurs an investigation is started regarding the circumstances surrounding the fall, looking for patterns, etc. in attempt to prevent further falls and/or minimize the risk of injury. The procedure included: (1) a meeting is conducted with the staff present at the time of the fall to determine whether preventive changes are indicated or the plan of care is current and satisfactory so that similar circumstances do not result in further falls. (2) interdisciplinary meeting is held for 2 falls in 24 hours or 3 falls in a month. (3) documentation of the fall and if there are any changes in the plan of care related to the fall is made in the progress notes. (4) care plan changes and care sheets are reviewed and updated when changes occur.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757		4/25/18

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F 757	Continued From page 71 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to attempt a gradual dose reduction (GDR) of an antidepressant (Cymbalta) with in two separate quarters (with a least one month between the attempts), unless clinically contraindicated for 1 of 5 residents (R89) reviewed for unnecessary medications. Findings include: R89's quarterly Minimum Data Set (MDS) assessment dated 2/7/18, identified admission date of 1/13/17, and included diagnoses of heart failure, diabetes, depression and received antidepressant medication. R89's current physician orders identified an orders for Cymbalta (antidepressant) 40 mg by mouth one time a day, start 4/18/17 related to major depressive disorder. R89's current medication administration record (MAR) identified R89 had received the medications as ordered for the past 11 months. R89's current care plan included I use antidepressant medication related to depression. Give antidepressant medications ordered by physician. R89's behavior sheets dated 1/9/18 through 3/18/18, identified the specific behavior of excessive sleeping was being monitored and only one night shift on 2/27/18 identified excessive sleep.	F 757	F 757 Samaritan Bethany strives to ensure that each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive does or for excessive duration or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicate the does should be reduced or discontinued or any combinations of the reasons. The physician is reviewing the use of Cymbalta as of 4/12/18 for R89 and we awaiting a recommendation. Residents who use psychotropic medications should receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue those medications. The consultant pharmacist completes monthly pharmacy recommendations that are addressed by the attending physician or NP/PA. The Care Coordinator is responsible for appropriate follow-up on these pharmacy recommendations. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F757 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff unnecessary medications and gradual dose reductions. Neighborhood audits will be conducted by	

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F 757	Continued From page 72 R89'S physician and psychiatric progress notes were reviewed for the past year and there was no indication of a GDR for Cymbalta identified nor a physicians clinical indication as to why a GDR was not attempted twice in the past year. During interview on 3/16/18, at 9:33 a.m., registered nurse (RN)-G reviewed R89's record and stated a pharmacy note (consultant pharmacist medication regimen review) dated 8/7/17, read no GDR had been completed for the Cymbalta. RN-G stated a physician note dated 12/6/17, read major depression will continue with psychotherapy and meds, seems to be doing quite well even though PHQ score was eight. RN-G felt this was the physicians clinical justification as to why a GDR had not been completed. During interview on 3/16/18, at 10:22 a.m., the director of nursing stated (regarding GDR) she would expect the pharmacy consultant to review and make recommendation to the physician a GDR needs to be completed. A policy for physician justification and care plan was requested, but not provided.	F 757	Care Coordinators for 3 months and on a random basis thereafter to ensure that residents' drug regimens are free of unnecessary medications and gradual dose reductions occur as needed. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident	F 807		4/25/18

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F 807	Continued From page 73 hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed provide adequate fluids for 1 of 2 residents (R52 and R340) reviewed for hydration. Findings include: R52's quarterly Minimum Data Set (MDS) an assessment dated 1/9/18, indicated R52 had moderate cognitive impairment, required supervision with eating, and extensive assistance with bed mobility and transfers. R52's care plan dated 1/6/18, identified R52 should have fluid passed with meal(s) and cares adding her fluid intake was, "Variable, but usually adequate." Further, the care plan directed staff to encourage fluids and R52 was independent with eating after her meal was set-up. During observation on 3/12/18, at 5:10 p.m. R52 was in a rocking chair in her room. A bedside table was approximately two feet away from R52 which had a call light draped over top. There were no visible glass, mug or container of drinking water or fluids for R52 to consume as desired. During subsequent observation(s) on 3/14/18, at 11:32 a.m., 1:43 p.m., 2:40 p.m., and 3/15/18, at 9:30 a.m., the resident did not have any fluids available to her. When interviewed on 3/14/18, at 3:15 p.m. nursing assistant (NA)-M had been queried regarding R52's fluid intake with likes and dislikes, NA-M said she has her moments, she likes coffee but we give her ensure at evening	F 807	F 807 Samaritan Bethany strives to ensure that each resident receives and the facility provides drinks including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. R52 has been observed by the Care Coordinator to ensure fluids including water was provided on 3/20/2018, 3/23/2018, 3/28/2018, 4/3/2018, 4/6/2018, 4/9/2018, and 4/10/2018. R340 was offered fluids including water through 3/25/18. R340 moved out on 3/25/18. Water will be offered to each resident during meals, anytime staff provide care to the resident and anytime a resident is observed to be needing/requesting water. Hydration policy and procedure developed and will be provided to staff during the neighborhood meetings. Additional education provided as needed. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F807 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff the hydration policy and the importance of residents' receiving adequate fluids. Neighborhood audits will be conducted by Neighborhood Coordinators and Care Coordinators for 3 months and on a random basis thereafter to ensure that residents' are receiving adequate fluids as needed and desired according to	

