Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 19, 2024

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

RE: CCN: 245530
Cycle Start Date: February 1, 2024

Dear Administrator:

On March 12, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 19, 2024

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

Re: Reinspection Results
Event ID: ULGN12

Dear Administrator:

On March 12, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 1, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2024

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

RE: CCN: 245530
Cycle Start Date: February 1, 2024

Dear Administrator:

On February 1, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	C 02/01/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 1/29/24 to 2/1/24, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. Samaritan Bethany Home On Eighth was found in compliance with the requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/29/24 to 2/1/24, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, multiple complaint investigations were also completed. Samaritan Bethany Home On Eighth was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no associated deficiencies cited: H55309262C (MN87941) H55309263C (MN91163) H55309264C (MN91161) H55309242C (MN100237) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will	F 000		

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

Electronically Signed | 02/23/2024

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

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F 000	Continued From page 1 be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess for ability or safety, and then care plan the self administration of medication for 1 of 1 resident (R48) observed to have medications prepared by staff and then left with him to take at leisure. Findings include: R48's quarterly Minimum Data Set (MDS) assessment, dated 11/9/23, identified R48 had intact cognition and had multiple medical conditions including high blood pressure, diabetes mellitus, and hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body). R48's most recent Nursing - Self Administration of Medication Evaluation, dated 5/2021, identified multiple questions to be answered which helped evaluate if R48 was able to safely self-administer medications including what, if any, medical diagnoses R48 had, if he was physically capable	F 554	Samaritan Bethany policies address the residents right to self-administer drugs after the interdisciplinary team has determined that this practice is safe. R48 was assessed for self-administration of medication on 1/31/24 that determined R48 could safely self-administer medications after set-up. A provider order was received for self-administration after set up of medication on 2/1/24. All residents wishing to self-administer medications will be comprehensively assessed to safely do so. If those identified residents are determined to safely self-administer medications, an order will be obtained from the provider and care plans will be updated. Self-administration of medication assessments will be completed upon resident request and if determined to safely self-administer, those residents will have assessments completed annually or with a significant change and then reviewed quarterly.	3/8/24

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F 554	Continued From page 2 to self-administer them, and if he had the ability to recognize the medications when provided. The evaluation identified R48 did not have knowledge on the purpose of his medications, was not able to recognize his medications, nor had the ability to read the medication label, if needed. The evaluation outlined R48 was determined to not be a candidate for self-administer medications with dictation present, " ... nursing will provide and administer medications to resident." However, on 1/31/24 at 7:28 a.m., licensed practical nurse (LPN)-C prepared R48's medications using a mobile computer station outside of his room where the medications were stored in a cabinet. LPN-C removed each medication punch-pack and placed a dose of each medication into a white-colored, disposable medication cup. A total of 11 oral medications were placed into the cup including baclofen (a muscle relaxant), Metformin (for diabetes), and lisinopril (for high blood pressure). In addition, a dose of Miralax (for constipation) was mixed into a glass of orange juice. LPN-C then brought the medication cup and medication-laced orange juice over to R48 who was seated in a wheelchair in the commons area of the unit with another female resident sitting immediately adjacent. R48 had a bedside table place in front of him which had another cup of orange juice present along with other various items (i.e., TV remote). LPN-C set the cup of prepared medications on the table and expressed aloud those were his morning medications. LPN-C then turned back to the mobile computer station and started to leave the area telling the surveyor aloud, "I am going to follow up with some others who wanted me [on the other unit]." LPN-C then left the unit with R48's prepared medications sitting in the	F 554	The Self-Administration Assessment of Medication policy was reviewed and updated. Neighborhood meetings will be held February 29th and March 1st and an all-staff meeting held on February 28th to review F554 and the POC. Audits will be conducted by the Care Coordinator for 3 months to ensure that the self-administration policy is being followed. Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.	

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F 554	Continued From page 3 medication cup on the table. A few minutes later, nursing assistant (NA)-B approached R48 with his morning breakfast meal and provided it to him on the same table. NA-B then left and returned to the kitchen. R48 started to eat the provided meal until several minutes later, at 7:38 a.m., when R48 picked up the cup of prepared medications, brought it to his mouth and took the entire cup at once. R48 then used the medication-laced orange juice to swallow them down. There were no dropped doses observed, and LPN-C was not observed ever returning to the area to ensure R48 consumed them all without complication. When interviewed immediately following, on 1/31/24 at 7:39 a.m., R48 stated the nurses usually give him cups of his medications and leave it with him to take later. R48 stated he could not recall ever being talked to or evaluated for this, however, voiced he felt comfortable taking them on his own. When asked if he had an issue taking them (i.e., dropped one, choked on them), R48 stated he "would yell" to get help. On 1/31/24 at 7:42 a.m., LPN-C was interviewed and verified they had left R48's prepared medications with him to take on his own. LPN-C stated doing such was their typically practice with R48, and they believed R48 had been evaluated for safety and ability to self-administer medications. LPN-C stated they believed R48 would "let me know" if any issues with taking his medications arouse. R48's Order Summary Report, signed 12/7/23, identified R48's current physician-ordered medications and interventions. These included active orders for Metformin, baclofen, and	F 554		

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F 554	Continued From page 4 lisinopril along with other medications, including Fosamax, which had special post-administration instructions (i.e., remain upright for 30 minutes afterward). However, the signed orders lacked approval or evidence R48's physician had approved the self-administration of medications. In addition, R48's care plan, last reviewed 11/2023, identified R48 was alert and oriented, had diabetes which was managed with medications, and had a history of behaviors which included verbal aggression to others. The care plan outlined R48 had a self-care deficit with resulted limited mobility due to several medical complications including spasms and a prior stroke. However, the care plan lacked any evidence R48 had been evaluated and approved to self-administer medications after set-up by the nurses, nor any interventions to ensure R48 safely consumed them (i.e., check back). R48's medical record was reviewed and lacked evidence R48 had been comprehensively assessed for safety and ability to self-administer medications since 2021, where he had been determined to be ineligible to do so for various reasons; nor evidence R48 had been evaluated by the interdisciplinary team (IDT) and approved to self-administer medications despite staff routinely leaving them with him to take at leisure. On 1/31/24 at 11:13 a.m., licensed practical nurse (LPN)-A and registered nurse (RN)-A were interviewed. LPN-A explained residents' who wished to self-administer were evaluated using the self-administration of medication evaluation tool (such as was completed for R48 in 2021) and the results were then reviewed by the IDT. LPN-A stated they felt R48 was physically able to	F 554		

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F 554	Continued From page 5 self-administer his own medications, after set-up, but may possibly not be able to recognize all of them, if asked. LPN-A reviewed R48's medical record and verified it lacked any further self-administration of medication evaluations or assessments since 2021; nor were there any care planned interventions for such on R48's care plan. LPN-A added, "This needs to be readdressed with him [R48]." LPN-A and RN-A both verified they were unaware the floor nurses were leaving the medications with R48 to take at leisure, and LPN-A stated it was important to ensure the ability to self-administer medications was assessed and care planned "so we know they can safely take their medications." A provided Administration of Medication policy, dated 11/2023, identified medications were administered only by licensed nursing or trained medication aides (i.e., TMA). The policy continued, "Residents are assessed for self-administration of medication ability when they move into the facility, quarterly, and PRN [as needed] as requested following." However, the policy lacked any further information to clarify that sentence meaning or how such would be evaluated (i.e., tools used, responsibility to do).	F 554		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.	F 577		3/8/24

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F 577	Continued From page 6 §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the most recent survey results were posted in a prominent location and readily accessible to any person wanting to review the information. This had the potential to affect all 84 residents residing in the nursing home or any visitors who wanted to review the information. Findings include: During observation on 1/29/24, at 2:35 p.m., 1/30/24, at 11:35 a.m., and 1/31/24, at 1:33 p.m., the facility had their past survey results, in a three-ring binder, situated behind their front door receptionist desk which was behind a partial glass partition. This prevented a resident or visitor from being able to readily access and review the past facility's survey results without either asking a staff member to retrieve the three-ring binder or	F 577	F577 Samaritan Bethany strives to ensure that residents have the right to examine the results of the most recent survey and any survey reports during the 3 preceding years posted and available in a prominent and accessible area to the public. The survey book was moved outside of the glass at the front desk on 1/31/24. Neighborhood meetings will be held February 29th and March 1st and an all-staff meeting held on February 28th to review F577 and the POC. Audits will be conducted by the Community Leader Mentor for 3 months to ensure the accessibility of the survey book. Community Leader will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.	

