

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 11, 2021

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

RE: CCN: 245530

Cycle Start Date: April 20, 2021

Dear Administrator:

On April 20, 2021, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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" 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 July 20, 2021 (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).

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In addition, if substantial compliance with the regulations is not verified by October 20, 2021 (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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 05/28/2021 FORM APPROVED OMB NO. 0938-0391

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F 000	INITIAL COMMEN	rs	F 0	00			
	abbreviated survey facility. Your facility compliance with the	4/20/2021, a standard was conducted at your was found to be NOT in requirements of 42 CFR quirements for Long Term					
	SUBSTANTIATED: H55300065C (MN7 (MN56161) with a 0 F584, and F684	Plaints were found to be (1916) and H55300067C (deficiencies cited at F557, (88831) no corresponding					
	The following comp UNSUBSTANTIATE H55300068C (MN6						
		f correction (POC) will serve of compliance upon the ottance.					
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.					
F 550 SS=D	an onsite revisit of to validate substan- regulations has bee Resident Rights/Ex	ercise of Rights	F 5	50			6/4/21
	§483.10(a) Resider	_					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		TITLE		(X6) DATE

Electronically Signed 05/21/2021

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 550	self-determination, access to persons outside the facility, this section. §483.10(a)(1) A fact with respect and diresident in a manner promotes maintenather quality of life, reindividuality. The fact promote the rights access to quality of severity of condition must establish and practices regarding provision of service residents regardles §483.10(b) Exercise The resident has the rights as a resident or resident of the U §483.10(b)(1) The resident can exerci interference, coercifrom the facility. §483.10(b)(2) The free of interference reprisal from the farights and to be su	right to a dignified existence, and communication with and and services inside and including those specified in cility must treat each resident gnity and care for each er and in an environment that ance or enhancement of his or ecognizing each resident's acility must protect and of the resident. Ifacility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and g transfer, discharge, and the es under the State plan for all es of payment source. The of Rights. The right to exercise his or her to fithe facility and as a citizen	F 55	50		

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F 550	This REQUIREMEI by: Based on observar review the facility fa 1 resident (R1) who and stained carpet. Findings include During an observat 4/19/2021, at 8:50 a upon entry to the represent; the odor so ther reclining chair of known as a soaker from incontinence); on the floor under fa was partially underned the pad had different R1 was asked why what was underneath, had be admitted, and the fland picked up the sawas more prominer the floor. The pad of approximately 2 feed black that was mois covered the area we stated she did not be carpet was deep clicleaned it herself. For carpet, During a supp.m. R1 sat in her of environmental server carpet. R1 stated, "care of the carpet,"	tion, interview, and document ailed to ensure dignity for 1 of to had an offensive room odors ion and interview on a.m. R1's door was closed, from a very strong odor was melt like stale urine. R1 sat in on a washable bed pad (also pad-used to protect mattress there was also a soaker pad R1's feet. The pad on the floor neath the recliner; that area of int shades of brown markings. The pad was on the floor and ath, R1 stated there was mold been there since she was or was leaking. R1 bent over soaker off the floor; the odor int when the pad was lifted off covered a large area that was set in diameter that was dark set. The back of the pad that was yellow and brown. R1 know when the last time her eaned/shampooed, and she R1 indicated she wanted new beequent interview at 1:45 chair, she was informed ices was going to clean her oh good, I hope they can take	F 550	Resident Rights/Exercise of Rights Samaritan Bethany strives to ensure resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and of the facility. R1's carpet was cleaned by environmental services on 4/19/21 carpet was also cleaned by an out carpet cleaning company on 4/28/care team along with the family arresident agreed on the following rocleaning schedule: R1's room will cleaned twice a week with carpet occurring on an as needed basis as as twice a month by environmental services. R1's room odor has sign improved. Samaritan Bethany is with Hillers Flooring to replace R1 carpet. The Carpet Cleaning policy was reand found appropriate. 5th neighborhood staff were educated 4/23 and 4/26 regarding R1's decloares/services and approaches for approach R1 when care/services adeclined. All neighborhood staff will be educated 5/27/21 and 5/28/21 on F550 alon resident room cleaning procedures approaches for residents who decloares/services. Neighborhood audits will be conducted to the conducted services and sughts will be conducted to the conducted services. Neighborhood Coordinators and	ire each outside at the combe cleaning as well all ifficantly porking as the combining of t	

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F 550	family has told me it really bad." R1 le pad covering the st bad I just can't star embarrassing. R1's face sheet inc generalized anxiety (fear of certain place person believes is spaces) R1's quarterly Minit 4/7/2021, indicated impairment and did behaviors. The MD independent ambur hygiene, and toileti was frequently incooccasionally incontinuous frequently incompand bathroom know I'm incontinuous occasionally incontinuous on any give to it some days. Stacleaning myself up myself, which in tur which I understand environment." The directed staff to re-During an interview nursing assistant (I stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand interview of the stated the soaker purinary overflow incompand in the stated the soaker purinary overflow in the stated the stated the soaker purinary overflow in the stated the stated the soaker purinary overflow in the stated	how bad it smells, I can smell aned down and removed the ain and stated, "It gets so very a dit anymore, it's just so a luded diagnoses of a disorder and agoraphobia are and situation that the difficult from such as public and have rejection of care and situation of care and in the situation of urine and in the situation of urine and in the situation of urine, stool, and have an about every two weeks. In the of urine, stool, and have an and in the situation of the	F 58	Coordinators for 3 months to carpets are cleaned and roo odor. Community Leader and Assi Mentor will monitor for comp Findings will be reported at 0 Assurance Committee meeti Date of completion: 6/4/21	ms are free of stant Clinical liance. Quality	

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F 550	room had an offens carpets were cleaner R1 was not in her reto beauty shop app cleaned the carpets the beauty shop. LF product Odor Be Grook up the urine of R1 did not always a R1 liked to do it her During an interview family member (FM very recently; R1's urine/bowel odor, a the floor. FM-A indicated staff room almost weekly RN-A indicated staff room almost weekly RN-A stated there we checklist outlined the each room. RN-A surveyor; the check room numbers unded in not outline specific stated NA's would coarpet cleaner for reenvironmental servicleaning.	cive odor and indicated R1's ed whenever they can; when com such as when she went ointments. LPN-A stated staff is last week when she was at PN-A stated staff used a cone/biomatic and towels to in the floor. LPN-A indicated allow staff to clean her carpet; riself. If on 4/19/2021, at 10:16 a.m. In the rewas a soaker pad on cated she had historically ern with the nurse manager is anything had been done If on 4/19/2021, at 10:45 a.m. In the rewas a soaker pad on cated she had historically ern with the nurse manager is anything had been done If on 4/19/2021, at 10:45 a.m. In the unit where R1 resided. If would attempt to clean R1's yeard when R1 would allow. It was a daily and a weekly completed by NA's; the ine cleaning schedules for howed the checklist to the clist had days of the week with the remeath the day of the week, it effic cleaning tasks. RN-A clean the carpet using the	F 5	550			

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F 550	she had not been in ESP-A indicated Nato shampoo the car unit had their own or R1's room, ESP-A in stained she couldn' observed R1's carp seen it [stain] that been cleaned in a lichair; there was the R1's chair. ESP-A in the carpet cleaner in odor/dirty carpet coother residents, and During an interview director of nursing of staff to clean the car often refuse her car indicated that once	ice partner (ESP)-A stated in R1's room for a long time. A's on the unit were supposed opet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were it get the stains out. ESP-A entered confirmed the presence of the dicated once the carpets were it get the stains out. ESP-A entered stated, "I've never plack, it doesn't look like it has ong time." ESP-A moved R1's estain extended underneath stated she was going to get now. ESP-A indicated that the ould be a health risk for R1,	F 5	550		
F 584 SS=D	CFR(s): 483.10(i)(1 §483.10(i) Safe Entransiste The resident has a comfortable and ho	vironment. right to a safe, clean, melike environment, including ceiving treatment and	F 5	584		6/4/21
	homelike environm	ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent				

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F 584	receive care and sephysical layout of the independence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) House services necessary orderly, and comford §483.10(i)(3) Clear in good condition; §483.10(i)(4) Privation resident room, as seed with the services in all areas; §483.10(i)(5) Adeq levels in all areas; §483.10(i)(6) Comford levels. Facilities initiated and seed in the service of the seed on observation review the facility factors are view the facility factors are from offert (R1) Findings include	suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary,	F 5	584	F584 Safe/Clean/Comfortable/Homelike Environment Samaritan Bethany strives to ensure resident has right to a safe, clean, comfortable and homelike environment including but not limited to receiving treatment and supports for daily live	nent,	