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F 807	Continued From page 74 meals. She likes chocolate milk so we give her ensure every night. We do offer water and other fluids every time we go into the room. What she drinks in the morning, I don't know. When interviewed on 3/15/18, at 9:30 a.m. registered nurse (RN)-B stated the facility lacked a system to ensure water is passed to the residents. The facility was trying to figure out a way to ensure this was completed. RN-B verified R52 was unable to get up and obtain her water glass on her own without staff assistance, nor was she likely to request a drink on her own. During interview on 3/15/18, at 9:50 a.m. the director of nursing (DON) stated the staff do not complete scheduled water passes to the residents, however, DON added she expected staff to provide fluids to residents as they requested or needed. Further, DON stated she could not explain why there was no water available for R52. R340's admission Minimum Data Set an assessment, dated 3/1/18, indicated R340 had moderate cognitive impairment. R340's current care plan included R14 was at risk for dehydration due to my poor intake, impaired mobility, recent hospitalization/acute illness, received a diuretic (medication), had dysphagia (difficulty swallowing) and I did not like the recommended thickened liquid. My family has signed shared risk agreement diet/liquid consistency of resident choice. Encourage fluids with cares. During observation and interview on 3/13/18, at 9:19 a.m., R340 stated I had to ask for water four times today and I have not got any except with	F 807	preferences. Neighborhood Coordinators and Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 807	Continued From page 75 my pills this a.m. There was an empty water glass on top of R340's tray table. At the time nursing assistant (NA)-I brought in R340's breakfast, which included a glass of cranberry juice. NA-I did not provide or offer R340 water to drink. During interview on 3/14/18, at 1:49 p.m., NA-I stated we usually offer water once per shift. We walk around and make sure everyone has a fresh glass of water. I usually do it in the a.m. During observation on 3/15/18, at 7:34 a.m., R340 was sleeping in bed. There was no water glass in R340's room. During observation and interview on 3/16/18, at 8:32 a.m., R340 laid in be awake. There was no water glass in R340's room. At the time, NA-J was asked about water for R340 in the room and she answered none available at this time. NA-J stated since R340 required nectar consistency fluid, water would be brought at mealtime, that is all I know. During interview on 3/16/18, at 10:07 a.m., the DON stated we provide water as the resident wanted or needed the water. We do not do a water pass. We are to ensure residents have access to water. When a resident asks for water, they should be given water and they should have access to water without asking for someone to get it for them.	F 807		
F 825 SS=D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but	F 825		4/25/18

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F 825	Continued From page 76 not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or §483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative services for 1 of 1 resident R37 who had a limitation in range of motion (ROM). Findings include: R37's face sheet printed 3/16/18, identified diagnosis including hemiplegia and hemiparesis following cerebral infarction, affecting left non-dominant side. R37 was observed on 3/12/18, at 4:31 p.m. seated in Broda chair a tilt and recline repositioning chair. R37 was leaning to the right with left hand resting on the seat of the chair curled into a fist. Left hand had 2-3 + edema that extended to just below the elbow. R37's family member (FM)-A was present and stated R37's left hand had more edema than it previously had.	F 825	F 825 Samaritan Bethany strives to ensure that if specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at 483.120(c) are required in the residents comprehensive plan of care the facility must provide the required services or obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. On 4/12/18 an order was obtained for R37	