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F 577	Continued From page 7 walking behind the receptionist's desk. On 1/31/24, at 2:08 p.m., an informal resident council meeting was held with R21, R22, and R72 present. The residents were asked, as part of the meeting, if the most recent survey results were readily posted within the facility for them to review. The three residents stated knowing where the past survey results were posted, at the facility's reception desk, behind a glass partition. When asked about how they would retrieve the survey results, since they were behind the desk and glass partition, the three residents stated they would ask a staff member to retrieve the results. On 01/31/24, at 11:08 a.m., the receptionist was interviewed. She stated facility's past survey binder is kept behind the main desk, also behind a glass partition, and is the only copy the facility keeps, to her knowledge. The receptionist further stated, if someone wants to review the binder, she'll, or whomever is working the reception desk, would retrieve it for them. Binder contained the last 5 years of survey results. On 01/31/24, at 5:43 p.m., the administrator was interviewed. She stated the facility's past survey binder has been in that same location for as long as she's been at the facility, which is around 12 years. The administrator further stated the glass partition was installed early on during the COVID-19 pandemic, as a safety barrier for staff, residents, and visitors, and the facility has left the glass partition up and has never moved the past survey binder from the location. When asked, the administrator stated the facility would not want residents or visitor going behind the receptionist desk to retrieve the binder.	F 577		

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F 577	Continued From page 8 On 02/01/24, at 12:30 p.m., the administrator stated "It's important the results are posted in a readily accessible location for transparency to staff, residents, family, and the community to show how we are doing in following state and federal regulations. This is important to show how the facility is doing in providing the best quality of care."	F 577		
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 ensure routine personal hygiene cares (i.e., nail care) was provided to reduce the risk of complication (i.e., infection, skin scratches) for 1 of 2 residents (R76) reviewed for activities of daily living (ADLs) and whom was dependent on staff for their care. Findings include: R76's quarterly Minimum Data Set (MDS) assessment, dated 11/28/23, identified R76 had intact cognition, demonstrated no rejection of care behaviors during the review period, and did not have diabetes mellitus. R76's care plan, dated 12/2023, identified R76 had a self care deficit and was enrolled in hospice care for end-stage heart failure. The care plan outlined an intervention which read, "PERSONAL HYGIENE ... [R76] require assist of 1 to help ...	F 677	Samaritan Bethany strives to ensure that residents who are unable to carry out activities of daily living receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R67 passed away on 2/1/24. Residents' dependent on staff for nail care were identified and nail care was provided. For those identified residents, their care plans will be updated and nail care tasks will be added in PointClickCare to ensure completion by the Caregiver weekly. The personal Hygiene policy was reviewed and updated to include the addition of nail care tasks in PointClickCare. Neighborhood meetings will be held February 29th and March 1st and an all-staff meeting held on February 28th to review F677 and the POC. Audits will be conducted by the	3/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	C 02/01/2024

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 677	Continued From page 9 brush hair, brush teeth, apply deodorant, wash/dry face and hands." However, the care plan lacked information or direction on nail care (i.e., how often, length preference, who would assist). On 1/29/24 at 2:13 p.m., R76 was observed lying in bed. R76's hands were present on top of the bed covers, and R76 had visibly long fingernails present on both hands with several nails having a dark-brown colored substance or debris present under the nail. R76 woke to verbal interaction and, when asked, expressed he would like them clipped but was unable to remain awake for additional questions when attempted. Later on 1/29/24, at 5:40 p.m., R76 was again observed lying in bed while in his room. R76's family member (FM)-A was present at the bedside and was interviewed. FM-A stated R76 was on hospice care and had declined fairly quickly over the past weeks with the pain medications making him very sleepy and hard to converse with. FM-A stated staff were "supposed to be" helping R76 with bathing and personal hygiene cares. FM-A then looked at R76's fingernails, which remained long and soiled, and said aloud, "They should be shorter." FM-A stated R76 typically had a shorter clipped nail as was his preference. The following day, on 1/30/24 at 11:33 a.m., R76 was again observed lying in bed while in his room, and his fingernails remained long and visibly soiled as they had been the day prior. R76's POC (Point of Care) Response History, printed 1/31/24, identified the past 30 days worth of bathing support provided to R76 by the care	F 677	Neighborhood Coordinator for 3 months to ensure that nail care is provided for those identified residents. Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.	

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F 677	Continued From page 10 center staff members. There were three completed episodes dated 1/3/24, 1/10/24, and 1/24/24; however, all of these were recorded with a response of, "ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time." There were no recorded tasks identified to demonstrate nail care had been offered, provided, or refused during the same period of time. R76's facility' progress notes, dated 1/1/24 to 1/30/24, were reviewed. These identified a series of notes labeled, "Bath/Skin Note," which were completed on 1/2/24, 1/9/24, 1/16/24, and 1/22/24, respectively. These outlined R76 received a bed bath last on 1/22/24, however, all of the notes lacked evidence R76 had been offered, provided or refused nail care. When interviewed on 1/30/24 at 12:04 p.m., nursing assistant (NA)-C explained they had cared for R76 multiple times prior and described him as declining in overall status now needing help to complete most cares. NA-C stated R76 did not have a history of refusing personal cares when offered but would, at times, refuse a full shower from the hospice caregivers. NA-C stated R76 was scheduled for a Monday bath (i.e., bed bath) and nail care should be completed then; however, there was no place to record such cares in the medical record to their knowledge adding, "There's not even a spot on our charting for that." NA-C then observed R76's fingernails while he laid in bed, and stated they were long and had "a couple spots" which had debris present (i.e., soiled) adding, "They could be clipped." NA-C stated R76 was not diabetic, to their knowledge, and so the NA(s) could clip them on bath days or when noticed adding a clipped, short kept nail	F 677		

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F 677	Continued From page 11 was important so R76 couldn't scratch himself and "because germs can stick under there [under the nail]." When interviewed on 1/31/24 at 10:18 a.m., licensed practical nurse (LPN)-D explained R76 was on hospice and their staff typically did the bathing and personal hygiene cares as a result. LPN-D stated R76 would, at times, use his fingers to pick up food items and eat them and, to their recall, had been somewhat resistant in the past to having his nails clipped as he liked to use them to get tops off containers. However, LPN-D stated they were unsure if that remained accurate now since R76 had declined in condition over the past week or so and added such preference would likely not be care planned for him, either, adding, "I don't think so." LPN-D explained baths, when completed, should be recorded in the 'bath/skin check' notes and any refusals of care, including nail care, should be documented in there, too. However, R76's medical record was reviewed and lacked evidence when the last time R76's fingernails had been clipped or cleaned; nor any evidence R76 had a preference to have long fingernails as mentioned by LPN-D. On 1/31/24 at 11:05 a.m., licensed practical nurse (LPN)-A and registered nurse (RN)-A were interviewed, and LPN-A explained R76 had been "more challenging" with cares of late due to a physical and mental decline. LPN-A stated either the nurse or NA would be able to complete nail care and expressed they "don't know why" the care was not provided. LPN-A stated nail care should be done when it's noticed as being needed and, if refused, then the nurse should be told so it could be documented accordingly as	F 677		

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F 677	Continued From page 12 there was no formal tracking system to record nail care currently in place (i.e., tasks). LPN-A stated R76 was on hospice and those staff members were doing a majority of R76's cares which is why the bath charting indicated such for the support recorded; however, LPN-A verified the medical record lacked evidence nail care had been offered or provided to R76 within the past several weeks. A facility' provided Personal Hygiene policy, dated 5/23, identified the care center would provide personal hygiene according to resident' preferences to maintain dignity. A procedure was listed which directed, "Nail care ... is provided at the time of bath and as needed. Nails should be cleaned and trimmed without jagged edges, according to resident preferences." The policy continued, "Personal hygiene cares are documented by the caregiver or nurse providing the care. Report any concerns, or if a resident chooses not to have care provided, to the nurse." Further, the policy concluded with, "The individual care plan must reflect resident care needs and preferences related to personal hygiene."	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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	F 686		3/8/24

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F 686	Continued From page 13 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 reassess and develop interventions, if needed, to ensure timely repositioning and appropriate care was provided to prevent pressure injuries for 1 of 2 residents (R60) reviewed who had a decline in status and was at risk for pressure ulcer formation. Findings include: R60's quarterly Minimum Data Set (MDS) assessment, dated 1/9/24, identified R60 had severe cognitive impairment, was dependent on staff for nearly all self-cares, and multiple mobility-related tasks (i.e., sitting to standing, walking) were not attempted due to medical condition or safety concerns. Further, the MDS outlined R60 was at risk for pressure ulcer development, however, had no current, unhealed ulcers present. R60's most recent Braden Scale For Predicting Pressure Sore Risk, dated 1/9/24, identified R60 had slightly limited perception to sensory items, had very moist skin, and was bedfast. The evaluation scored all R60's risk factors with a recorded score of, "12.0," which was outlined as, "HIGH RISK [for skin breakdown]." Further, R60's care plan, last reviewed 1/23/24, identified R60 was at risk for impaired skin integrity due to limited mobility, incontinence and dementia. The care plan listed several interventions which	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. R60's care plan was updated on 1/30/24 to reflect an appropriate repositioning schedule of every 2-3 hours. R60 passed away on 2/8/24. Residents identified to be dependent with repositioning or had a decline in status will be comprehensively assessed with interventions developed, and care planned to ensure timely repositioning to prevent pressure injuries. Neighborhood meetings will be held February 29th and March 1st and an all-staff meeting held on February 28th to review F686 and the POC. Audits will be conducted by the Care Coordinator for 3 months to ensure that identified residents are comprehensively assessed to ensure timely repositioning to prevent pressure injuries.	

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F 686	Continued From page 14 included use of a pressure relieving mattress and cushion, keeping the skin clean and dry, and observing R60's skin with peri-care and bathing. The care plan continued and outlined R60 had a self-care deficit due to dementia and physical frailty with several interventions including, "BED MOBILITY: I am able to reposition myself." However, on 1/29/24 at 2:32 p.m., R60 was observed lying in bed while in her room. R60 appeared comfortable and was on her left side with a pillow placed behind her right-side back. R60 was non-verbal with conversation and did not open her eyes. Immediately following, nursing assistant (NA)-C was interviewed, and they expressed R60 was on hospice care and had declined in condition over the last few weeks now being mostly unresponsive. On 1/29/24 at 4:35 p.m. (over two hours later), R60 was again observed and remained in bed as prior on her left side with a pillow placed behind her. Further, again on 1/29/24 at 6:20 p.m. (nearly four hours later), R60 was observed and again remained in bed as prior, on her left side with a pillow placed behind her. R60 remained nearly unresponsive to verbal interaction. On 1/29/24 at 6:21 p.m., NA-D was interviewed and stated they were an agency NA who had only worked a few shifts on campus prior; however, they verified they were currently assigned and responsible for R60's cares. NA-D stated they started working at 4:00 p.m. and had not yet been in to provide any cares, including repositioning, to R60 further adding, "I have not seen her yet." NA-D stated the previous NA had told them R60 "was OK" but didn't mention when they had last repositioned her so, as a result, NA-D stated they	F 686	Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.	