OLIVILI	RS FUR MEDICARE	& MEDICAID SERVICES			UI	<u>VIB NO.</u>	0938-0391
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SAMARI	TAN BETHANY HOME	ON EIGHTH		R	OCHESTER, MN 55901		
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F 584	upon entry to the ropresent; the odor wher reclining chair, floor under R1's fee partially underneath pad had different slasked why the pad was underneath, Runderneath and the over and picked up odor was more prolifted off the floor. That was approximated was dark black that pad that covered the R1 stated she did rher carpet was dees she cleaned it hers new carpet. During an interview nursing assistant (N stated the pad was overflow incontinentherself and indicated clean her carpets. During an interview licensed practical in room had an offens carpets were clean R1 was not in her reto beauty shop app. During an interview family member (FM)	a.m. R1's door was closed, om a very strong odor was as like stale urine. R1 sat in there was also a pad on the let. The pad on the floor was a the recliner; that area of the nades of brown. R1 was was on the floor and what 1 stated there was mold a floor was leaking. R1 bent the soaker off the floor; the minent when the pad was the pad covered a large area lately 2 feet in diameter that it was moist. The back of the let area was yellow and brown. In the thought was the pad covered a large area lately 2 feet in diameter that it was moist. The back of the let area was yellow and brown. In the last time is a proposed of the last time in the proposed of the last time in the last time is a proposed of the last time in the last time	F 5	584	safely. R1's carpet was cleaned by environmental services on 4/19/21 carpet was also cleaned by an outs carpet cleaning company on 4/28/2 care team along with the family and resident agreed on the following rocleaning schedule: R1's room will be cleaned twice a week with carpet coccurring on an as needed basis a as twice a month by environmental services. R1's room odor has signitimproved. Samaritan Bethany is we with Hillers Flooring to replace R1's carpet. The Carpet Cleaning policy was reand found appropriate. 5th neighborhood staff were educated 4/23 and 4/26 regarding R1's declincares/services and approaches for approach R1 when care/services and declined. All neighborhood staff will be educated 5/27/21 and 5/28/21 on F584 along resident room cleaning procedures approaches for residents who declicare/services. Neighborhood audits will be conducted Neighborhood Coordinators and Coordinators for 3 months to ensure carpets are cleaned and rooms are odor. Community Leader and Assistant Community Leader and Assistant Community Leader and Assistant Community Weader and Coordinators for Community Leader and Assistant Community Leader and Assistant Community Leader and Coordinators for Community Leader and Assistant Community Leader and Coordinators for Community Leader and Assistant Community Leader and Coordinators for Community Leader and Assistant Community Leader and Coordinators for Community Leader and Assistant Community Leader and Coordinators for Community Leader and Assistant Community Leader and Coordinators for Community Leader and Assistant Community Leader and Coordinators for Community Leader and Assistant Community Leader and Coordinators for Coordinators f	side 21. The d om oe leaning s well ficantly orking s viewed ted on ning of how to re ated on g with and ine cted by are e free of	

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F 584	there was a soaker indicated she had he concern with the nuthink anything had be built anything an interview registered nurse (Registered nurse (Registered nurse (Registered nurse manager for RN-A indicated staffer room almost weekly RN-A stated there weeklist that was concerned the deep carpet cleaning and environmental service she had not been in ESP-A indicated National shad their own of R1's room, ESP-A in stained she couldn'e observed R1's carpeseen it [stain] that be been cleaned in a lechair; there was the R1's chair. ESP-A sthe carpet cleaner in the stained she carpet cleaner in the carpet cleaner in	pad on the floor. FM-A historically discussed the bree manager however, didn't been done about it. I on 4/19/2021, at 10:45 a.m. N)-A stated she was the the unit where R1 resided. If would attempt to clean R1's y and when R1 would allow. I was a daily and a weekly completed by NA's; the ne cleaning schedules for tated NA's would clean the repet cleaner for routine commental services would do aning. I on 4/19/2021, at 2:30 p.m. ince partner (ESP)-A stated in R1's room for a long time. A's on the unit were supposed pet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were to get the stains out. ESP-A et and stated, "I've never black, it doesn't look like it has ong time." ESP-A moved R1's estain extended underneath stated she was going to get how. ESP-A indicated that the uld be a health risk for R1,	F 5	584			
	R1 had been move	ion on 4/20/2021, at 8:15 a.m. d temporarily out of her room m so that the carpet could dry					

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	<u>.</u>	
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F 584	odor was now noti of R1's room; inside unchanged from 4 the area of carpet black. During an interview neighborhood coowas responsible for checklist for compound manager. NC-A standard shampoo carpets a conce per month. We checklist when was shampooed, NC-A the last time the care cleaned/shampoor indicated that just informed environmore sponsible for the stock the supplies. During an interview director of nursing staff to clean the conference of the conference of the stock that one but would have to alternatives. Facility policy Carpincluded: Samaritato ensure carpet in and maintained. 1. Household carpeach neighborhood	s room door was opened, the ceable in the hallway outside le R1's room the odor was /19, industrial fans pointed at that continued to be a dark of on 4/20/2021, at 8:35 a.m. rdinator (NC)-A indicated she for reviewing and auditing letion along with the unit nurse lated NA's were supposed to as needed and deep cleaned when asked, Based on the sethelast time the carpets were stated she could not tell when	F 5	84		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '		E CONSTRUCTION (E SURVEY PLETED
		245530	B. WING _				C 20/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				2	4 - 8TH STREET NORTHWEST		
SAMARI	TAN BETHANY HOME	ON EIGHTH			OCHESTER, MN 55901		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 584	Continued From pa	ae 10	F 58	84			
	·	ea needs further cleaning by		٠.			
	environmental servi						
F 684	Quality of Care		F 68	84			6/4/21
SS=D	CFR(s): 483.25		1 00	J +			0/4/21
00 B	O1 11(0). 400.20						
	§ 483.25 Quality of	care					
		fundamental principle that					
	,	ent and care provided to					
		ased on the comprehensive					
	assessment of a res	sident, the facility must ensure					
	that residents receive	ve treatment and care in					
		ofessional standards of					
		ehensive person-centered					
	care plan, and the r						
		NT is not met as evidenced					
	by:						
		tion, interview, and document			F684 Quality of Care		
	review the facility fa				Quality of care is a fundamental prin		
		ssess, monitor, and manage			that applies to all treatment and care		
		eglect and/or rejection of care residents (R1) who had			provided to residents. Based on the comprehensive assessment of a res		
		ssure related wounds and			the facility must ensure that residen		
		vith odors as a result of			receive treatment and care in accord		
	unmanaged inconti				with professional standards of pract		
	difficial aged filocital	nonoe.			the comprehensive person-centered		
	Findings include				plan, and the residents' choices.	2 0010	
	· ····································				Several areas of self-neglect for R1	were	
	R1's quarterly Minir	num Data Set (MDS)			reviewed and the following items		
		4/7/2021, indicated R1 did not			implemented based on R1's prefere	ences:	
		airment and did not have			R1's care plan for Mood/Behavior w		
		haviors. The MDS indicated			updated on 4/23/21 and the overall	care	
		nt ambulating in her room,			plan was updated on 5/21/21. R1's		
		and toileting. The MDS			shower was changed to Tuesday		
		equently incontinent of urine			mornings per R1's request on 5/4/2	1. On	
		continent of bowel. The MDS			5/18/21 a skin assessment was		
		ad 3 venous or arterial ulcers			completed. On 5/21/21 a bladder		
	•	onal intervention, nonsurgical			assessment was initiated. On 5/20 /	21 the	
	dressings and appli	ication of			weight order changed from daily to		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY
		245530	B. WING		04/2	; 0/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	•	
SAMARI	TAN BETHANY HOM	E ON EIGHTH		24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	R1's face sheet in agoraphobia (extre entering open or cone's own home, descape is difficult) dependence, veno chronic ulcer of low and morbid obesit. During an interview family member (FI to the long term can assisted living who incontinence, wou which caused hear required long term self-neglect behave making good decisand didn't have the R1 had a strong predirect. FM-1 staff R1 could not be gicares because shot to be direct with hed dressing change" change?", stated as FM-1 indicated the interventions with refusals. FM-1 star recently; R1's roor urine/bowel odor, the floor. FM-1 indiscussed the conditions on the star of the conditions.	cluded diagnoses of eme or irrational fear of rowded places, of leaving or of being in places from which anxiety disorder, opioid ous insufficiency, non-pressure wer leg left leg, diabetes type II,	F 6	3x/week per NP. An ord on 5/20 to conduct ST for 5/14/21 the LacHydrin to changed from evenings. Treatments to R1's lower was changed from even 4/23/21. R1's skin chect from evenings to days of wraps and elevation of low order was changed to PNP dictation was received outlining R1's choices of choice to reject or decling reviewing the risks of the is scheduled to visit R1 review overall goals of the bladder incontinence are order changes as a rest implemented. All neighborhood staff with 5/27/21 and 5/28/21 on comprehensive assess approaches for resident pattern of self-neglect acare. Care Coordinators will be education on 6/3/21 on comprehensively assess display a pattern of self-rejection of care. Neighborhood audits with Care Coordinators and Mentor for 3 months to comprehensive assessing completed for those rest a pattern of self-neglect of care. Clinical Mentor and Asset Clinical Ment	or a MOCA. On reatment was to days. er extremity wound hings to days on k was changed on 5/4/21. R1's leg ower extremity PRN on 5/20/21. ed on 5/19/21 of care including the care as well as ose choices. NP on 5/21/21 to care including and orders. Any cult will be educated on F684 including the ments and the process of sing residents that the eneglect and/or rejection of the process of sing residents that eneglect and/or libe conducted Assistant Clinical ensure ments are idents that display and/or rejection	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		245530	B. WING			C / 20/2021	
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	(CAA) dated 7/13/2 actual problem with CAA indicated cont psychological/psycrestricted mobility. is able to ask for as MDS note 7/7/2020 transfers and ambualerting staff. Staff as needed." R1's p 7/13/2020, included venous ulcers bilate treatments and are [registered nurse]. skin breakdown anulcers related to imincontinence, obes Physician orders in -Lasix 40 milligram bilateral lower extre 1/25/2021) -lac-hydrin 12% loticalloused/thickenershift (start date 7/13-Bilateral knee-high until stockingettes a 9/24/2020) -To bilateral venous normal saline, pat of dressing cut to wow wound with barrier non-adherent gauz and as needed for -Left foot ulcer: size approximately less	inence Care Area Assessment (2020, identified R1 had an aurinary incontinence. The iributing modifiable factors as hiatric problems, pain, and The CAA included, "Resident esistance as needed but her is she chooses to initiate allation in her room without assist with incontinence care ressure ulcer/injury CAA dated do "Resident has 3 chronic erally that have daily assessed periodically by RN Resident is at risk for further do the development of pressure paired mobility and ity, other diagnosis" cluded: s (mg) one time a day for emity edema (start date ion apply daily to do skin on toes every evening (8/2020) in stretch compression wraps arrive twice per day (start date is ulcers cleanse daily with dry, apply calcium alginate and bed size, spray around the spray to dry, cover with e and secure with kerlix daily soiling (start date 5/2/2020)	F 684	Mentor will monitor for compliar Findings will be reported at Qua Assurance Committee meeting: Date of completion: 6/4/21	ality		