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F 825	Continued From page 77 FM-A stated the left hand is supposed to have a glove on it and I think he has a splint somewhere. I haven't seen either one for a long time. FM-A looked through closets and drawers in room and did not find either glove or splint. 37's significant change Minimum Data Set (MDS) an assessment dated 12/20/17, R37 had moderately impaired cognition, needed extensive assistance of 2 staff with bed mobility and had a functional limitation in the upper and lower extremities on one side. The ADL (activities of daily living)/rehabilitation Care Area Assessment (CAA) dated 12/21/17, identified R37 required the use of the ceiling lift and two staff for all transfers, extensive assist of two staff for bed mobility, dressing, toileting, personal hygiene, locomotion and requires set up assist with eating. The CAA also identified R37 as having left sided hemiparesis that was a result of a CVA (cerebrovascular accident). R37's care plan initiated last reviewed 12/26/17, identified a focus of risk for acute pain related to (r/t) CVA with left hemiparesis and neuropathy of left hand. Interventions included wear compression glove during day and hand brace at night to left hand to help with swelling/comfort. The care plan also identified R37 as having a risk for pressure ulcer development r/t immobility from CVA and use of compression glove/hand brace. R37's bedside kardex report used by nursing assistants to provide assessed needs/cares, printed 3/16/18, did not identify the use of the compression glove or hand brace. Review of occupational therapy (OT) note dated 8/16/16, identified recommendations for nursing	F 825	to evaluate and treat for wheelchair positioning, trough use and edema in (L) hand. Each resident is to receive specialized rehabilitative services based on their comprehensive-person centered assessment completed initially, quarterly, with a significant change and as needed and documented in the care plan. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F825 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding the provision of specialized rehabilitative services based on each residents' comprehensive person-centered plan of care. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure that specialized rehabilitative services are provided to residents' based on their comprehensive person-centered plan of care. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 825	Continued From page 78	F 825		

to put on resting hand splint to left upper extremity and have patient wear at night only. This was discussed with nursing assistant (NA), nurse manager (NM) and staff registered nurse (RN). A therapy note dated 9/26/16, identified R37 was to wear compression glove in the morning and to be removed prior to putting splint on at night, wash hand when donning (put on) and doffing (take off). A therapy progress note dated 11/11/16, identified educated caregiver in positioning in bed with left hand elevated, training with donning Isotoner glove for edema.

On 3/12/18, at 5:30 p.m. R37 was observed eating supper. Left hand down by side resting on seat curled in fist. Hand had 3+ edema. Edema glove not present.

On 3/14/18, at 10:45 a.m. R37 was observed sleeping in broda chair leaning to the right. Left hand resting on seat of chair curled in fist. Left hand has 2+ edema. Edema glove not present.

On 3/14/18, at 1:00 p.m. R37 was observed lying in bed with left hand beside him on the bed. Left hand closed into a fist. Hand had 2-3+ edema and an odor was noted to come from the hand. At 2:37 p.m. R37 was observed in bed with left hand lying on mattress almost under him. Hand and arm remained edematous, closed into a fist and odorous. At 3:17 p.m. R37 was observed in bed in the same position with left hand lying on mattress. Hand remained edematous. Edema glove not present.

On 3/15/18, at 8:37 a.m. R37 was observed in bed. Left hand lying beside him on bed, hand remains edematous. Edema glove not present. At 9:40 a.m. NA-G stated he didn't have the

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F 825	Continued From page 79	F 825		

brace on when I got him up this morning, I get him up all the time. NA-G also stated I know he had a brace that comes off at night. At 12:55 p.m. R37 was observed in bed. Left hand lying beside him on bed, hand remains edematous. Edema glove not present.

On 3/16/18, at 9:07 a.m. R37 was observed in the Broda chair leaning to the right attempting to eat. R37 was noted to have an edema glove on the left hand at this time.

During interview on 3/13/18, at 10:52 a.m. FM-B stated they used a compression glove at one time I don't know why they don't use it anymore. They tried massage. They don't use the splint anymore, I don't know why. FM-B stated sometimes staff will roll a wash cloth and put it in his hand. He can't open that hand or straighten his fingers at all, he lifts it up with his other hand.

During interview with occupational therapist registered (OTR)-D on 3/15/18, at 8:15 a.m. he stated he worked with R37 when he first came in facility. He stated they should keep that hand/arm elevated and he definitely should have the Isotoner glove on for edema. OTR-D was not sure what happened with the splint, but stated he definitely needs the splint too.