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F 686	Continued From page 15 could not answer when R60 had been last formally repositioned (i.e., significant change in position, or one-minute off-loading). NA-D stated they tried to reposition all residents "every two hours" as a "rule of thumb" but expressed they were not sure how often R60's care plan called for R60 to be repositioned. NA-D verified they had not repositioned R60 since their shift started which was over two hours ago, and they attributed the delay in "being new" and not having enough staff present to do home-maker duties (i.e., serve meals, clean up) which caused them to have those tasks, too, that shift. NA-D explained, to their knowledge, there was no tracking system or charting done when someone was repositioned and added they had "just learned" resident' care plans were stored on their supply cabinets to reference, when needed, while doing cares. NA-D then showed this care plan to the surveyor which was attached to their supply cabinet inner door. The care plan listed R60's name with a revised date 10/2023 which NA-D stated was "almost four months ago." The care plan instructed R60 was able to reposition independently which NA-D stated aloud, "I don't think that's correct." NA-D stated the care plan needed to be updated as R60 had declined and now needed more help with cares. Immediately following, on 1/29/24 at 6:29 p.m., NA-D and the surveyor observed R60's skin. NA-D removed the covers from R60 which exposed the pillow placed under her back. R60 was visibly saturated and incontinent of urine to which NA-D stated, "[R60] definitely needs to be changed." R60 was assisted by NA-D to turn onto her side with no physical assistance provided by R60. R60's coccyx' skin intact, with no redness present, however, R60's left shoulder and the left	F 686		

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F 686	Continued From page 16	F 686		

lateral side of her back had multiple light-pink colored areas present where the linen had creased and indented her skin. NA-D verified these observations.

On 1/29/24 at 7:11 p.m., licensed practical nurse (LPN)-E was interviewed. LPN-E explained there was typically one NA on each side of the unit with 'staggered' hours being completed; however, there had been a call-in so the NA was helping to do homemaker duties in addition to their own assigned workload. LPN-E stated resident' care plans were attached to the inner-cabinet doors for each resident to help the NA(s) know what, if needed, cares were to be done for each person. Those along with a verbal report were used to relay information like repositioning and toileting episodes. LPN-E stated R60 seemed to have "nine lives" but verified R60 had had a decline over the past week or so and, as a result, staff were now doing a majority of her cares like toileting and repositioning. LPN-E stated they believed R60 was on a "every two hours" schedule for repositioning. LPN-E stated the care coordinators were responsible to assess any changes and update the cabinet-attached care plans.

When interviewed on 1/30/24 at 11:57 a.m., NA-C explained they had worked with R60 in the past, and they described R60 has being on hospice care and having declined in condition which had been for "a good two months" or so. NA-C stated R60 still would, at times, open their eyes to verbal interaction but was mostly unresponsive and needed help to complete repositioning cares. NA-C stated they were trying to reposition R60 "every two or three hours or so" adding R60 seemed to have increased incontinence and

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F 686	Continued From page 17 "flood out" in the later-day hours. NA-C stated the facility used care plans attached to the inner-cabinet doors to help ensure staff are aware of what is needed for each resident. NA-C then reviewed R60's door-attached care plan at the request of the surveyor. The care plan prior (dated 10/2023) remained and NA-C stated multiple interventions listed, including R60 being independent with repositioning, were inaccurate since she had declined so much. NA-C stated the care coordinator was usually the person who updated the care plans but added, "When we have one." NA-C verified they had not been given guidance or direction on how often R60 needed to be repositioned since she had declined adding they had "just kind of been doing it" when able on the shift. R60's POC (Point of Care) Response History, printed 1/31/24, identified a look-back period of 30 days and included a generic question for staff to answer on their shift which read, "Did you turn and reposition?" This was answered affirmatively for each shift, however, lacked direction or guidance on how often R60 should be turned or repositioned; nor documentation on how many times a shift such task was completed to demonstrate consistency or continuity of care. In addition, R60's medical record was reviewed and lacked evidence R60 had been comprehensively reassessed to determine what, if any, interventions for skin care and management to prevent pressure injuries (i.e., repositioning) were needed or appropriate despite an obvious physical decline in condition; nor evidence the skin care plan had been re-evaluated or updated with current interventions to ensure R60's skin management needs, if any, were being met.	F 686		

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F 686	Continued From page 18 On 1/31/24 at 10:41 a.m., licensed practical nurse (LPN)-A and registered nurse (RN)-A were interviewed, and LPN-A explained condition changes were "everybody's responsibility" to monitor and respond to with any changes being promptly reported to the care coordinators. LPN-A stated it had been "approximately a month" since they had seen R60 get up from bed, and expressed repositioning needs were typically evaluated using a "tissue tolerance" which helped determine how long a resident could be left in the same position without having breakdown begin. LPN-A verified R60 was no longer able to reposition herself, as outlined in her care plan, and the medical record lacked evidence R60 had been comprehensively evaluated for what, if any, skin interventions were needed since she had declined adding, "I think that's very fair to say." LPN-A and RN-A both reiterated if direct care staff members were seeing changes, such as obvious declines in condition, then it needed to be brought to the care coordinators for action adding such was important to do for resident' comfort and ensuring all their needs are being met and addressed. A provided Skin/Wound Care Policy, dated 9/2023, identified the care center would provide care to prevent or heal skin impairments or wounds unless such was unavoidable. The policy outlined, "All residents are evaluated for skin integrity using the Braden Scale ... [it] will be done on all residents quarterly, and with any significant change in condition." Further, the policy outlined, "Caregivers will report any concerns related to skin to the licensed nurse."	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)	F 690		3/8/24

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F 690	Continued From page 19 §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure developed bowel	F 690	Samaritan Bethany strives to ensure that for a resident with fecal incontinence,	

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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

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F 690	Continued From page 20 incontinence was comprehensively reassessed to determine what, if any, interventions were needed to promote routine, normal bowel function and reduce the risk of bowel incontinence for 1 of 1 resident (R13) reviewed who complained about their bowel function. Findings include: R13's significant change in status Minimum Data Set (MDS) assessment, dated 10/30/23, identified R13 had moderate cognitive impairment but demonstrated no delusional episodes or behaviors. The MDS outlined R13 as always incontinent of bowel, having no constipation, and not being on a bowel toileting program. On 1/29/24 at 7:06 p.m., R13 was interviewed and expressed concerns about their bowel patterns. R13 felt she had been having more issues with bowel incontinence and, at times, bowel constipation over the past few months. R13 stated they were unsure of what, if any, medications for bowel function they consumed and expressed the staff had never discussed a bowel management program, or subsequent options for one, to her recall adding, "Not really." R13 stated staff just keep telling her "you have to be patient" with her bowel issues adding staff seemed "so unsympathetic sometimes." R13's most recent Nursing - Bowel Assessment - V4, dated 9/2023, identified the evaluation as R13's admission assessment. R13 was recorded as being incontinent of bowel along with multiple questions to be addressed or answered for bowel incontinence including signs and symptoms of incontinence; however, these were left blank and not completed. The evaluation outlined R13 as	F 690	based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. R13 will be comprehensively assessed after a 4 day bowel evaluation to determine interventions needed to promote routine, normal bowel function and reduce the risk of incontinence. Identified interventions for R13 will be care planned. All residents identified with bowel incontinence will be reviewed to ensure their bowel evaluations have been complete. For those found incomplete, a comprehensive assessment will be completed, interventions identified, and care planned. All residents moving in will be comprehensively assessed upon move in, evaluations complete and reviewed annually, quarterly with a significant change and or change in continence to ensure appropriate interventions are implemented to restore as much normal bowel function as possible. The Bowel and Bladder evaluation policy was reviewed and remained appropriate. Neighborhood meetings will be held February 29th and March 1st and an all-staff meeting held on February 28th to review F690 and the POC. Audits will be conducted by the Care Coordinator for 3 months to ensure that each resident with bowel incontinence is comprehensively assessed and has complete bowel evaluations according to the Bowel and Bladder evaluation policy.	

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F 690	Continued From page 21 having an 'every other day' bowel pattern and concluded with dictation reading, " ... has had one continent and one incontinent bowel movement since move in ... requires A01 [assist of one] with transfers and clean up." A subsequent Nursing - Bowel Assessment - V4, dated 1/18/24, identified a quarterly review was to be completed, however, the assessment was unsigned and had dictation present on top reading, "Errors." The assessment outlined R13 was incontinent of bowel, however, again, the section to record signs and symptoms of incontinence and the normal bowel pattern was left blank. The assessment included sections to review R13's medical conditions which could impact bowel continence along with her medication use, however, these also were left blank and not completed. The assessment identified R13 was able to recognize the time and place to defecate and feel the urge to do so concluding with dictation, "Resident is aware of when she needs to use the toilet to have a bowel movement but does not always put her call light on in time ... transfers with the e-z stand [mechanical lift] and AO1 [assist of one]." R13's medical record lacked any further completed bowel assessment(s) for R13 since admission to the care center in 9/2023. R13's care plan, last reviewed 11/14/23, identified R13 had a self-care deficit due to limited mobility, pain, and incontinence. However, the care plan outlined a problem statement which read, "I am continent of bowel," along with several risk factors including limited mobility, pain, history of stroke, and needing assistance with toileting. The care plan outlined to give medications as ordered, observe for changes in bowel continence and update the nurse, and toilet every morning around 6:30 a.m.	F 690	Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.	