` '		IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		245530	B. WING _			C / 20/2021	
	PROVIDER OR SUPPLIER	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP COD 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	one time a day (star R1's March and Ap administration records identified in physician ordered to records identified in physician ordered to records identified in physician ordered to records identified interventions. The R1 was consistently risks versus benefit physician was notificare. In addition, R analysis of R1's rejorder to determine worsening/increasi improving/decreasi any impact the rejementing R1's care urinary incontinence. March MAR identifities—Daily weights; 3/5/indicated R1 refused (weighed only twices—Lac-Hydrin; R1 refull times) March TAR identifities—Left foot ulcer treat boxes were left blattreatment 12 times—Lower extremity versus and 3/11/2021 boxer refused/rejected tres—Knee high stretch	gauze, and secure with kerlix art date 9/11/2020) ril medication/treatment rds were reviewed in ursing progress notes; the nultiple refusals/rejection of treatments without consistent entation of attempted records also lacked evidence by provided with education of its and lacked evidence the ied of the rejection/refusals of 1's record lacked evidence of ection/refusal behaviors in if R1's behavior was ng in frequency or ng in frequency and what if ction/refusal behaviors had on plan goals for safety, dignity, e and wound management. ed the following: 2021 was left blank and ed to be weighed 28 times e) itsed/rejected the medication and the following: the f	F 6	84			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE (CON	COMPLETED		
		245530	B. WING _			C / 20/2021
	PROVIDER OR SUPPLIER	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP COD 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	was left blank and in which totaled 18 dar-low extremity vence 9 out of 20 opporturing. Left foot ulcer trea out of 20 opportunities out of 20 opportunities. April MAR identified Lac-hyrdin; R1 refropportunities -Daily weights; R1 weighed twice, 4/9/R1's MDS's dated 1/5/2021 did not ideand despite docum multiple rejection/re 4/7/2021, rejection/identified and or as R1's MDS progress included "resident hextremity] edema be wraps when offered independent with to bowel and bladder accept help from care "Resident chooses ambulation in her refuses wound care give her a shower significant in the care of t	the following: compression wraps; R1 4/9/21 refused/rejected all other days ays. bus ulcers: R1 refused/rejected nities tment; R1 refused/rejected 8 ties d the following: used/rejected 5 out of 20 refused/rejected 18 times, was //2021 was left blank. 7/8/20202, 10/7/2020, and entify R1 rejected refused care entation in R1's record of efusals the MDS dated /refusals behaviors was not sessed. s note dated 4/5/2021, has BLE [bilateral lower out declines compression		34		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		245530	B. WING			04/2	20/2021
	PROVIDER OR SUPPLIER	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZII 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	PCODE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 684	R1's record include Shared Risk Agreed representative on 4 1/19/2021, indicate benefits of refusing transfer. The assess understood the potential chains choice that includislocation of bones. R1's care plan date exercise my right to sometimes chosen offer. I have decline R1's goal was not to consequences related Corresponding intercontinue to offer cate 7/12/2019). Do not judge me [F7/12/2019). Explain the need to consequences to sibathing (start daterlallow staff to clear about every two we urine, stool, and ham My room has an od offer to assist me in choose to do it mystoom to smell which live in this environmental reproach later 7/12/2019). Bathing	d on risk assessment. R1's ment first signed by R1 and /30/2019 and reviewed on d R1 understood the risks and one staff assist with all sment indicated R1 ential negative outcomes of uded falls fracture, cuts, s, up to death. Ind 7/12/2021, included "[R1] on make decisions. I have to not accept cares that staff ed a shower or bath at times. To experience adverse ted to her decisions. I reventions included: ares and bath/showers (start R1] for my decision (start date on the continuation of the continu	F6	584			
	K I S BAIN/SKIN NOT	es identified R1 refused					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245530	B. WING				C 20/2021
NAME OF PROVIDER OR SUPPLIE SAMARITAN BETHANY HON			24 - 8TH S	DDRESS, CITY, STATE, ZIP CODE STREET NORTHWEST STER, MN 55901	1 0-11	
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI ROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
lacked evidence lacked attempts rinterventionsBath/Skin note diresident was offe evening shift and was not complete extremity} treatmetable. Bath/Skin note directed dressing assess skin checker fused dressing assess skin head this time "no" Will and any other day as a dressing changes and any other day as a dressing changes and any other day and any other day as a dressing changes and any other day as a dressing changes and a stated she is sick want to be disturbed. Wound Care R1's skin care pla R1 had wounds to wounds. Corresp keep skin clean a monitor and report to physician.	March and April. The record R1 was provided education and nade to attempt new ated 3/2/2021, included ered her regular shower this refused. A skin assessment ed, however, BLE [bilateral lower ents were completed." ated 3/9/2021, included dishower evening of 3/9/2021 as k." The note also indicated R1 changes to her leg wounds. ated 3/22/2021, included "Writer ident would allow writer to and toes. Resident chose at continue to try on bath days y if resident allows." ated 3/28/2021, did not identify if given, however R1 refused stated 4/6/2021, included dis bath/shower. She also refused wound dressing change. She to her stomach and does not		884			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		, , COV	COMPLETED		
		245530	B. WING			C / 20/2021
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP COD 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	treatments. The no interventions aside education and risk not include/identify evidence of new re attempted and/or o additional wound to 3/19 to 4/15 and incleg wound had dete R1's Wound/Presson 3/19/2021, included 8.7 cm area, 5.2 cm bottom wound meal length, and 1.1 cm measured 4.2 cm awidth, right inner wound wound wound with a tan draitis pink/red in color. The wounds were continued to the wounds were continued to the wound wound meal length, and 1.1 cm measured 4.2 cm awidth, right inner wound on length wound for a wound on length wound wound wound on length wound wound wound on length wound wo	that R1 had rejected/refused tes did not identify from R1 was provided versus benefits; the record did root cause of refusals and/or visions to the care plan were ffered. The notes identified and the left lower extremity from dicated the wounds to the right eriorated between those dates. The Injury Note dated dried to the wound measured in length, 2.0 cm width, left sured 1.9 cm area, 2.2 cm width. Right lower outer legurea, 4.1 cm length, 1.4 cm bound measured 0.3 cm area, cm width. All wounds had an inage except inner right wound. The note indicated that after leaned there was more odor. ded, "Surrounding skin is very ump nodules all over lower."	F 6	84		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	NG	COM	E SURVEY IPLETED
		245530	B. WING			C 20/2021
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	them. "I have done help. I been to wou what to do for me." encouraged resider legs by following or educate, encourage healing her own leg treatments. Nutrition R1's nutrition note or physician decline to related to ongoing a gastrointestinal discincluded, "Resident per preference and symptoms of nause not. She has margin vegetables and also Nutrition services for Incontinence R1's activities of dat 1/16/2021, indicate assist with toileting initiate self- transfer also identified R1 retwo wheeled walke identified R1 had blimpaired mobility at medication. R1's go skin breakdown due Corresponding inter assistance alert nurare wet or soiled so date 1/22/2021), R1	all that before and it does not not clinic and they cannot find Staff and CNP has at to take part in healing lower ders. Staff will continue to a resident to take part in as along with present all that the prescribe a multivitamin and intermittent comfort. The note also according to [gastrointestinal beal/vomiting] being present or anal intake of fruits and accordines nutritional support. It is all the prescribe and indicated are plan indicated bequired one staff assist with a rand would self-transfer. R1's ladder incontinence related to and received a diuretic and was to remain free from	F 6	84		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		COV	COMPLETED		
		245530	B. WING _			C / 20/2021