During interview with certified occupational therapy aide (COTA)-E on 3/15/18, at 8:37 a.m. she sated that last time OT worked with R37 was 11/10/16. She stated if any changes occur the nurse managers should let us know. She stated they had trained FM-B to do massage. Stated R37 should have the hand/arm elevated and the glove and splint should be being used. COTA-E checked R37's hand and stated the hand is not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 825	Continued From page 80	F 825		

worse, it has no tone.

During interview on 3/15/18, at 10:46 a.m. NA-G stated he hasn't had a glove on for a long time and he has a hand brace in the bathroom closet. She stated she just found the edema glove under a bag of clothes in R37's drawer.

During interview with nurse manager (NM)-E on 3/15/18, at 10:50 a.m. she stated R37 is supposed to have a brace on at night and an edema sock during the day. NM-E did not know why these had not been in place.

During interview on 3/15/18, at 12:55 p.m. NA-F was observed putting R37 to bed. NA-F showed surveyor a hand splint and stated I have seen it on him sometimes. At 1:13 p.m. NA-F stated we know what they get by our care plan, it's inside the closet door. NA-F showed surveyor the bedside kardex sheet (aide care plan) and verified it did not identify the use of the splint or glove.

During interview with the director of nursing on 3/15/18, at 1:48 p.m. the director of nursing stated if therapy recommended the splint and glove then R37 should be receiving that. She stated if he refused it we should have documented and reassessed as needed. She verified the splint and glove should have been identified on the NA kardex. She stated the resident had come back from the hospital and there were not orders for the glove. She stated he then went on hospice. When he came off hospice in December he wasn't re-evaluated for the edema glove.

A policy for ROM was requested but none was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	03/16/2018

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 825	Continued From page 81 provided.	F 825		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		4/25/18

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	245530	A. BUILDING _____ B. WING _____	03/16/2018

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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F 880	Continued From page 82 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure hand hygiene practices were practiced to reduce the spread of infection during treatments/services for 1 of 1 resident (R69) observed for wound cares. Findings include:	F 880	F 880 Samaritan Bethany strives to ensure that we establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases	

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F 880	Continued From page 83 R69 had been observed on 3/15/18, at 8:38 a.m., when licensed practical nurse (LPN)-H and registered nurse (RN)-F were observed to provide wound treatment for R69's pressure wounds. LPN-H and RN-F washed hands, then LPN-H applied gloves, cleansed a pair of scissors, picked up a sterile wound packing strip from a bottle, cut two pieces off the strip, placed them into a medication cup, and then added normal saline to the cup. LPN-H then removed gloves and carried supplies into R69's room. LPN-H again washed hands, applied gloves and removed the soiled dressing from left hip wound, removed gloves and washed hands. LPN-H applied gloves, and applied new dressing to the left hip wound, removed gloves and washed hands. LPN-H applied gloves, removed soiled wound dressing from coccyx wound, which had a moderate amount of drainage on the dressing. LPN-H with the soiled gloves held the resident while RN-F measured the wound. LPN-H then removed gloves and washed hands. LPN-H stated I should have taken my gloves off and washed hands after removing the dressing. LPN-H applied gloves, cleansed the wound with sea cleans and gauze and with the same soiled gloves on packed wound with strips using a Q-tip. The soiled Q-tip had been placed on R69's sheet. LPN-H then completed the wound treatment. With soiled soiled gloves LPN-H removed the soiled dressing from the right hip wound, removed gloves and washed hands. LPN-H applied gloves, cleansed the wound and with the soiled gloves applied a clean dressing over the wound. RN-F with gloves on removed old dressing form right lateral foot and right ankle (skin intact) and measured the areas. LPN-H with the same soiled gloves on cleansed the right lateral foot wound, removed gloves, gathered	F 880	and infections. On 3/15/18 LPN-H was re-educated on proper hand hygiene and glove use practices during treatments for R69 and all other residents when applicable. Each time a licensed nurse provides wound care to a resident they are to wash hands before gloving, then after soiled dressing is removed, soiled gloves are removed and hands are washed, next clean gloves are put on, clean dressing is put on, then soiled gloves are removed and hands are washed – repeat process for each wound. Hand hygiene and glove use policy was reviewed. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F880 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding proper hand hygiene and glove use for wound care. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure that proper hand hygiene and glove use is followed by all licensed nurses during wound cares. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 880	Continued From page 84 supplies, walked out of R69's room, placed the supplies in R69's cupboard located in the hallway and washed hands in a sink located in the hallway. RN-F with the same soiled gloves on applied clean dressings to R69's right lateral foot and right ankle. During interview on 3/15/18, at 9:08 a.m., RN-F stated her gloves remained on after removing old dressings form right lateral foot/right ankle, measuring and had applied new dressings to the areas. RN-F stated gloves should be changed and hands washed between each wound treatment. RN-F stated the used Q-tip should not be set on bed to avoid cross contamination. During interview on 3/15/18, at 9:19 a.m., LPN-H stated she had not changed gloves, or washed hands after being soiled. During interview on 3/16/18, at 10:09 a.m., the director of nursing (DON) stated she would expect staff to follow wound requirements for infection control. Change gloves at appropriate times and wash hands after gloves were removed. The DON stated she would expect dirty items, including the Q-tip to be placed in the appropriate place. A facility policy was requested for wound treatment, glove use and handwashing, but was not provided.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop	F 883		4/25/18