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F 690	Continued From page 22 R13's POC (Point of Care) Response History, printed 1/31/24, identified R13's recorded bowel continence over the past 30 day period. This identified a total 23 continent bowel movements and seven (7) incontinent bowel movements with one recorded as, "Loose." There were no recorded constipation episodes identified on the record. In addition, R13's Order Summary Report, printed 2/1/24, identified R13's active, discontinued, and completed physician's orders and interventions. R13 had current, active orders listed for Miralax (a laxative medication) as needed (i.e., PRN) with a start date listed, "10/23/2023;" and for Senna-Docusate Sodium (a laxative medication) as needed with a start date listed, "01/04/2024." The orders included a discontinued order, ended 1/4/24, for a daily, scheduled dose of Senna-Docusate for constipation. When interviewed on 1/31/24 at 9:04 a.m., nursing assistant (NA)-E explained R13 had "really bad" anxiety and could be forgetful, however, did "remember some." NA-E stated R13 used the mechanical lift to use the toilet, however, NA-E was "not sure" if R13 was continent or not of bowel as R13 "doesn't go that much." NA-E verified R13 was able to ask for help when she needed to use the bathroom but expressed they were not sure if R13 was on any type of bowel management program or not adding, "We just help her whenever she wants most of the time." On 1/31/24 at 10:02 a.m., licensed practical nurse (LPN)-D was interviewed and verified they had worked with R13 prior describing her as needing assistance from staff "with everything." LPN-D	F 690		

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F 690	Continued From page 23 explained R13 used the toilet for voiding and defecation, and she was able to verbalize when she needed to do so most times adding R13 was "both" continent and incontinent of stool. LPN-D stated R13 had sustained a hip fracture prior and with the associated narcotics was given bowel medications. However, LPN-D stated they had, about a month prior, changed R13's bowel medications due to increased incontinence and had them now only as-needed and not routinely scheduled. LPN-D stated they believed R13 was more continent of bowel now as a result, but explained the care coordinators were the ones who do the formal assessments and evaluations adding, "They do the follow-up." However, R13's medical record was reviewed and lacked evidence R13 had been comprehensively reassessed for her total bowel status and what, if needed, interventions (i.e., bowel management program, toileting program) were needed to promote continence and reduce the risk of complication (i.e., constipation) since she admitted to the care center nearly four months prior; nor evidence the care plan had been revised to match the actual bowel continence level of R13 despite multiple recorded incontinent episodes. Further, the record lacked evidence R13 had been re-evaluated for her bowel needs and overall status, including with R13's input and wishes, since 1/4/24 when her scheduled bowel medications were discontinued and changed to as-needed only. On 1/31/24 at 10:24 a.m., licensed practical nurse (LPN)-A and registered nurse (RN)-A were interviewed. LPN-A verified they had reviewed R13's medical record and explained R13 seemed to have "regular bowel movements" on a	F 690		

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F 690	Continued From page 24 near-daily basis with "periods of incontinence" noted. LPN-A explained the evaluations, including the bowel assessments, were placed in the record and the floor staff helped to complete them in accordance with the MDS' schedule (i.e., quarterly) and then routed to the care coordinator to be reviewed and care plan updated with interventions, if needed. LPN-A acknowledged R13's incomplete and unsigned bowel assessment (dated 1/18/24) and expressed they were unsure why it was not completed adding, "I don't know why it didn't come to me." LPN-A reviewed R13's care plan and acknowledged it outlined R13 as continent when she had multiple incontinent episodes adding, "Her [R13] care plan needs to be adjusted." LPN-A and RN-A both verified any incontinence episodes need to be reported and acted upon, and LPN-A stated timely evaluation or reassessment of bowel incontinence was important to do so "everybody is informed" of R13's needs and for "continuity of care." A provided Bowel and Bladder Evaluation policy, dated 4/2023, identified a systematic evaluation would be completed to assist with determining what, if any, treatment and management of bowel and bladder function was needed. The policy outlined, "Based on the resident's comprehensive assessment the facility will determine casual and contributing factors of bowel and bladder incontinence, develop regularity of body excretory functions for incontinent residents, and develop a plan for bowel and bladder retraining when indicated. In these ways the facility will ensure that each resident with bowel and/or bladder incontinence will receive appropriate individualized treatment and services to restore as much normal function as possible." The policy	F 690		

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F 690	Continued From page 25 listed a procedure which directed a licensed nurse would complete any required bowel or bladder assessments and, based on those, a toileting plan would be noted in the care plan.	F 690		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure completion of a laboratory test ordered by the provider for 1 of 1 residents (R11) evaluated for urinary tract infection (UTI). Findings include: R11's quarterly Minimum Data Set (MDS)assessment, dated 12/28/23, identified R11 was cognitively intact with frequent incontinence and had a UTI in the previous 30 days. R11's care plan dated 1/10/24, identified R11 required 1 assist for toileting, stand by assist for activities of daily living, and is incontinent of bladder. During an interview on 1/29/24 at 2:28 p.m., R11 indicated she was receiving antibiotics for a UTI. She reported being unsure why a urine sample	F 770	Samaritan Bethany strives to obtain laboratory services to meet the needs of the residents and responsible for the quality and timeliness of the services. R11 was treated with an antibiotic starting on 1/25/24 by the Nurse Practitioner. On 1/31/24 the Nurse Practitioner followed up with the lab regarding R11's culture results. The Nurse Practitioner reported the lab for not fulfilling R11's urine culture. On 2/1/24, R11 had denied any further UTI symptoms after completing the prescribed course of antibiotics. All UA/UC laboratory tests ordered by the provider will be followed up on by the Care Coordinator by day 4 after collection to ensure completion. Neighborhood meetings will be held February 29th and March 1st and an all-staff meeting held on February 28th to	3/8/24

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F 770	Continued From page 26 was collected. She stated she has to "go go go all the time" and her urine "runs out" of her. R11's indicated orders were received for a "midstream urine" on 1/25/24. With a follow up note from 1/25/24 indicates R11 was diagnosed with a UTI by the nurse practitioner based on urinalysis results. Nurse practitioner wrote orders for Cefdinir (antibiotic) 300 mg twice a day for 7 days. During an interview on 1/30/24 at 2:10 p.m., licensed practical nurse (LPN)-B indicated the provider is updated when a resident has a "certain number" of urinary symptoms. The provider will occasionally start an antibiotic immediately after receiving the results of the urinalysis (test to determine presence of infection) and change the antibiotic when the urine culture returns. During an interview on 1/31/24 at 12:42 p.m., LPN-A indicated R11's urine culture results had not returned, and she would need to follow up with the nurse practitioner. LPN-A called the nurse practitioner and stated the nurse practitioner was not sure why the culture results had not returned and would "look into it". LPN-A indicated lab results usually go directly to the provider for evaluation and it is very rare for the provider to not follow up on urine culture results. During an interview on 1/31/24 at 2:02 p.m., the assistant clinical mentor (ACM), indicated R11 had "quite a few" symptoms prompting a urinalysis to be ordered. The ACM confirmed the urine culture was not performed as ordered. She stated the providers check for the results and update the facility of changes. The ACM	F 770	review F770 and the POC. Audits will be conducted by the MDS Coordinator for 3 months to ensure completion of laboratory tests ordered by a provider. Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.	

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F 770	Continued From page 27 indicated it would normally be the care coordinator's responsibility to follow up on urine labs. During an interview on 2/1/24 at 8:46 a.m., LPN-A stated the provider follows up on urine culture results. She indicated the care coordinator should be following up to make sure urine culture results come back and update the provider. LPN-A stated it is the facility's responsibility to make sure ordered labs are performed. During an interview on 2/1/24 at 8:55 a.m., registered nurse (RN)-A indicated she was the nurse at the time R11's urine sample was collected. She stated the provider informs the facility if an antibiotic needs to be ordered. She stated it is usually the care coordinator or ACM who watch for urine culture results. During an interview on 2/1/24 at 9:21 a.m., the administrator stated it is the provider's responsibility to follow up on labs ordered. During an interview on 2/1/24 at 9:42 a.m., the director of nursing indicated it is the facility's responsibility to make sure labs are performed.	F 770		
F 880 SS=E	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.	F 880		3/8/24

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F 880	Continued From page 28 §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 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	F 880		

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F 880	Continued From page 29 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, interview, and record review, the facility failed to ensure appropriate use of personal protective equipment (PPE) when entering a COVID positive resident (R73) room after the facility failed to ensure all staff were fit tested (test used to determine appropriately sized N95 mask) for the use of N95 masks. This had the potential to affect all 84 residents in the facility. In addition, the facility failed to ensure protection from blood-borne pathogens when an outside lab technician (lab tech) was observed drawing blood from R334 at the dining room table. This had the potential to affect 2 of 2 residents (R3 and R51) and a family member who were also seated at the table. Findings include: During an observation on 1/30/24 at 12:25 p.m., a dietary aide (DA-A) was observed entering R73's	F 880	Samaritan Bethany strives to 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 and follow standard and transmission-based precautions to be followed to prevent spread of infections. R73 no longer required transmission-based precautions as of 2/1/24. R334 moved out on 2/15/24. Fit Testing for the use of the N95 will occur for all nursing staff February 26th □ March 6th. Fit Testing for use of an N95 will be conducted upon hire for all new staff members. All blood draws will occur in the resident□s room. Laboratory services will be educated on the blood	