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP COE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	when she needed I episodes. The care assist with toileting decrease episodes R1's record lacked assessment to determine to determine the pisoder refusing/rejecting shathroom. Room cleaning/offestaining. Progress note datermight shift, resident herself. She was varound in her room she said she could assistant] helped in Resident insisted on her until she we Progress note datereported that reside to kneel toward record the seat of the chain incontinent episodes staff assist with the and able to voice hone assist with ADI Staff try to educate voice, staff to leave seen by staff vacuu. "Will continue to ha and offer staff assist	ed herself and called for help ots of help with incontinent plan also instructed staff to at 6:30 a.m. and 10:00 p.m. to of incontinence. evidence of bladder ermine if R1's had increases in	F 6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245530	B. WING			C 04/20/2021
	PROVIDER OR SUPPLIER	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP C 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	CODE	3 1/20/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		N SHOULD BE E APPROPRIA	
F 684	rejection/refusals of toileting/ambulation environment that succontrol. The physicion going behaviora refusal/rejections are involvement or reference R1's physician programment and had an The overview section included; Edema Strecurrent cellulitis in Intermittently comp (multiple compression uncomfortable for housers bilateral; dail sometimes refuse (weekends/with unfadisorder-Primary (Comissed all short-terin drawing o'clock. The represents mild cool dementia. Function prior to cognitive disconding the significant of the physical limitations ascertain if she is for cognitive basis. IterimportantFluctual complicated by chronical prior of the physical prior to the physical phy	es did not address all areas of f care including assistance for and keeping a clean apported dignity and infection an notes also did not address I management of ind/or professional psychiatry reals. Gress notes dated 4/9/2021, allus formation to both ankle order for lac-hydrin lotion. On of the progress note tasis bilateral (chronic) with an context of edema. It is in the context of edema. It is in	F6	584		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245530	B. WING			C 20/2021
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	R1 sat in her reclining pad (also known as mattress from income soaker pad on the foon the floor was pathat area of the pad brown markings. From the floor and what there was mold und since she was admileaking. R1 bent own off the floor; the odd the pad was lifted to large area that was diameter that	as consistent with stale urine. Ing chair on a washable bed a soaker pad-used to protect attinence); there was also a floor under R1's feet. The pad rtially underneath the recliner; I had different shades of the was asked why the pad was at was underneath, R1 stated derneath, had been there itted, and the floor was fer and picked up the soaker or was more prominent when off the floor. The pad covered a approximately 2 feet in dark black that was moist. The transport to the area was yellowed she did not know when the was deep d, and she cleaned it herself, anted new carpet. R1 stated deerns with her care however, anges to the staff schedule and only providing her cares. During view at 1:45 p.m. R1 sat in her med environmental services her carpet. R1 stated, "oh an take of the carpet, the arrassing, I can't have friends has told me how bad it smells, bad." R1 leaned down and overing the stain and stated, I just can't stand it anymore,	F 6	84		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED				
		245530	B. WING	i			C 20/2021
	PROVIDER OR SUPPLIER	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	CODE	0-41.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 684	urinary overflow inco "was completely de R1 would say that to "she has to come us odor." NA-A stated toileting without proskin was checked of however R1 refused liked to do things in would refuse cares her. During an interview licensed practical in refused showers the evening. LPN-A rev indicated that it did extremities dressing 4/18/2021. During an interview LPN-A indicated R1 changes, refused s	continence. NA-A stated R1 lusional", and didn't know why here was mildew on the floor, p with another motive for the R1 was independent with impting. NA-A indicated R1's on shower days by the nurse, d showers. NA-A stated R1 dependently and when she she would "conversate" with on 4/19/2021, at 9:01 a.m. urse (LPN)-A stated R1 at were scheduled in the riewed R1's record and not look like R1's lower gs were changed on on 4/19/2021, at 10:04 a.m. I sometimes refused dressing howers, refused staff	Fé	584			
	room, and refused to she would have a fathem. LPN-A stated to the facility she us LPN-A did not know showers or why. LF re-approach when seducation. LPN-A coffensive odor and cleaned whenever ther room such as wappointments. LPN carpets last week was to she would be seen to she wou	to allow staff to clean her to go to clinic appointments; amily member call and cancel I when R1 was first admitted sed to take shower/bath; when R1 started refusing PN-A indicated staff she refuses care and provide confirmed R1's room had an indicated R1's carpets were they can; when R1 was not in when she went to beauty shop -A stated staff cleaned the when she was at the beauty I staff used a product Odor Be					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245530	B. WING			C / 20/2021
	PROVIDER OR SUPPLIER	E ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP COD 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	Gone/biometric and on the floor. LPN-A allow staff to clean herself. During an interview registered nurse (Finurse manager for RN-A stated staff gallows us to. RN-A treatment, the staff of completing the tathe staff would re-a RN-A stated R1 refined were scheduled to stated she didn't the treatment had been wounds were getting social worker and it psych services was unawareness if R1 assessed and anal would attempt to clean would a	d towels to soak up the urine indicated R1 did not always her carpet; R1 liked to do it on 4/19/2021, at 10:45 a.m. RN)-A stated she was the the unit where R1 resided. To into assist R1 when she stated when it's time for a would nicely present options ask now or later. RN-A stated approach if she would refuse. The fused dressing changes that be completed in the evening; ink changing the wound attempted. RN-A stated R1's and worse. RN-A stated the NP were involved, did not think is involved. RN-A indicated an 's rejection/refusals were yzed. RN-A indicated staff ean R1's room almost weekly did allow. RN-A stated there was ly checklist that was; the checklist outlined the store ach room. RN-A showed surveyor; the checklist had with room numbers underneath k, it did not outline specific -A stated NA's would clean the impet cleaner for routine onmental services would do	F6	84		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		245530	B. WING			C / 20/2021
	PROVIDER OR SUPPLIER	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 684	to shampoo the car unit had their own of R1's room, ESP-A in stained she couldn' observed R1's carp seen it [stain] that is been cleaned in a lichair; there was the R1's chair. ESP-A is the carpet cleaner odor/dirty carpet coother residents, and During an interview MDS coordinator reconfirmed rejection identified on the MI she was informed to a resident choice the identified on the as also indicated staff information for the MDS. During an interview licensed social wor would complete be and implement care indicated it would be what the repercuss decisions or refusal re-approach to mar rejection/refusal. Lisuse indirect approar after R1 refused.	A's on the unit were supposed repet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were it get the stains out. ESP-A et and stated, "I've never black, it doesn't look like it has ong time." ESP-A moved R1's e stain extended underneath stated she was going to get now. ESP-A indicated that the buld be a health risk for R1,	F 6	84		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245530	B. WING			C / 20/2021
	PROVIDER OR SUPPLIER TAN BETHANY HOME	ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	director of nursing (indicated R1 had the treatment/care and rejection/refusals as DON indicated she carpets however, Recarpets to be clean stained, the stains of talk to maintenance. During an interview nurse practitioner is R1 was rejecting as cleaning her room. Facility policy Behat Tracking dated 12/2 presence of mood a management in ordination and treated and psychosocial with prevention and psychosocial with prevention and treated and psychosocial with psychosocial with prevention and psychosocial with prevention and psychosocial with psy	on 4/20/2021, at 1:49 p.m. (DON) and administrator regist to refuse looked at R1's s a choice and not a behavior. expected staff to clean the the would often refuse her ed. DON indicated that once do not lift, but would have to	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245530	B. WING		0	C 4/20/2021	
NAME OF PROVIDER OR SUPPLIER SAMARITAN BETHANY HOME ON EIGHTH				STREET ADDRESS, CITY, STATE, ZIP CODE 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)			X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	their family or repre	esentative is used to address od, and psychosocial needs of	F6	684			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 11, 2021