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F 883	Continued From page 85 policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and	F 883		

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F 883	Continued From page 86 (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 5 residents (R10 & R113) received pneumococcal vaccinations in accordance with Center for Disease Control (CDC). Findings include: The Center for Disease Control (CDC) and Prevention identified "Adults 65 years of age or older who have not previously received Pneumococcal Conjugate Vaccine (PCV13) and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R10's immunization record included an admission date of 4/14/2014. Most current PPSV23 dated 9/7/2007, and no indication PCV13 had been given as required by CDC and R10 was over 65 years of age. R113's immunization record included an admission date of 1/23/18. Most current PPSV23	F 883	F 883 Samaritan Bethany strives to ensure policies and procedures are developed to ensure that before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization and that each resident is offered a pneumococcal immunization October 1 through March 31 annually unless the immunization is medically contraindicated or the resident has already been immunized. R10 was offered the pneumococcal vaccine on 4/12/18 and resident's representative gave approval on 4/12/18. Order sent to pharmacy on 4/12/18 and awaiting delivery. R113 was given the pneumococcal vaccine on 4/12/18. Upon a resident moving we inquire about their vaccination history specially the pneumococcal vaccine. The pneumococcal vaccine will be offered according to the pneumococcal	

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

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F 883	Continued From page 87 dated 3/3/2009, and no indication PCV13 had been given as required by CDC and R113 was over 65 years of age. On 3/16/18 at 10:30 a.m. during an interview with the ADON, it was learned that the PCV13 had not been given to R10 or R113. ADON said she would follow-up with that today, in regards to PCV13 for both R10 and R113.	F 883	immunization policy. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F883 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff regarding the pneumococcal immunization policy. Neighborhood audits will be conducted by Care Coordinators for 3 months and on a random basis thereafter to ensure that the pneumococcal immunization policy is followed for all residents. Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident use equipment were maintained in a clean and functional for 1 of 1 resident (R14) reviewed for environment. Findings include: R14's room was observed on 3/13/18, at 9:23 a.m., the side rails on R14's bed were noted to have buildup of debris, walls located in room had multiple scratched areas/black marks and two	F 921	F 921 Samaritan Bethany strives to ensure that we provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. R14's assist rails were cleaned on 3/15/18, wheelchair was cleaned on 3/15/18, and carpet was cleaned on 3/15/18. R14's walls were repaired on 3/16/18. The neighborhood cleaning schedule will be reviewed and updated to ensure that	4/25/18

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F 921	Continued From page 88 holes in the wall below the call light box, and the carpet was soiled in multiple areas. Also R14's wheel chair had a build-up of debris of food on the seat and bars of the wheelchair frame. During observation on 3/14/18, at 11:50 a.m., R14 was seated in his wheelchair at a dining room table eating lunch. R14's wheelchair had debris of food on the seat and bars of the wheelchair frame. During observation on 3/15/18, at 7:33 a.m., R14 was seated in his wheelchair at a dining room table eating breakfast and the food debris remained on the wheel chair. Also the soiled bed rails, holes, soiled carpet and scratches remained unchanged from the 3/13/18 observation. During interview on 3/15/18, at 11:10 a.m., nursing assistant (NA)-H observed R14's wheelchair and stated the night shift usually washed the wheelchairs. I would probably have to clean the side rails, as we do not have a housekeeper that comes in to do that. It is my job to clean the room. Housekeeping is responsible to clean the carpets. The walls would be maintenance responsibility, we have a report to fill out. At the time licensed practical nurse (LPN)-H confirmed R14's carpet was soiled, wheelchair had debris on it, side rails had buildup of debris that should have been cleaned and R14's walls needed repair. LPN-H stated a work order should be filled out for the wall repair and a painter was now on the form. During interview on 3/15/18, at 11:43 a.m., with maintenance (M)-A and M-B, M-A stated the system was the neighborhood coordinator in charge of the floor was supposed to notify	F 921	each resident is provided a sanitary and comfortable environment. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review F921 and the POC. Neighborhood meetings will be held the week of April 23, 2018 and information will be provided to all staff ensuring that a sanitary and comfortable environment is provided for all resident specifically cleanliness. Neighborhood audits will be conducted by Neighborhood Coordinators and Care Coordinators for 3 months and on a random basis thereafter to ensure that the neighborhood cleaning schedules are being followed to ensure all residents are provided a sanitary and comfortable environment. Neighborhood Coordinators and Care Coordinators will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 4/25/18	