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F 880	Continued From page 30 room wearing face shield, gown, and surgical mask. A sign on the outside of R73's room indicated "caution PPE required". Another sign on the door demonstrated putting on PPE. A white cart containing PPE supplies was located outside of the room. A sign on top of the cart indicated contents of the cart, including N95 masks. DA-A walked out of R73's room, removed PPE, washed hands, and replaced surgical mask. During an interview on 1/30/24 at 12:28 p.m., DA-A indicated the nurses told her PPE was required to protect the resident's and herself due to R73 having COVID. She was not told a different mask was required. DA-A stated she was unsure if she had been fit tested but did receive transmission-based precautions education through the facility. During an observation on 1/31/24 at 8:40 a.m., DA-A applied PPE including an N95 mask prior to entering R73's room. During an interview on 1/31/24 at 8:27 a.m., NA-A was observed entering R73's room wearing an N95 mask. She indicated she had not been fit tested at the facility. During an interview on 1/31/24 at 2:02 p.m., the assistant clinical mentor (ACM) stated COVID positive residents are placed on modified droplet precautions. Staff are required to wear N95 masks when in a COVID positive resident's room. The director of nursing (DON) stated staff have been fit tested in the past and fit testing will be implemented with onboarding. Documentation of fit tested staff members was requested.	F 880	draw location of the resident□s room. Neighborhood meetings will be held February 29th and March 1st and an all-staff meeting held on February 28th to review F880 and the POC. Audits will be conducted for 3 months by the Care and Neighborhood Coordinators to ensure blood draws occur in the resident□s room. Audits will be conducted for 3 months by the Clinical Mentor and Assistant Clinical Mentor to ensure all nursing staff and new staff members are fit tested. Community Leader, Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.	

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F 880	Continued From page 31 During an interview on 2/1/24 at 10:11 a.m., the ACM stated staff are expected to be fit tested. If staff are not fit tested, they are expected to do a seal check (a procedure to ensure there is no air escaping around the mask). The ACM stated seal checks were approved by the regulation and would provide her source. During an interview on 2/1/24 at 11:18 a.m., The DON was unable to provide list of fit tested staff members and the employee who performed the fit testing is no longer with the facility. The ACM stated the facility's current practice is for staff to perform seal checks when putting on N95 masks. A Donning/Doffing (on/off) for confirmed COVID-19 (droplet precautions) policy dated 9/2023, indicates when a resident is confirmed positive with COVID-19, the facility's practice is "to utilize droplet Personal Protective Equipment in attempt to prevent and spread further infection to resident, staff, and visitors." Supplies needed include: PPE cart, gowns, N95 respirator, eye protection, gloves, hand sanitizer, and garbage bags. Donning procedure indicates, in part, staff are to "put on N95 face mask (if available) and ensure mask is fitted to nose bridge and has a tight seal over face, completing a seal check". A COVID-19 N95 Face Mask policy dated February 2023, indicates it is the facilities policy to "ensure staff are protected from respiratory hazards through proper use of respirators (N95 mask) when working with confirmed COVID-19 positive residents. If [the facility] is unable to perform fit-testing, a seal check method will be completed." Staff who will use an N95 mask will be evaluated by a medical provider to ensure they are physically able to perform their tasks. A fit	F 880		

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	245530	A. BUILDING _____ B. WING _____	C 02/01/2024

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F 880	Continued From page 32 test will be completed after a medical evaluation is performed. "A Fit-Test is conducted to ensure that the N95 face mask fits the staff member properly and a good seal is obtained. If the face mask does not seal, the face mask does not offer adequate protection and the staff member will need to try another mask. After the initial Fit-Test, the Fit-Test will occur annually, per frequency of medical provider discretion for staff members (if applicable), if a change in model of type of respirator occurs, or change in staff members body weight by more than 20 pounds". Seal check procedure indicates, "staff who use an N95 face mask will perform a positive pressure seal check to ensure that adequate seal is achieved each time the respirator is put on." A Centers for Disease Control and Prevention (CDC)/National Institute for Occupational Safety and Health (NIOSH) User Seal Check FAQ provided by the facility indicates, "The Occupational Safety and Health Administration (OSHA) (29 CFR 1920.134) requires an annual fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace. Once a fit test has been done to determine the best respirator model and size for a particular user, a user seal check should be done every time the respirator is to be worn to ensure an adequate seal is achieved" ... ... "A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual." "The user seal check does not have the sensitivity and specificity to replace either fit test methods, qualitative or quantitative, that are accepted by OSHA. A user should only wear	F 880		

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F 880	Continued From page 33 respirator models with which they have achieved a successful fit test within the last year." Blood Draw R334's Admission Minimum data set (MDS) assessment dated 1/23/24, indicates R334 is cognitively intact and requires partial to moderate assist for activities of daily living. R334's medical record indicates lab orders for comprehensive metabolic profile, vitamin B12, TSH, and Vitamin D total to be drawn the week of 1/29/24. During an observation on 2/1/24 at 8:20 a.m., a lab tech was in the dining room drawing blood at table while 3 residents and a family member ate breakfast. R334 was seated at the table, R3 was seated to the right of R334, R51 was seated at the head of the table to the left of R334, and R334's family member was seated across the table from him. All three resident's and the family member had food in front of them. The lab tech knelt on the floor between R334 and R51. R334 was angled away from table far enough for the lab tech to reach R334's right hand. The lab tech was observed to attempt to draw blood from resident's right hand. When unsuccessful, the lab tech wrapped R334's right hand and attempted to draw blood from left hand. R334 remained at the table. Used items were placed in sharps container that was on the floor. During an interview on 2/1/24 at 8:35 a.m., the lab tech stated if a resident is at table she will ask resident to move back away from table prior to drawing blood. She stated she did not ask resident if R334 was ok with being drawn at the	F 880		

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F 880	Continued From page 34 table. The lab tech stated they can usually draw labs at the table. She stated it would not be ok to draw blood at table and confirmed she did not move resident away from table. During an interview on 2/1/24 at 8:43 a.m., TMA-A and LPN-B indicated residents are supposed to go back to their room for blood draws per facility policy. During an interview on 2/1/24 at 8:47 a.m., LPN-A indicated blood draws should be done in a resident's room for sanitary and dignity purposes. If a resident is ok with labs being drawn in public, they should be pulled away from the table. During an interview on 2/1/24 at 9:21 a.m., the administrator stated lab draws should not be done at the table. During an interview on 2/1/24 at 9:50 a.m., the DON indicated blood draws should not be performed at the dining room table due to dignity and infection control issues.	F 880		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 13, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: ULGN11

Dear Administrator:

The above facility was surveyed on January 29, 2024 through February 1, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/29/24 to 2/1/24, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the MN State Licensure requirements. In addition, multiple complaint investigations were completed.	2 000		

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2 000	Continued From page 1 The following complaints were reviewed with no licensed orders associated: H55309262C (MN87941), H55309263C (MN91163), H55309264C (MN91161), H55309242C (MN100237) As a result of the survey, the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. The MDH is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively	2 900	Corrected	3/8/24

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2 900	Continued From page 3 reassess and develop interventions, if needed, to ensure timely repositioning and appropriate care was provided to prevent pressure injuries for 1 of 2 residents (R60) reviewed who had a decline in status and was at risk for pressure ulcer formation. Findings include: R60's quarterly Minimum Data Set (MDS) assessment, dated 1/9/24, identified R60 had severe cognitive impairment, was dependent on staff for nearly all self-cares, and multiple mobility-related tasks (i.e., sitting to standing, walking) were not attempted due to medical condition or safety concerns. Further, the MDS outlined R60 was at risk for pressure ulcer development, however, had no current, unhealed ulcers present. R60's most recent Braden Scale For Predicting Pressure Sore Risk, dated 1/9/24, identified R60 had slightly limited perception to sensory items, had very moist skin, and was bedfast. The evaluation scored all R60's risk factors with a recorded score of, "12.0," which was outlined as, "HIGH RISK [for skin breakdown]." Further, R60's care plan, last reviewed 1/23/24, identified R60 was at risk for impaired skin integrity due to limited mobility, incontinence and dementia. The care plan listed several interventions which included use of a pressure relieving mattress and cushion, keeping the skin clean and dry, and observing R60's skin with peri-care and bathing. The care plan continued and outlined R60 had a self-care deficit due to dementia and physical frailty with several interventions including, "BED MOBILITY: I am able to reposition myself." However, on 1/29/24 at 2:32 p.m., R60 was	2 900		

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2 900	Continued From page 4 observed lying in bed while in her room. R60 appeared comfortable and was on her left side with a pillow placed behind her right-side back. R60 was non-verbal with conversation and did not open her eyes. Immediately following, nursing assistant (NA)-C was interviewed, and they expressed R60 was on hospice care and had declined in condition over the last few weeks now being mostly unresponsive. On 1/29/24 at 4:35 p.m. (over two hours later), R60 was again observed and remained in bed as prior on her left side with a pillow placed behind her. Further, again on 1/29/24 at 6:20 p.m. (nearly four hours later), R60 was observed and again remained in bed as prior, on her left side with a pillow placed behind her. R60 remained nearly unresponsive to verbal interaction. On 1/29/24 at 6:21 p.m., NA-D was interviewed and stated they were an agency NA who had only worked a few shifts on campus prior; however, they verified they were currently assigned and responsible for R60's cares. NA-D stated they started working at 4:00 p.m. and had not yet been in to provide any cares, including repositioning, to R60 further adding, "I have not seen her yet." NA-D stated the previous NA had told them R60 "was OK" but didn't mention when they had last repositioned her so, as a result, NA-D stated they could not answer when R60 had been last formally repositioned (i.e., significant change in position, or one-minute off-loading). NA-D stated they tried to reposition all residents "every two hours" as a "rule of thumb" but expressed they were not sure how often R60's care plan called for R60 to be repositioned. NA-D verified they had not repositioned R60 since their shift started which was over two hours ago, and they attributed the delay in "being new" and not having	2 900		