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

Re: State Nursing Home Licensing Orders

Event ID: CM4L11

Dear Administrator:

The above facility was surveyed on April 19, 2021 through April 20, 2021 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 <u>only a suggestion</u> 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.

Samaritan Bethany Home On Eighth May 11, 2021 Page 2

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

P.O. Box 64970

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 05/28/2021 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o. `	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		00427	l _B	. WING		04/2		
		00427				04/2	0/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 24 - 8TH STREET NORTHWEST								
SAMARI	TAN BETHANY HOME	ON FIGHTH		R, MN 559				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 000	Initial Comments		2	2 000				
	****ATTE	NTION*****						
	NH LICENSING	CORRECTION ORDER						
	144A.10, this corre pursuant to a surve found that the defic herein are not corre not corrected shall	Minnesota Statute, sectiction order has been issuey. If, upon reinspection, iency or deficiencies cite ected, a fine for each viol be assessed in accordar fines promulgated by rule artment of Health.	ued it is ed ation nce					
	corrected requires requirements of the number and MN Ru When a rule contain comply with any of lack of compliance re-inspection with a result in the assess	hether a violation has be- compliance with all rule provided at the tag- ule number indicated belons several items, failure to the items will be consided. Lack of compliance upon any item of multi-part rulestment of a fine even if the uring the initial inspection	ow. to ered on e will e item					
	that may result from orders provided that the Department wit	hearing on any assessment non-compliance with the standard written request is manifer the standard for the standard for non-compliance.	ese de to					
	was conducted at y the Minnesota Dep facility was found N State Licensure. PI electronic plan of co	IS: 4/20/2021, a complaint so wour facility by surveyors artment of Health (MDH) IOT in compliance with the ease indicate in your orrection you have review dentify the date when the	from . Your ne MN wed					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/21/21

STATE FORM 6899 CM4L11 If continuation sheet 1 of 27

TITLE

(X6) DATE

Minnesota Department of Health

AND BLAN OF CORRECTION TO TRANSPORT TO THE ANTI-		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
				A. BUILDING.	•		
		00427		B. WING			20/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH		STREET NOF TER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
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2 000	Continued From pa	ge 1		2 000			
	be completed.						
	SUBSTANTIATED: H55300065C (MN7 (MN56161) with lice and 1805. H55300066C (MN6 were issued	plaints were found to (1916) and H553000 ensing orders at 0836 (8831) no licensing o	67C 0, 1695, rders				
	UNSUBSTANTIATE H55300068C (MN6	ED:					
	the State Licensing Federal software. The assigned to Minnes Nursing Homes. The appears in the far leading." The state stallisted in the "Summe column and replace the correction order the findings which a statute after the state as evidence by." For findings are the Sugand Time Period for You have agreed to receipt of State lice the Minnesota Deput Informational Bullet http://www.health.sobul.htm. The State delineated on the assignment of the minnesota of the state of	participate in the ele nsure orders consist artment of Health in 14-01, available a tate.mn.us/divs/fpc/p e licensing orders are	sing en les for oer D Prefix bliance is ficiencies" ortion of ncludes state s not met 's orrection ectronic ent with t rofinfo/inf				

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
00427		B. WING		0.4/0			
		00427		B. WING		04/2	20/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
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2 000				2 000			
	you electronically. is necessary for State in the word "CO available for text. Ye electronic State lice heading completion will be corrected prito the Minnesota Defacility is enrolled in signature is not requage of state form. PLEASE DISREGATOURTH COLUMN "PROVIDER'S PLATOURTH COLUMN TOURTH COLUMN TOURTH COLUMN TOUR TOUR THIS WILL APPEAR	ate Statutes/Rules, RRECTED" in the ou must then indica ensure process, under the date you for to electronically epartment of Health are POC and therefore at the bottom ARD THE HEADING WHICH STATES, AN OF CORRECTION CERAL DEFICIENCII	please box ate in the der the ir orders submitting n. The ore a of the first GOF THE DN." THIS ES ONLY.				
2 830	MN Rule 4658.0520 Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des and 4658.0405. At be out of bed as muis a written order from that the resident muresident prefers to a	general. A resider e and treatment, po supervision based d preferences as id resident assessment assessment as possible unlumn the attending plust remain in bed o	nt must ersonal and on dentified in ent and 68.0400 lent must ess there nysician	2 830			6/4/21
	This MN Requirements by: Based on observation				Corrected		

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING	:		_
		00427	B. WING			C 20/2021
NAME OF F	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	- ON FIGHTH	TH STREET NO ESTER, MN 55			
(V4) ID	SHIMMADV STA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORI	PECTION	(VE)
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2 830	Continued From pa	age 3	2 830			
	behaviors of self-ne behaviors for 1 of 1 worsening non-pres	ssess, monitor, and manage eglect and/or rejection of ca residents (R1) who had ssure related wounds and with odors as a result of				
	Findings include					
	assessment dated have cognitive imparejection of care be R1 was independed personal hygiene, a identified R1 was from also indicated R1 hand required nutrition dressings and applointments/medication. R1's face sheet incompagoraphobia (extreentering open or crone's own home, of escape is difficult),	ons other than to feet. luded diagnoses of me or irrational fear of owded places, of leaving r of being in places from wh anxiety disorder, opioid	e S rs al			
	chronic ulcer of low and morbid obesity During an interview family member (FM to the long term car assisted living whe incontinence, woun which caused healt	us insufficiency, non-pressurer leg left leg, diabetes type of a constant of the constant of t	: II, ı. ı			

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Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND FLAN	TOF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:	:	COIVIE	OOMI EETEB	
		00427	B. WING			C 20/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE			
SAMARI	TAN BETHANY HOME	- ON FIGHTH	STREET NOI				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
2 830	self-neglect behavimaking good decis and didn't have the R1 had a strong peredirect. FM-1 state R1 could not be give cares because she to be direct with he dressing change" rehange?", stated state FM-1 indicated the interventions with herefusals. FM-1 state recently; R1's room urine/bowel odor, at the floor. FM-1 indicated the indicated the interventions with herefusals. FM-1 state recently; R1's room urine/bowel odor, at the floor. FM-1 indicated condowever, didn't thin about it. R1's urinary incontice (CAA) dated 7/13/2 actual problem with CAA indicated condomicated c	ors. FM-1 stated R1 was not ions for her own well-being capacity to. FM-1 indicated ersonality, and was difficult to ed she has informed the facilityen a choice to complete daily would not do it, staff needed er and say "It's time to do your not "Is it ok to do your dressing taff also have to be persistent facility had not discussed new ner in order to manage R1's ed she had visited R1 very					

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00427	B. WING		04/2	0/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI"	TAN BETHANY HOME	ON FIGHTH	STREET NOF			
		ROCHEST	TER, MN 559	901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTIES OF THE A	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 5	2 830			
2 830	Physician orders in -Lasix 40 milligrams bilateral lower extre 1/25/2021) -lac-hydrin 12% loticalloused/thickened shift (start date 7/12-Bilateral knee-high until stockingettes a 9/24/2020) -To bilateral venous normal saline, pat odressing cut to wou wound with barrier non-adherent gauz and as needed for -Left foot ulcer: size approximately less with normal saline, with non-adherent gone time a day (start R1's March and Ap administration records identified in physician ordered to or sufficient docum interventions. The in R1 was consistently risks versus benefit	cluded: s (mg) one time a day for emity edema (start date) on apply daily to diskin on toes every evening (3/2020) a stretch compression wraps arrive twice per day (start date) s ulcers cleanse daily with dry, apply calcium alginate and bed size, spray around the spray to dry, cover with e and secure with kerlix daily soiling (start date 5/2/2020) e unknown. Depth than 0.2 cm. Cleansed daily pat dry, apply iodosorb, cover gauze, and secure with kerlix rt date 9/11/2020) ril medication/treatment rds were reviewed in ursing progress notes; the nultiple refusals/rejection of reatments without consistent entation of attempted records also lacked evidence by provided with education of its and lacked evidence the	2 830			
	care. In addition, R analysis of R1's rej order to determine worsening/increasi improving/decreasi any impact the reje	ied of the rejection/refusals of 1's record lacked evidence of ection/refusal behaviors in if R1's behavior was ng in frequency or ng in frequency and what if ction/refusal behaviors had on blan goals for safety, dignity,				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.	A. Boilbino.		;
		00427	B. WING			0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	·ONFIGHTH	STREET NOF TER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 6	2 830			
	urinary incontinenc	e and wound management.				
	indicated R1 refuse (weighed only twice	2021 was left blank and ed to be weighed 28 times				
	boxes were left bla treatment 12 times. -Lower extremity ve and 3/11/2021 boxe refused/rejected tre -Knee high stretch	tment: 3/10 and 3/11/2021 nk, R1 refused/rejected enous treatment orders: 3/10 es were left blank, R1				
	was left blank and i which totaled 18 da -low extremity vend 9 out of 20 opportu	compression wraps; R1 4/9/21 refused/rejected all other days bys. bus ulcers: R1 refused/rejected nities tment; R1 refused/rejected 8				
	opportunities -Daily weights; R1	d the following: used/rejected 5 out of 20 refused/rejected 18 times, was 2021 was left blank.				
	1/5/2021 did not ide and despite docum	7/8/20202, 10/7/2020, and entify R1 rejected refused care entation in R1's record of efusals the MDS dated				