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F 921	Continued From page 89	F 921		

maintenance when needed and then the facility manager is notified. We have a painter that comes in to repair damaged walls. The housekeepers clean the carpets. There are work requests in the charting room that can be filled out. I was not aware of the identified areas of concern. M-A stated the holes in the wall were from where the call light was located before. The call light was moved and the holes were never patched.

During interview on 3/15/18, at 1:08 p.m. registered nurse (RN)-F stated any of us can notify maintenance by filling out a work order. Maintenance comes around and collects the work orders. RN-F stated the expectation would be to keep R14's equipment clean.

During interview on 3/16/18, at 10:12 a.m., the director of nursing (DON) stated we clean rooms as needed. Each neighborhood has a plan in place. Night shift cleans most often, but it can be anybody. The staff in the neighborhood are responsible for cleaning the side rails. Environmental services is responsible to clean the carpet. Staff are to notify them when needed. Maintenance does repairs.

A facility policy was requested for cleaning equipment and room repair, but not provided.

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	245530	A. BUILDING **02 - NEW** B. WING _____	**03/13/2018**

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K 000	INITIAL COMMENTS	K 000		

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 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

"If participating in the E-POC process, a paper copy of the plan of correction is not required."

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/12/2018

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	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

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) is a 6-story building with a basement built in 2010 with an attached 3 story building with a basement built in 1976 and remodeled in 2012. Review of the construction drawings determined both buildings to be type II (111). Each floor of the 6 story is divided into two smoke compartments and each floor of the three story is divided into two smoke compartments as well.

The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. There is smoke detection in all resident rooms.

This was surveyed as one building.

The facility has a capacity of 155 beds and had a

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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
K 000	Continued From page 2 census of 149 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect 13 of the 155 residents and an undetermined amount of residents staff and visitors.	K 353	K353 Ceiling tile was replaced on 3/14/18 in the housekeeping storage room on 6th Neighborhood. Maintenance staff was educated on the important of having ceiling tiles in place on 3/14/18 The Building Operations Mentor and Community Leader will monitor to prevent reoccurrence.	5/4/18

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 _____	**03/13/2018**

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

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K 353	Continued From page 3 Findings include:	K 353	Date of Completion: 5/4/18	
K 923 SS=D	On the facility tour between 8:00 am to 2:30 pm on 03/13/2018 observations and staff interview revealed a ceiling tile missing in the housekeeping storage room on the 6th floor next to resident room 2567. This deficient condition was confirmed by the Facility Administrator and the Building Operations Manager Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on	K 923		5/4/18

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 _____	03/13/2018

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 923	Continued From page 4 each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 11.6.2.3 item 11. This deficient practice could create an oxygen filled atmosphere and accelerate the spread of fire. This condition could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 2:30 pm on 03/13/2018 observations and staff interview revealed 2 oxygen bottles in the lower level oxygen storage room were not restrained, and there was no separation or identification of the full and empty tanks. This deficient condition was confirmed by the Facility Administrator and the Building Operations Manager.	K 923	K923 Facility will ensure that medical gas storage areas are protected in accordance with 2012 Life Safety Code. On 4/11/18 Northwest Respiratory Services (oxygen supplier) installed oxygen cylinder storage containers. Empty and full signs were placed above storage containers on 4/12/18. All staff meetings will be held on April 17, 2018 and April 20, 2018 to review the proper handling and storage of oxygen cylinders. Building Operation Mentor and Clinical Mentor will monitor to prevent reoccurrence. Date of Completion: 5/4/18	