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2 900	Continued From page 5 enough staff present to do home-maker duties (i.e., serve meals, clean up) which caused them to have those tasks, too, that shift. NA-D explained, to their knowledge, there was no tracking system or charting done when someone was repositioned and added they had "just learned" resident' care plans were stored on their supply cabinets to reference, when needed, while doing cares. NA-D then showed this care plan to the surveyor which was attached to their supply cabinet inner door. The care plan listed R60's name with a revised date 10/2023 which NA-D stated was "almost four months ago." The care plan instructed R60 was able to reposition independently which NA-D stated aloud, "I don't think that's correct." NA-D stated the care plan needed to be updated as R60 had declined and now needed more help with cares. Immediately following, on 1/29/24 at 6:29 p.m., NA-D and the surveyor observed R60's skin. NA-D removed the covers from R60 which exposed the pillow placed under her back. R60 was visibly saturated and incontinent of urine to which NA-D stated, "[R60] definitely needs to be changed." R60 was assisted by NA-D to turn onto her side with no physical assistance provided by R60. R60's coccyx' skin intact, with no redness present, however, R60's left shoulder and the left lateral side of her back had multiple light-pink colored areas present where the linen had creased and indented her skin. NA-D verified these observations. On 1/29/24 at 7:11 p.m., licensed practical nurse (LPN)-E was interviewed. LPN-E explained there was typically one NA on each side of the unit with 'staggered' hours being completed; however, there had been a call-in so the NA was helping to do homemaker duties in addition to their own	2 900		

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2 900	Continued From page 6 assigned workload. LPN-E stated resident' care plans were attached to the inner-cabinet doors for each resident to help the NA(s) know what, if needed, cares were to be done for each person. Those along with a verbal report were used to relay information like repositioning and toileting episodes. LPN-E stated R60 seemed to have "nine lives" but verified R60 had had a decline over the past week or so and, as a result, staff were now doing a majority of her cares like toileting and repositioning. LPN-E stated they believed R60 was on a "every two hours" schedule for repositioning. LPN-E stated the care coordinators were responsible to assess any changes and update the cabinet-attached care plans. When interviewed on 1/30/24 at 11:57 a.m., NA-C explained they had worked with R60 in the past, and they described R60 has being on hospice care and having declined in condition which had been for "a good two months" or so. NA-C stated R60 still would, at times, open their eyes to verbal interaction but was mostly unresponsive and needed help to complete repositioning cares. NA-C stated they were trying to reposition R60 "every two or three hours or so" adding R60 seemed to have increased incontinence and "flood out" in the later-day hours. NA-C stated the facility used care plans attached to the inner-cabinet doors to help ensure staff are aware of what is needed for each resident. NA-C then reviewed R60's door-attached care plan at the request of the surveyor. The care plan prior (dated 10/2023) remained and NA-C stated multiple interventions listed, including R60 being independent with repositioning, were inaccurate since she had declined so much. NA-C stated the care coordinator was usually the person who updated the care plans but added, "When we	2 900		

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2 900	Continued From page 7 have one." NA-C verified they had not been given guidance or direction on how often R60 needed to be repositioned since she had declined adding they had "just kind of been doing it" when able on the shift. R60's POC (Point of Care) Response History, printed 1/31/24, identified a look-back period of 30 days and included a generic question for staff to answer on their shift which read, "Did you turn and reposition?" This was answered affirmatively for each shift, however, lacked direction or guidance on how often R60 should be turned or repositioned; nor documentation on how many times a shift such task was completed to demonstrate consistency or continuity of care. In addition, R60's medical record was reviewed and lacked evidence R60 had been comprehensively reassessed to determine what, if any, interventions for skin care and management to prevent pressure injuries (i.e., repositioning) were needed or appropriate despite an obvious physical decline in condition; nor evidence the skin care plan had been re-evaluated or updated with current interventions to ensure R60's skin management needs, if any, were being met. On 1/31/24 at 10:41 a.m., licensed practical nurse (LPN)-A and registered nurse (RN)-A were interviewed, and LPN-A explained condition changes were "everybody's responsibility" to monitor and respond to with any changes being promptly reported to the care coordinators. LPN-A stated it had been "approximately a month" since they had seen R60 get up from bed, and expressed repositioning needs were typically evaluated using a "tissue tolerance" which helped determine how long a resident could be left in the same position without having breakdown begin. LPN-A verified R60 was no longer able to	2 900		

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2 900	Continued From page 8 reposition herself, as outlined in her care plan, and the medical record lacked evidence R60 had been comprehensively evaluated for what, if any, skin interventions were needed since she had declined adding, "I think that's very fair to say." LPN-A and RN-A both reiterated if direct care staff members were seeing changes, such as obvious declines in condition, then it needed to be brought to the care coordinators for action adding such was important to do for resident' comfort and ensuring all their needs are being met and addressed. A provided Skin/Wound Care Policy, dated 9/2023, identified the care center would provide care to prevent or heal skin impairments or wounds unless such was unavoidable. The policy outlined, "All residents are evaluated for skin integrity using the Braden Scale ... [it] will be done on all residents quarterly, and with any significant change in condition." Further, the policy outlined, "Caregivers will report any concerns related to skin to the licensed nurse." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures with pressure ulcer assessment and timely repositioning to ensure accuracy; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 920		3/8/24

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2 920	Continued From page 9 B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene cares (i.e., nail care) was provided to reduce the risk of complication (i.e., infection, skin scratches) for 1 of 2 residents (R76) reviewed for activities of daily living (ADLs) and whom was dependent on staff for their care. Findings include: R76's quarterly Minimum Data Set (MDS) assessment, dated 11/28/23, identified R76 had intact cognition, demonstrated no rejection of care behaviors during the review period, and did not have diabetes mellitus. R76's care plan, dated 12/2023, identified R76 had a self care deficit and was enrolled in hospice care for end-stage heart failure. The care plan outlined an intervention which read, "PERSONAL HYGIENE ... [R76] require assist of 1 to help ... brush hair, brush teeth, apply deodorant, wash/dry face and hands." However, the care plan lacked information or direction on nail care (i.e., how often, length preference, who would assist). On 1/29/24 at 2:13 p.m., R76 was observed lying in bed. R76's hands were present on top of the bed covers, and R76 had visibly long fingernails present on both hands with several nails having a dark-brown colored substance or debris present	2 920	Corrected	

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2 920	Continued From page 10 under the nail. R76 woke to verbal interaction and, when asked, expressed he would like them clipped but was unable to remain awake for additional questions when attempted. Later on 1/29/24, at 5:40 p.m., R76 was again observed lying in bed while in his room. R76's family member (FM)-A was present at the bedside and was interviewed. FM-A stated R76 was on hospice care and had declined fairly quickly over the past weeks with the pain medications making him very sleepy and hard to converse with. FM-A stated staff were "supposed to be" helping R76 with bathing and personal hygiene cares. FM-A then looked at R76's fingernails, which remained long and soiled, and said aloud, "They should be shorter." FM-A stated R76 typically had a shorter clipped nail as was his preference. The following day, on 1/30/24 at 11:33 a.m., R76 was again observed lying in bed while in his room, and his fingernails remained long and visibly soiled as they had been the day prior. R76's POC (Point of Care) Response History, printed 1/31/24, identified the past 30 days worth of bathing support provided to R76 by the care center staff members. There were three completed episodes dated 1/3/24, 1/10/24, and 1/24/24; however, all of these were recorded with a response of, "ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time." There were no recorded tasks identified to demonstrate nail care had been offered, provided, or refused during the same period of time. R76's facility' progress notes, dated 1/1/24 to 1/30/24, were reviewed. These identified a series	2 920		

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2 920	Continued From page 11 of notes labeled, "Bath/Skin Note," which were completed on 1/2/24, 1/9/24, 1/16/24, and 1/22/24, respectively. These outlined R76 received a bed bath last on 1/22/24, however, all of the notes lacked evidence R76 had been offered, provided or refused nail care. When interviewed on 1/30/24 at 12:04 p.m., nursing assistant (NA)-C explained they had cared for R76 multiple times prior and described him as declining in overall status now needing help to complete most cares. NA-C stated R76 did not have a history of refusing personal cares when offered but would, at times, refuse a full shower from the hospice caregivers. NA-C stated R76 was scheduled for a Monday bath (i.e., bed bath) and nail care should be completed then; however, there was no place to record such cares in the medical record to their knowledge adding, "There's not even a spot on our charting for that." NA-C then observed R76's fingernails while he laid in bed, and stated they were long and had "a couple spots" which had debris present (i.e., soiled) adding, "They could be clipped." NA-C stated R76 was not diabetic, to their knowledge, and so the NA(s) could clip them on bath days or when noticed adding a clipped, short kept nail was important so R76 couldn't scratch himself and "because germs can stick under there [under the nail]." When interviewed on 1/31/24 at 10:18 a.m., licensed practical nurse (LPN)-D explained R76 was on hospice and their staff typically did the bathing and personal hygiene cares as a result. LPN-D stated R76 would, at times, use his fingers to pick up food items and eat them and, to their recall, had been somewhat resistant in the past to having his nails clipped as he liked to use them to get tops off containers. However, LPN-D stated	2 920		