Minnesota Department of Health

STATE FORM 6899 CM4L11 If continuation sheet 7 of 27

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00427	B WING		04/2	
		00427			04/2	0/2021
NAME OF I	PROVIDER OR SUPPLIER		BTREET NOF	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	ΓER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 7	2 830			
	4/7/2021, rejection/identified and or as	refusals behaviors was not sessed.				
	included "resident I extremity] edema b wraps when offered independent with to bowel and bladder accept help from ca "Resident chooses ambulation in her rounderstands the ris refuses wound care give her a shower shaily sponge bath a at her skin." R1's record include Shared Risk Agree representative on 4 1/19/2021, indicate benefits of refusing transfer. The assess understood the potthis choice that includislocation of bone. R1's care plan date exercise my right to sometimes chosen offer. I have declined	bileting but has episodes of incontinence but will not aregivers for peri care." and to initiate self-transfers and from without alerting staff and lks." and Resident often e and does not allow staff to stating that she gives herself a and does not need us to look and on risk assessment. R1's ment first signed by R1 and law				
	Corresponding inte- continue to offer ca date 7/12/2019)	ted to her decisions. rventions included: ares and bath/showers (start R1] for my decision (start date				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			,
		00427	B. WING		04/2	, 0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	· ON FIGHTH	STREET NOF TER, MN 559			
(VA) ID	CLIMMADV CTA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTI	ON	(VF)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	age 8	2 830			
2 000	-Explain the need to consequences to sl bathing (start date 1-1 allow staff to clea about every two we urine, stool, and ha My room has an od offer to assist me in choose to do it mys room to smell which live in this environm -Re-approach later 7/12/2019) Bathing R1'S Bath/Skin not weekly bathing in N	o be clean and the kin integrity and self due to not				
	lacked attempts mainterventionsBath/Skin note dat "resident was offere evening shift and rewas not completed, extremity} treatmenture. Bath/Skin note dat "Resident refused swell as skin check" refused dressing chapter as skin head a this time "no" Will cand any other day in Bath/skin note date shower/bath was gid dressing changesBath/skin note date shower/bath note date.	ade to attempt new ted 3/2/2021, included ed her regular shower this efused. A skin assessment , however, BLE [bilateral lower nts were completed." ted 3/9/2021, included shower evening of 3/9/2021 as The note also indicated R1 nanges to her leg wounds. ed 3/22/2021, included "Writer ent would allow writer to and toes. Resident chose at continue to try on bath days				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00427	B. WING			C 20/2021	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE			
SAMARI	SAMARITAN BETHANY HOME ON EIGHTH 24 - 8TH ROCHES			RTHWEST 901			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 9	2 830				
		ound dressing change. She o her stomach and does not d."					
	R1 had wounds to l R1's goal was to ha wounds. Correspor keep skin clean and	dated 1/22/2021, indicated both calves and top of feet, ave no complications to the ading interventions included: d dry, use lotion on dry skin, abnormalities or failure to hea	ſ				
	to 4/15/2021; the reassessments, and the treatments. The not interventions aside education and risk to not include/identify evidence of new reattempted and/or of additional wound to 3/19 to 4/15 and include/identify evidence.	were reviewed from 3/19/2021 ecord identified weekly wound that R1 had rejected/refused tes did not identify from R1 was provided versus benefits; the record did root cause of refusals and/or visions to the care plan were ffered. The notes identified and the left lower extremity from dicated the wounds to the righeriorated between those dates	i t				
	3/19/2021, included 8.7 cm area, 5.2 cm bottom wound mea length, and 1.1 cm measured 4.2 cm a width, right inner wo 0.9 cm length, 0.5 codor with a tan drai is pink/red in color. the wounds were cl. The note also include.	ure Injury Note dated d; Left top wound measured in length, 2.0 cm width, left sured 1.9 cm area, 2.2 cm width. Right lower outer legurea, 4.1 cm length, 1.4 cm ound measured 0.3 cm area, cm width. All wounds had an inage except inner right wound. The note indicated that after leaned there was more odor. ded, "Surrounding skin is very ump nodules all over lower."					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
				A. BUILDING:			,
		00427		B. WING			2 <mark>0/2021</mark>
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH		STREET NOF FER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	ΓΙΟΝ	(X5)
PREFIX TAG	,	MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		PREFIX TAG	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETE DATE
2 830	Continued From pa	ge 10		2 830			
	leg with no drainag	e from them."					
	included; Left out to 8.0 cm area, 4.7 cm 20% granulation and Bottom wound on to 1.6 cm area, 2.3 cm 90% slough and 10 leg measured 6.0 cwidth, 50% granular lower legs still red apitting edema noted hard when touch. Stake part in wrappir them. "I have done help. I been to wou what to do for me." encouraged resider legs by following or educate, encouraged.	ure Note dated 4/15/2 ower top wound bed man length, 2.2 cm width at 80% slough in would be to uter lower leg mean length, 0.9 cm width a granulation. The right area, 4.7 cm length tion and 50% slough, and scaly foot to kneed except both lower lest aff encourage reside and linic and they can staff and CNP has and to take part in healing ders. Staff will continue resident to take part is along with present	neasured with nd bed. asured , with ght outer n, 1.5 cm Both s. No gs feels ent to neal does not enot find ng lower ue to				
	physician decline to related to ongoing a gastrointestinal disc included, "Resident per preference and symptoms of nause not. She has margi	comfort. The note also continues to self-sele according to [gastroir ea/vomiting] being pre nal intake of fruits and o declines nutritional s	eamin ect food ntestinal sent or				
	R1's activities of da	ily living care plan dat d R1 required one sta					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			С	
		00427	B. WING			0/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOF FER, MN 559				
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE	ILD BE	COMPLETE DATE	
2 830	Continued From pa	ige 11	2 830				
	assist with toileting initiate self- transfe also identified R1 retwo wheeled walke identified R1 had be impaired mobility at medication. R1's go skin breakdown dur Corresponding interestinate assistance alert nurare wet or soiled so date 1/22/2021), Rincontinence care, daily that she clean when she needed I episodes. The care	except at times she chose to rs. The care plan indicated equired one staff assist with a r and would self-transfer. R1's ladder incontinence related to nd received a diuretic pal was to remain free from the to incontinence. In remain included: nursing rese when lower leg dressings to they can be replaced (start 1 was one assistant with R1 had incontinent episodes and called for help ots of help with incontinent a plan also instructed staff to at 6:30 a.m. and 10:00 p.m. to					
	R1's record lacked evidence of bladder assessment to determine if R1's had increases in incontinent episodes as a result of refusing/rejecting staff assistance to the bathroom.						
	staining. Progress note date night shift, resident herself. She was va around in her room she said she could assistant] helped in Resident insisted o she wasn't stable o on her until she we	ensive odor and carpet d 4/1/2021, included "During was cleaning her room by acuuming and moving boxes . Staff offered to help her, but do it herself. NAR [nursing moving the boxes for her. In doing the cleaning although in her own. Staff kept checking int back in her chair. d 4/14/2021, included "It was ent had put herself on the floor					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00427	B. WING		04/2	0/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0-1/2	.072021
SAMARI	TAN BETHANY HOME	·ONFIGHTH	STREET NOF			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	to kneel toward recthe seat of the chai incontinent episode staff assist with the and able to voice hone assist with ADL Staff try to educate voice, staff to leave seen by staff vacuu "Will continue to ha and offer staff assis resident to allow staresident to allow staresident to allow starejection/refusals or toileting/ambulation environment that sucontrol. The physicion going behaviora refusal/rejections a involvement or reference R1's physician progindicated R1 was caregions and had an The overview section included; Edema Sirecurrent cellulitis in Intermittently comp (multiple compress uncomfortable for hulcers bilateral; dail sometimes refuse (weekends/with unfadisorder-Primary (Cmissed all short-ter in drawing o'clock. represents mild cog	liner and was scabbing [sic] r herself. Resident has had a Resident choose not have cleaning. Resident is alert er daily needs. Resident is alert er daily needs. Resident is as needed and resident will as needed and resident will her room. Resident has been uning her own room at times. We staff go into resident room at often. Then encourage aff assistance with cleaning. As did not address all areas of and keeping a clean apported dignity and infection ian notes also did not address I management of and/or professional psychiatry rrals. Agress notes dated 4/9/2021, allus formation to both ankles order for lac-hydrin lotion. For of the progress note tasis bilateral (chronic) with a context of edema. I liant with compression ion strategies have been neer. Hyper venous chronic by dressing- she will				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		X3) DATE SURVEY COMPLETED	
			,			;	
		00427	B. WING			0/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
SAMARI	TAN BETHANY HOME	ON FIGHTH	TREET NOF				
040.15	CLIMANADY CTA		TER, MN 559		ON.	0.45	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 13	2 830				
	(long-term skilled n physical limitations ascertain if she is for cognitive basis. Itel importantFluctual complicated by christian	ion and interview on					
	upon entry to the ro present; the odor w R1 sat in her reclin pad (also known as mattress from incor soaker pad on the on the floor was pa	a.m. R1's door was closed, from a very strong odor was ras consistent with stale urine. Ing chair on a washable bed is a soaker pad-used to protect intinence); there was also a floor under R1's feet. The pad rtially underneath the recliner;					
	that area of the pad had different shades of brown markings. R1 was asked why the pad was on the floor and what was underneath, R1 stated there was mold underneath, had been there since she was admitted, and the floor was leaking. R1 bent over and picked up the soaker off the floor; the odor was more prominent when						
	large area that was diameter that was diameter that was do back of the pad that and brown. R1 stat last time her carpet						
	R1 indicated she w she didn't have cor did not like the cha didn't like new peop a subsequent inter chair, she was infor was going to clean	d, and she cleaned it herself. anted new carpet. R1 stated icerns with her care however, nges to the staff schedule and ble providing her cares. During view at 1:45 p.m. R1 sat in her med environmental services her carpet. R1 stated, "oh an take of the carpet, the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00427	B. WING		04/2	0/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOF TER, MN 559				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE	
2 830	Continued From pa	ige 14	2 830				
	smell is really embain here. My family here. My family here in here. My family here is a smell it really removed the pad or "It gets so very bad it's just so embarra." During an interview nursing assistant (No stated the soaker purinary overflow income "was completely de R1 would say that the "she has to come upodor." NA-A stated toileting without proskin was checked to however R1 refuse liked to do things in	arrassing, I can't have friends has told me how bad it smells, bad." R1 leaned down and overing the stain and stated, I I just can't stand it anymore,					
	licensed practical negligible refused showers the evening. LPN-A revindicated that it did extremities dressing 4/18/2021. During an interview LPN-A indicated Rechanges, refused sassistance, refused room, and refused she would have a futhern. LPN-A stated to the facility she used.	on 4/19/2021, at 9:01 a.m. hurse (LPN)-A stated R1 at were scheduled in the viewed R1's record and not look like R1's lower gs were changed on on 4/19/2021, at 10:04 a.m. 1 sometimes refused dressing howers, refused staff to allow staff to clean her to go to clinic appointments; amily member call and cancel d when R1 was first admitted sed to take shower/bath; when R1 started refusing					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			,
00427		B. WING		04/2	20/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAMARITAN BETHANY HOME ON EIGHTH		STREET NOF TER, MN 559			
(X4) ID SUMMARY STATEMENT OF DEFICIENCE PREFIX (EACH DEFICIENCY MUST BE PRECEDED B REGULATORY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
showers or why. LPN-A indicated staff re-approach when she refuses care an education. LPN-A confirmed R1's roor offensive odor and indicated R1's carp cleaned whenever they can; when R1 her room such as when she went to be appointments. LPN-A stated staff clea carpets last week when she was at the shop. LPN-A stated staff used a produ Gone/biometric and towels to soak up on the floor. LPN-A indicated R1 did not allow staff to clean her carpet; R1 liked herself. During an interview on 4/19/2021, at 1 registered nurse (RN)-A stated she wan urse manager for the unit where R1 r RN-A stated staff go into assist R1 wh allows us to. RN-A stated when it's time treatment, the staff would nicely prese of completing the task now or later. R1 the staff would re-approach if she would RN-A stated R1 refused dressing char were scheduled to be completed in the stated she didn't think changing the water scheduled to be completed. RN-A swounds were getting worse. RN-A stated she didn't think changing the water scheduled to be completed. RN-A stated she didn't think changing the water scheduled to be completed. RN-A stated she didn't think changing the water scheduled to be completed. RN-A stated she didn't think changing the water scheduled to be completed. RN-A stated she didn't think changing the water scheduled. RN-A stated she didn't think changing the water scheduled. RN-A stated she didn't should allow. RN-A stated a daily and a weekly checklist that was completed by NA's; the checklist outling cleaning schedules for each room. RN the checklist to the surveyor; the checklist of the week, it did not outline stated and of the week, it did not outline stated she day of the week, it did not outline stated she day of the week, it did not outline stated she day of the week, it did not outline stated she day of the week, it did not outline stated she day of the week, it did not outline stated she day of the week, it did not outline stated she and the stated she staff undicated staff undicated she and the stated she and the state	nd provide in had an pets were was not in eauty shop ned the e beauty oct Odor Be the urine ot always d to do it 0:45 a.m. as the resided. en she per for a not options N-A stated lid refuse. In the resided of the lid not think dicated an were end staff oost weekly d there was so ned the li-A showed klist had underneath	2 830			