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2 920	Continued From page 12 they were unsure if that remained accurate now since R76 had declined in condition over the past week or so and added such preference would likely not be care planned for him, either, adding, "I don't think so." LPN-D explained baths, when completed, should be recorded in the 'bath/skin check' notes and any refusals of care, including nail care, should be documented in there, too. However, R76's medical record was reviewed and lacked evidence when the last time R76's fingernails had been clipped or cleaned; nor any evidence R76 had a preference to have long fingernails as mentioned by LPN-D. On 1/31/24 at 11:05 a.m., licensed practical nurse (LPN)-A and registered nurse (RN)-A were interviewed, and LPN-A explained R76 had been "more challenging" with cares of late due to a physical and mental decline. LPN-A stated either the nurse or NA would be able to complete nail care and expressed they "don't know why" the care was not provided. LPN-A stated nail care should be done when it's noticed as being needed and, if refused, then the nurse should be told so it could be documented accordingly as there was no formal tracking system to record nail care currently in place (i.e., tasks). LPN-A stated R76 was on hospice and those staff members were doing a majority of R76's cares which is why the bath charting indicated such for the support recorded; however, LPN-A verified the medical record lacked evidence nail care had been offered or provided to R76 within the past several weeks. A facility' provided Personal Hygiene policy, dated 5/23, identified the care center would provide personal hygiene according to resident' preferences to maintain dignity. A procedure was	2 920		

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2 920	Continued From page 13 listed which directed, "Nail care ... is provided at the time of bath and as needed. Nails should be cleaned and trimmed without jagged edges, according to resident preferences." The policy continued, "Personal hygiene cares are documented by the caregiver or nurse providing the care. Report any concerns, or if a resident chooses not to have care provided, to the nurse." Further, the policy concluded with, "The individual care plan must reflect resident care needs and preferences related to personal hygiene." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures with resident' personal hygiene care/needs to ensure accuracy; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 920		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate use of personal protective equipment (PPE) when entering a COVID positive resident (R73) room after the facility failed to ensure all staff were fit tested (test used to determine appropriately sized N95 mask) for the use of N95 masks. This had	21375	Corrected	3/8/24

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21375	Continued From page 14 the potential to affect all 84 residents in the facility. In addition, the facility failed to ensure protection from blood-borne pathogens when an outside lab technician (lab tech) was observed drawing blood from R334 at the dining room table. This had the potential to affect 2 of 2 residents (R3 and R51) and a family member who were also seated at the table. Findings include: During an observation on 1/30/24 at 12:25 p.m., a dietary aide (DA-A) was observed entering R73's room wearing face shield, gown, and surgical mask. A sign on the outside of R73's room indicated "caution PPE required". Another sign on the door demonstrated putting on PPE. A white cart containing PPE supplies was located outside of the room. A sign on top of the cart indicated contents of the cart, including N95 masks. DA-A walked out of R73's room, removed PPE, washed hands, and replaced surgical mask. During an interview on 1/30/24 at 12:28 p.m., DA-A indicated the nurses told her PPE was required to protect the resident's and herself due to R73 having COVID. She was not told a different mask was required. DA-A stated she was unsure if she had been fit tested but did receive transmission-based precautions education through the facility. During an observation on 1/31/24 at 8:40 a.m., DA-A applied PPE including an N95 mask prior to entering R73's room. During an interview on 1/31/24 at 8:27 a.m., NA-A was observed entering R73's room wearing an N95 mask. She indicated she had not been fit	21375		

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21375	Continued From page 15 tested at the facility. During an interview on 1/31/24 at 2:02 p.m., the assistant clinical mentor (ACM) stated COVID positive residents are placed on modified droplet precautions. Staff are required to wear N95 masks when in a COVID positive resident's room. The director of nursing (DON) stated staff have been fit tested in the past and fit testing will be implemented with onboarding. Documentation of fit tested staff members was requested. During an interview on 2/1/24 at 10:11 a.m., the ACM stated staff are expected to be fit tested. If staff are not fit tested, they are expected to do a seal check (a procedure to ensure there is no air escaping around the mask). The ACM stated seal checks were approved by the regulation and would provide her source. During an interview on 2/1/24 at 11:18 a.m., The DON was unable to provide list of fit tested staff members and the employee who performed the fit testing is no longer with the facility. The ACM stated the facility's current practice is for staff to perform seal checks when putting on N95 masks. A Donning/Doffing (on/off) for confirmed COVID-19 (droplet precautions) policy dated 9/2023, indicates when a resident is confirmed positive with COVID-19, the facility's practice is "to utilize droplet Personal Protective Equipment in attempt to prevent and spread further infection to resident, staff, and visitors." Supplies needed include: PPE cart, gowns, N95 respirator, eye protection, gloves, hand sanitizer, and garbage bags. Donning procedure indicates, in part, staff are to "put on N95 face mask (if available) and ensure mask is fitted to nose bridge and has a tight seal over face, completing a seal check".	21375		

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21375	Continued From page 16 A COVID-19 N95 Face Mask policy dated February 2023, indicates it is the facilities policy to "ensure staff are protected from respiratory hazards through proper use of respirators (N95 mask) when working with confirmed COVID-19 positive residents. If [the facility] is unable to perform fit-testing, a seal check method will be completed." Staff who will use an N95 mask will be evaluated by a medical provider to ensure they are physically able to perform their tasks. A fit test will be completed after a medical evaluation is performed. "A Fit-Test is conducted to ensure that the N95 face mask fits the staff member properly and a good seal is obtained. If the face mask does not seal, the face mask does not offer adequate protection and the staff member will need to try another mask. After the initial Fit-Test, the Fit-Test will occur annually, per frequency of medical provider discretion for staff members (if applicable), if a change in model of type of respirator occurs, or change in staff members body weight by more than 20 pounds". Seal check procedure indicates, "staff who use an N95 face mask will perform a positive pressure seal check to ensure that adequate seal is achieved each time the respirator is put on." A Centers for Disease Control and Prevention (CDC)/National Institute for Occupational Safety and Health (NIOSH) User Seal Check FAQ provided by the facility indicates, "The Occupational Safety and Health Administration (OSHA) (29 CFR 1920.134) requires an annual fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace. Once a fit test has been done to determine the best respirator model and size for a particular user, a user seal check should be done every time the respirator is to be worn to	21375		

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21375	Continued From page 17 ensure an adequate seal is achieved" ... ... "A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual." "The user seal check does not have the sensitivity and specificity to replace either fit test methods, qualitative or quantitative, that are accepted by OSHA. A user should only wear respirator models with which they have achieved a successful fit test within the last year." Blood Draw R334's Admission Minimum data set (MDS) assessment dated 1/23/24, indicates R334 is cognitively intact and requires partial to moderate assist for activities of daily living. R334's medical record indicates lab orders for comprehensive metabolic profile, vitamin B12, TSH, and Vitamin D total to be drawn the week of 1/29/24. During an observation on 2/1/24 at 8:20 a.m., a lab tech was in the dining room drawing blood at table while 3 residents and a family member ate breakfast. R334 was seated at the table, R3 was seated to the right of R334, R51 was seated at the head of the table to the left of R334, and R334's family member was seated across the table from him. All three resident's and the family member had food in front of them. The lab tech knelt on the floor between R334 and R51. R334 was angled away from table far enough for the lab tech to reach R334's right hand. The lab tech was observed to attempt to draw blood from resident's right hand. When unsuccessful, the lab tech wrapped R334's right hand and	21375		

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21375	Continued From page 18 attempted to draw blood from left hand. R334 remained at the table. Used items were placed in sharps container that was on the floor. During an interview on 2/1/24 at 8:35 a.m., the lab tech stated if a resident is at table she will ask resident to move back away from table prior to drawing blood. She stated she did not ask resident if R334 was ok with being drawn at the table. The lab tech stated they can usually draw labs at the table. She stated it would not be ok to draw blood at table and confirmed she did not move resident away from table. During an interview on 2/1/24 at 8:43 a.m., TMA-A and LPN-B indicated residents are supposed to go back to their room for blood draws per facility policy. During an interview on 2/1/24 at 8:47 a.m., LPN-A indicated blood draws should be done in a resident's room for sanitary and dignity purposes. If a resident is ok with labs being drawn in public, they should be pulled away from the table. During an interview on 2/1/24 at 9:21 a.m., the administrator stated lab draws should not be done at the table. During an interview on 2/1/24 at 9:50 a.m., the DON indicated blood draws should not be performed at the dining room table due to dignity and infection control issues. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures with blood collection (i.e., lab draws) and respirator or N95 mask fit-testing to ensure accuracy; then	21375		

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21375	Continued From page 19 educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	21375		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess for ability or safety, and then care plan the self administration of medication for 1 of 1 resident (R48) observed to have medications prepared by staff and then left with him to take at leisure. Findings include: R48's quarterly Minimum Data Set (MDS) assessment, dated 11/9/23, identified R48 had intact cognition and had multiple medical conditions including high blood pressure, diabetes mellitus, and hemiplegia/hemiparesis (muscle weakness or partial paralysis on one side of the body). R48's most recent Nursing - Self Administration of Medication Evaluation, dated 5/2021, identified multiple questions to be answered which helped evaluate if R48 was able to safely self-administer	21565	Corrected	3/8/24

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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) COMPLETE DATE
21565	Continued From page 20 medications including what, if any, medical diagnoses R48 had, if he was physically capable to self-administer them, and if he had the ability to recognize the medications when provided. The evaluation identified R48 did not have knowledge on the purpose of his medications, was not able to recognize his medications, nor had the ability to read the medication label, if needed. The evaluation outlined R48 was determined to not be a candidate for self-administer medications with dictation present, " ... nursing will provide and administer medications to resident." However, on 1/31/24 at 7:28 a.m., licensed practical nurse (LPN)-C prepared R48's medications using a mobile computer station outside of his room where the medications were stored in a cabinet. LPN-C removed each medication punch-pack and placed a dose of each medication into a white-colored, disposable medication cup. A total of 11 oral medications were placed into the cup including baclofen (a muscle relaxant), Metformin (for diabetes), and lisinopril (for high blood pressure). In addition, a dose of Miralax (for constipation) was mixed into a glass of orange juice. LPN-C then brought the medication cup and medication-laced orange juice over to R48 who was seated in a wheelchair in the commons area of the unit with another female resident sitting immediately adjacent. R48 had a bedside table place in front of him which had another cup of orange juice present along with other various items (i.e., TV remote). LPN-C set the cup of prepared medications on the table and expressed aloud those were his morning medications. LPN-C then turned back to the mobile computer station and started to leave the area telling the surveyor aloud, "I am going to follow up with some others who wanted me [on the other unit]." LPN-C then left the unit with	21565		

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21565	Continued From page 21 R48's prepared medications sitting in the medication cup on the table. A few minutes later, nursing assistant (NA)-B approached R48 with his morning breakfast meal and provided it to him on the same table. NA-B then left and returned to the kitchen. R48 started to eat the provided meal until several minutes later, at 7:38 a.m., when R48 picked up the cup of prepared medications, brought it to his mouth and took the entire cup at once. R48 then used the medication-laced orange juice to swallow them down. There were no dropped doses observed, and LPN-C was not observed ever returning to the area to ensure R48 consumed them all without complication. When interviewed immediately following, on 1/31/24 at 7:39 a.m., R48 stated the nurses usually give him cups of his medications and leave it with him to take later. R48 stated he could not recall ever being talked to or evaluated for this, however, voiced he felt comfortable taking them on his own. When asked if he had an issue taking them (i.e., dropped one, choked on them), R48 stated he "would yell" to get help. On 1/31/24 at 7:42 a.m., LPN-C was interviewed and verified they had left R48's prepared medications with him to take on his own. LPN-C stated doing such was their typically practice with R48, and they believed R48 had been evaluated for safety and ability to self-administer medications. LPN-C stated they believed R48 would "let me know" if any issues with taking his medications arouse. R48's Order Summary Report, signed 12/7/23, identified R48's current physician-ordered medications and interventions. These included active orders for Metformin, baclofen, and	21565		

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21565	Continued From page 22 lisinopril along with other medications, including Fosamax, which had special post-administration instructions (i.e., remain upright for 30 minutes afterward). However, the signed orders lacked approval or evidence R48's physician had approved the self-administration of medications. In addition, R48's care plan, last reviewed 11/2023, identified R48 was alert and oriented, had diabetes which was managed with medications, and had a history of behaviors which included verbal aggression to others. The care plan outlined R48 had a self-care deficit with resulted limited mobility due to several medical complications including spasms and a prior stroke. However, the care plan lacked any evidence R48 had been evaluated and approved to self-administer medications after set-up by the nurses, nor any interventions to ensure R48 safely consumed them (i.e., check back). R48's medical record was reviewed and lacked evidence R48 had been comprehensively assessed for safety and ability to self-administer medications since 2021, where he had been determined to be ineligible to do so for various reasons; nor evidence R48 had been evaluated by the interdisciplinary team (IDT) and approved to self-administer medications despite staff routinely leaving them with him to take at leisure. On 1/31/24 at 11:13 a.m., licensed practical nurse (LPN)-A and registered nurse (RN)-A were interviewed. LPN-A explained residents' who wished to self-administer were evaluated using the self-administration of medication evaluation tool (such as was completed for R48 in 2021) and the results were then reviewed by the IDT. LPN-A stated they felt R48 was physically able to self-administer his own medications, after set-up,	21565		

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21565	Continued From page 23 but may possibly not be able to recognize all of them, if asked. LPN-A reviewed R48's medical record and verified it lacked any further self-administration of medication evaluations or assessments since 2021; nor were there any care planned interventions for such on R48's care plan. LPN-A added, "This needs to be readdressed with him [R48]." LPN-A and RN-A both verified they were unaware the floor nurses were leaving the medications with R48 to take at leisure, and LPN-A stated it was important to ensure the ability to self-administer medications was assessed and care planned "so we know they can safely take their medications." A provided Administration of Medication policy, dated 11/2023, identified medications were administered only by licensed nursing or trained medication aides (i.e., TMA). The policy continued, "Residents are assessed for self-administration of medication ability when they move into the facility, quarterly, and PRN [as needed] as requested following." However, the policy lacked any further information to clarify that sentence meaning or how such would be evaluated (i.e., tools used, responsibility to do). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures with medication self-administration to ensure accuracy; then educate direct care staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	21565		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/01/2024. At the time of this survey, SAMARITAN BETHANY HOME ON EIGHTH was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 02/23/2024

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

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

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K 000	Continued From page 2 2012, the original 3 story building with basement was remodel, maintaining its Type II (222) construction. Each floor of the 6-story structure is divided into 2 smoke compartments. Each floor of the 3-story structure is divided into 2 smoke compartments. Because the original building and addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (222). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 128 beds and had a census of 105 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 324 SS=F	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply	K 324		3/8/24

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K 324	Continued From page 3 with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper safety and security measures related to a residential cooking device in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient condition could have a widespread impact on the residents within the facility. Findings Include: On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that the residential stoves located in the following areas were not outfitted with lock-out, timeout, and disconnect hardware: 6TH , 5TH , 4TH , 3RD ,and 2ND Floor neighborhood kitchens. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 324	The neighborhood stoves on the 2nd, 3rd, 4th, 5th and 6th neighborhoods will have a system installed with lock-out, time-out functions and disconnect hardware. The Building Operations Mentor and Community Leader will monitor to ensure installation and proper functioning of the stove functions.	
K 353 SS=F	Sprinkler System - Maintenance and Testing	K 353		3/8/24

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K 353	Continued From page 4 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, documentation review, and staff interview the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, 9.7.6, NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section(s), 5.2.1.1.2(2)(5). These deficient findings could have an isolated impact on the residents within the facility. Findings include: 1. On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that sprinkler heads in the following locations exhibited signs of	K 353	The debris will be removed from the sprinkler heads in the kitchen areas on the 3rd, 4th, 5th and 6th neighborhoods as well as the sprinkler head on the neighborhood laundry room. The oxidation will be removed from the sprinkler head on the 1st floor dishwashing area. The fire protective overspray will be removed from the sprinkler head on 1st floor adjacent to the walk-in freezer. Audits will be conducted by maintenance quarterly to ensure that all sprinkler heads are free of oxidation and foreign substances. The Building Operations Mentor will	

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K 353	Continued From page 5 debris loading: 6TH , 5TH , 4TH , and 3RD Floor neighborhood kitchen areas. 2. On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that sprinkler head(s) in the 5TH Floor - Laundry Room exhibited signs of debris loading. 3. On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that sprinkler head(s) located on the 1ST Floor in the Kitchen / Dishwashing area(s) exhibited signs of oxidation. 4. On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that sprinkler head(s) located on the 1ST Floor, adjacent to the walk-in freezer area exhibited signs of loading in the form of loading - coated with fire-protective overspray. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 353	monitor to prevent reoccurrence.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum	K 374		3/8/24

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K 374	Continued From page 6 clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and inspect the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7 and 8.5.4 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that fire / smoke barrier doors in the following locations exhibited an air-gap greater than 1/8 inch, which would allow the passage of smoke: 6TH , 5TH , 4TH , 3RD , 2ND Floor assemblies. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	The air-gap for the smoke barrier doors on the 2nd, 3rd, 4th, 5th and 6th neighborhoods has been eliminated by installing astragals on each smoke barrier door. Maintenance will continue monthly inspections to ensure a proper gap of smoke barrier doors. The Building Operations Mentor will monitor to prevent reoccurrence.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for	K 920		3/8/24

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K 920	Continued From page 7 PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to manage usage of relocatable power taps in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, and NFPA 70, (2011 edition), National Electrical Code, sections 110.3(B), 400.8 (1) and UL 1363. These deficient findings could have an isolated impact on the residents within the facility. Findings include: On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation that on the 2ND Floor - RM 2251, that relocatable power taps were found daisy-chained together. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	On 2/1/24 the relocatable power taps were removed from room 2251. Neighborhood meetings will be held on February 29th and March 1st to educate staff on the use of relocatable power taps and the POC regarding K920. The Building Operations Mentor and Community Leader will monitor to prevent reoccurrence.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage	K 923		3/8/24

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

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K 923	Continued From page 8 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 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 maintain proper medical gas	K 923	A new motor was installed on the ventilation fan in the Med Gas room has	

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 _____	**02/01/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 9 storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 9.3.7, 9.3.7.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/01/2024 between 9:00 AM and 1:00 PM, it was revealed by observation in RM 2507 that on the 1ST Floor in the Med Gas (O2) Room, containing liquid oxygen tanks, it could not be confirmed that the ventilation fan was operational. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	the week of 2/5/24. The Building Operations Mentor will monitor to prevent reoccurrence.	