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		00.407	B. WING		0.4/0		
		00427		NATE TIP CORE	04/2	0/2021	
				STATE, ZIP CODE RTHWEST			
SAMARITAN BETHANY HOME ON EIGHTH ROCHES			ER, MN 55				
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 830	Continued From pa	ge 16	2 830				
	cleaning tasks. RN-A stated NA's would clean the carpet using the carpet cleaner for routine cleaning and environmental services would do the deep carpet cleaning.						
	environmental servishe had not been in ESP-A indicated NA to shampoo the car unit had their own of R1's room, ESP-A in stained she couldn' observed R1's carpiseen it [stain] that been cleaned in a lochair; there was the R1's chair. ESP-A sthe carpet cleaner in the stained she carpet cleaner in the carpet cleaner in the stained she carpet she c	on 4/19/2021, at 2:30 p.m. ice partner (ESP)-A stated in R1's room for a long time. A's on the unit were supposed the pet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were it get the stains out. ESP-A eet and stated, "I've never plack, it doesn't look like it has ong time." ESP-A moved R1's estain extended underneath stated she was going to get now. ESP-A indicated that the full be a health risk for R1, it staff.					
	MDS coordinator reconfirmed rejection, identified on the MD she was informed the aresident choice the identified on the assalso indicated staff	on 4/20/2021, at 8:46 a.m. eviewed the MDS's and /refusal behaviors were not DS. MDS coordinator stated, hat if the rejection/refusal was nen it did not have to be sessment. MDS coordinator did not document enough behavior to be identified on					
	licensed social work would complete bell and implement care	on 4/20/2021, at 12:43 p.m. ker (LSW)-A indicated nursing havior assessments, develop e plan interventions. LSW-A e the nursing side of things					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVIP	LEIED
		00427	B. WING		04/2	20/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
0.444.51		24 - 8TH :	STREET NO			
SAMARI	TAN BETHANY HOME	ROCHES	TER, MN 55	901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	O Continued From page 17		2 830			
	what the repercuss decisions or refusa re-approach to mar rejection/refusal. LS use indirect approa after R1 refused. LS recognized the right own decisions. During an interview director of nursing of the refused.	sions were as a result of R1's ls. LSW-A stated staff use nage R1's behaviors of SW-A indicated staff would first ach and then be more direct SW-B stated the facility ats for residents to make their on 4/20/2021, at 1:49 p.m. (DON) and administrator				
	indicated R1 had the right to refuse treatment/care and looked at R1's rejection/refusals as a choice and not a behavior. DON indicated she expected staff to clean the carpets however, R1 would often refuse her carpets to be cleaned. DON indicated that once stained, the stains do not lift, but would have to talk to maintenance for alternatives.					
	nurse practitioner s	on 4/20/2021, at 3:00 p.m. stated she was not aware that ssistance for toileting and				
	Tracking dated 12/2 presence of mood a management in order maintain the highest and psychosocial was prevention and treat-Behavior and mood recorded in the electric behaviors in the occur. -The information garresident behavioral	avior and Mood Symptom 2020 included, To identify the and behavioral symptoms for der for the resident to attain or st practical physical, mental, well-being. This includes atment of mental disorders. In dispute the symptom tracking is ctronic health record. Nurses the progress notes as they athered is used to assess I health needs and is IDS, CAA, and the care plan				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED			
		00427		B. WING	B. WING		C 04/20/2021	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
SAMARIT	TAN BETHANY HOME	ON EIGHTH		STREET NO				
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIE		ID ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	Y FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETE DATE	
2 830	Continued From pa	ige 18		2 830				
	upon move in, quar changeThis information is resident's provider as neededAn interdisciplinary their family or reprete the behavioral, most the resident.	communicated with during recertification approach including esentative is used to	n the n visits and g resident, n address					
	SUGGESTED MET director of nursing/o and procedure for be self-neglect/rejection DON/designee courejection/refusals of management of. The develop an auditing facility's quality assongoing compliance	designee could reviously reviously behavioral manager on/refusals of care. It then re-educate so feare and behaviorate DON/designee constructions as part of the urance activities to	ew policies nent for The staff on al ould then he					
	TIME PERIOD FOR (21) days.	R CORRECTION: T	wenty-one					
21695	MN Rule 4658.1419 Housekeeping, Ope		nce	21695			6/4/21	
	Subp. 4. Houseke provide housekeep necessary to mainta comfortable interior ceilings, registers, f and furnishings.	ain a clean, orderly, r, including walls, flo	e services and oors,					
	This MN Requirements	ent is not met as ev	videnced					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00427	B. WING		04/2) 0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE		<u></u>
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOF			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	Continued From page 19		21695			
	Based on observation, interviews, and document review the facility failed to ensure resident room was free from offensive odors for 1 of 3 residents (R1)			Corrected		
	Findings include					
	4/19/2021, at 8:50 a upon entry to the represent; the odor wher reclining chair, floor under R1's fee partially underneath pad had different slasked why the pad was underneath, Runderneath and the over and picked up odor was more prolifted off the floor. That was approximate was dark black that pad that covered the R1 stated she did in her carpet was deep	ion and interview on a.m. R1's door was closed, form a very strong odor was as like stale urine. R1 sat in there was also a pad on the let. The pad on the floor was a the recliner; that area of the nades of brown. R1 was was on the floor and what 1 stated there was mold a floor was leaking. R1 bent the soaker off the floor; the minent when the pad was the pad covered a large area ately 2 feet in diameter that a was moist. The back of the lee area was yellow and brown, not know when the last time p cleaned/shampooed, and left. R1 indicated she wanted				
	nursing assistant (N stated the pad was overflow incontinen	on 4/19/2021, at 8:57 a.m. NA)-A entered the room. NA-A on the floor for R1 urinary ice. NA-A stated R1 toileted and she did not want staff to				
	licensed practical n	on 4/19/2021, at 10:04 a.m. urse (LPN)-A confirmed R1's sive odor and indicated R1's				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,			;
		00427	B. WING			0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOF FER, MN 559			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	`	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
21695	Continued From page 20		21695			
	carpets were cleaned whenever they can; when R1 was not in her room such as when she went to beauty shop appointments.					
	family member (FM very recently; R1's there was a soaker indicated she had had concern with the number (FM).	on 4/19/2021, at 10:16 a.m. I)-A stated she had visited R1 had offensive odors, and pad on the floor. FM-A historically discussed the arse manager however, didn't been done about it.				
	registered nurse (R nurse manager for RN-A indicated star room almost week! RN-A stated there we checklist that was of checklist outlined the each room. RN-A s carpet using the car	on 4/19/2021, at 10:45 a.m. (N)-A stated she was the the unit where R1 resided. If would attempt to clean R1's y and when R1 would allow. If was a daily and a weekly completed by NA's; the ne cleaning schedules for tated NA's would clean the repet cleaner for routine commental services would do eaning.				
	environmental services she had not been in ESP-A indicated Nato shampoo the calcunit had their own of R1's room, ESP-A in stained she couldnobserved R1's carpseen it [stain] that is been cleaned in a I chair; there was the	on 4/19/2021, at 2:30 p.m. ice partner (ESP)-A stated in R1's room for a long time. A's on the unit were supposed pet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were it get the stains out. ESP-A pet and stated, "I've never plack, it doesn't look like it has ong time." ESP-A moved R1's estain extended underneath stated she was going to get				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11.	o. oo20.1.01.1	152111110711101		A. BUILDING:			
		00427		B. WING		04/2	: :0/2021
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH		TREET NOF			
	OLIMANA DV OTA	TEMENT OF DEFICIENCIE		TER, MN 559		1011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21695	Continued From page 21			21695			
21695	the carpet cleaner in odor/dirty carpet coother residents, and During an observat R1 had been move to an adjoining room after cleaned. R1's odor was now notic of R1's room; inside unchanged from 4/the area of carpet to black. During an interview neighborhood coord was responsible for checklist for complemanager. NC-A stat shampoo carpets and other residence.	now. ESP-A indicate	for R1, 8:15 a.m. her room could dry ned, the r outside r was binted at a dark 35 a.m. ated she ting unit nurse osed to cleaned	21695			
	checklist when was shampooed, NC-A the last time the ca cleaned/shampooe indicated that just to informed environment responsible for the	the last time the car stated she could not	rpets were t tell when -A s ot only				
	director of nursing (staff to clean the ca often refuse her ca indicated that once	on 4/20/2021, at 1:4 (DON) indicated shearpets however, R1 was repets to be cleaned. stained, the stains calk to maintenance f	e expected would DON do not lift,				
		et Cleaning dated 11 n Bethany makes ev					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED		
		00427		B. WING			C 20/2021
NAME OF I	PROVIDER OR SUPPLIER	00.2.	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u> </u>	10/2021
	TAN BETHANY HOME	ON FIGHTH		STREET NOI			
				TER, MN 55	T		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCII / MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From pa	ige 22		21695			
	to ensure carpet in and maintained. 1. Household carpe each neighborhood Use to clean soils, work order if the are environmental serv	et cleaners are avail I for neighborhood s spills, odorous area ea needs further cle	able on staff use. s. Fill out a				
	SUGGESTED MET The administrator, it designee could ension maintenance progra accurately reflect of maintenance sched on a routine basis, policies and proced changes and perfor rounds/audits perior maintenance is ade facility could report assurance performs committee for furthe ongoing compliance	maintenance super- sure a preventative am was developed ngoing preventative duled or needed in to The facility could colures, educate staff am environmental dically to ensure pre- equately completed. those findings to the ance improvement of	visor, or to he facility reate on these eventative The e quality (QAPI)				
	TIME PERIOD FOR (21) days.	R CORRECTION: T	wenty-one				
21805	MN St. Statute 144 Residents of HC Fa		nts &	21805			6/4/21
	Subd. 5. Courted residents have the courtesy and respe employees of or pe health care facility.	ct for their individua	vith ality by				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
			A. BOILDING.			
		00427	B. WING			, 0/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOF			
	T	ROCHES	TER, MN 559			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21805	5 Continued From page 23		21805			
	by: Based on observation review the facility far 1 resident (R1) who and stained carpet.	ent is not met as evidenced fon, interview, and document ailed to ensure dignity for 1 of b had an offensive room odors		Corrected		
	Findings include					
	4/19/2021, at 8:50 a upon entry to the represent; the odor so her reclining chair of known as a soaker from incontinence); on the floor under floor underneath, had be admitted, and the floor underneath, had be admitted, and the floor floor. The pad capproximately 2 feedblack that was mois covered the area we stated she did not floar floor. During a sup.m. R1 sat in her cenvironmental service.	ion and interview on a.m. R1's door was closed, from a very strong odor was melt like stale urine. R1 sat in on a washable bed pad (also pad-used to protect mattress there was also a soaker pad R1's feet. The pad on the floor neath the recliner; that area of int shades of brown markings, the pad was on the floor and ath, R1 stated there was mold then there since she was oor was leaking. R1 bent over soaker off the floor; the odor in when the pad was lifted off covered a large area that was et in diameter that was dark set. The back of the pad that has yellow and brown. R1 know when the last time her eaned/shampooed, and she R1 indicated she wanted new beequent interview at 1:45 chair, she was informed ices was going to clean her oh good, I hope they can take the smell is really				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7.1.12 . 27.11.	0. 0020	.52		A. BUILDING:			
		00427		B. WING			2 <mark>0/2021</mark>
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH		STREET NOF			
(VA) ID	STIMMADV STA	TEMENT OF DESIGIENC		TER, MN 559	PROVIDER'S PLAN OF CORREC	TION!	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC / MUST BE PRECEDED E SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21805	Continued From page 24			21805			
		now bad it smells, aned down and rer ain and stated, "It g id it anymore, it's ju luded diagnoses of disorder and agor es and situation th	I can smell moved the gets so very ust so f raphobia at the				
	person believes is difficult from such as public spaces) R1's quarterly Minimum Data Set (MDS) dated 4/7/2021, indicated R1 did not have cognitive impairment and did not have rejection of care behaviors. The MDS indicated R1 was independent ambulating in her room, personal hygiene, and toileting. The MDS identified R1 was frequently incontinent of urine and occasionally incontinent of bowel.						
	R1's care plan incluroom and bathroom know I'm incontiner emesis on any give to it some days. Stacleaning myself up. myself, which in tur which I understand environment." The directed staff to reduring an interview nursing assistant (N stated the soaker purinary overflow incompanded in the state of the state of the soaker purinary overflow incompanies.	n about every two want of urine, stool, and an day. My room has aff will offer to assist I usually choose to nearly choose to live corresponding integraphs and I choose to live and I cho	weeks. I and have as an odor at me in o do it to smell re in this rvention eeded. 3:57 a.m. room. NA-A				
	licensed practical n	urse (LPN)-A confi	rmed R1's				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	00427	B. WING			0/2021
NAME OF PROVIDER OR SUPPLIER			TATE, ZIP CODE		
SAMARITAN BETHANY HOME C	ON FIGHTH	TREET NOF TER, MN 559			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
carpets were cleaned R1 was not in her root to beauty shop appoint cleaned the carpets lathe beauty shop. LPN product Odor Be Gonsoak up the urine on R1 did not always allow R1 liked to do it herse. During an interview of family member (FM)-very recently; R1's rourine/bowel odor, and the floor. FM-A indicated discussed the concernowever, didn't think about it. During an interview of registered nurse (RN) nurse manager for the RN-A indicated staff or room almost weekly at RN-A stated there was checklist that was conchecklist outlined the each room. RN-A shot surveyor; the checklist room numbers under did not outline specificated NA's would cleaner for rought of the carpet cleaner for	re odor and indicated R1's d whenever they can; when om such as when she went intments. LPN-A stated staff last week when she was at N-A stated staff used a ne/biomatic and towels to the floor. LPN-A indicated ow staff to clean her carpet; elf. on 4/19/2021, at 10:16 a.m. A stated she had visited R1 om had a very strong d there was a soaker pad on ated she had historically rn with the nurse manager anything had been done on 4/19/2021, at 10:45 a.m. 1)-A stated she was the ine unit where R1 resided. would attempt to clean R1's and when R1 would allow. The cleaning schedules for owed the checklist to the st had days of the week with meath the day of the week, it ic cleaning tasks. RN-A ean the carpet using the	21805			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00.407			0.4/0	
		00427			04/2	0/2021
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S STREET NOF	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	TER, MN 559			
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	she had not been in ESP-A indicated NA to shampoo the car unit had their own of R1's room, ESP-A in stained she couldn' observed R1's carp seen it [stain] that is been cleaned in a lochair; there was the R1's chair. ESP-A is the carpet cleaner odor/dirty carpet coother residents, and During an interview director of nursing of staff to clean the car often refuse her car indicated that once but would have to traiternatives. SUGGESTED MET The administrator, of designee could devicare by the interdis residents dignity is could update policies staff on these chan resident(s) dignity at these audits will be assurance committed.	n R1's room for a long time. A's on the unit were supposed the pet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were it get the stains out. ESP-A the and stated, "I've never black, it doesn't look like it has ong time." ESP-A moved R1's estain extended underneath stated she was going to get now. ESP-A indicated that the old be a health risk for R1,	21805			