



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 24, 2024

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

RE: CCN: 245530
Cycle Start Date: March 14, 2024

Dear Administrator:

On March 25, 2024, we notified you a remedy was imposed. On April 17, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 12, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective April 9, 2024 be discontinued as of April 12, 2024. (42 CFR 488.417 (b))

In our letter of March 25, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 9, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 24, 2024

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

Re: Reinspection Results
Event ID: XCVQ12

Dear Administrator:

On April 17, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 14, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Melissa Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2024

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

RE: CCN: 245530
Cycle Start Date: March 14, 2024

Dear Administrator:

On March 14, 2024, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 9, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 9, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 9, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 9, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Samaritan Bethany Home On Eighth will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 9, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 14, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

Samaritan Bethany Home On Eighth

March 25, 2024

Page 5

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://forms.web.health.state.mn.us/form/NHDisputeResolution>

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,

A handwritten signature in black ink, appearing to read "Melissa Poepping". The signature is fluid and cursive, with a large initial "M" and a long, sweeping underline.

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

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 3/13/24 and 3/14/24 a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55301646C (MN101437 and MN101365) with a deficiency cited at F689 and F755. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the care plan for	F 689	Samaritan Bethany strives to ensure that each resident receives adequate	4/12/24	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/04/2024

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

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 1</p> <p>transfers to prevent or mitigate risk for falls and/or falls with major injury for 2 of 4 residents (R1 and R4) reviewed for falls. This resulted in actual harm for R1 who experienced a witnessed ground level fall resulting in a subdural, subarachnoid, and intraventricular hemorrhages, two left rib fractures, and a left clavicle fracture, requiring intensive care unit (ICU) hospitalization for eight days.</p> <p>Findings include:</p> <p>Subdural hemorrhage is a serious medical condition where blood collects beneath the dura mater, the outermost membrane surrounding the brain. This accumulation of blood puts pressure on the brain, potentially causing life-threatening consequences.</p> <p>Subarachnoid hemorrhage is bleeding in the space between the brain and the tissue covering the brain.</p> <p>Intraventricular hemorrhage is bleeding inside or around the ventricles-spaces in the brain that contain the cerebral spinal fluid. Bleeding in the brain can put pressure on the nerve cells and damage them. If the nerve cells are severely damaged, it can result in irreversible brain injury.</p> <p>R1's admission Minimum Data Set (MDS) dated 2/28/24, identified R1 had severe cognitive impairment and had diagnoses of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), thrombocytopenia (low platelets) and hypertension (high blood pressure). R1 had impairment in bilateral (both) upper extremities, required extensive assist of one staff with bed mobility, transfers, eating and toilet use,</p>	F 689	<p>supervision and assistance devices to prevent accidents.</p> <p>Upon returning from the hospital on 3/19/24, R1's care plan was reviewed and updated to the following: I require an assistance of 2 staff using the EZ lift with a medium sling, and I am not ambulating at this time.</p> <p>NA-D was educated on checking/following the resident's individualized care plan for transfers. NA- A no longer works for the organization.</p> <p>Residents that fell in the past 30 days relating to transfers were identified. The care plans of those residents identified will be reviewed to ensure the type of transfers are accurate. Transfers for each resident will be observed by the Care Coordinator to ensure they are transferred according to the care plan.</p> <p>Resident Transfer Policy was reviewed and updated to include definitions of each type of transfer.</p> <p>Neighborhood Meetings will be held with all nursing staff April 5th through April 12th regarding the POC for F689 including the transfer policy and following the residents care plans for transfers and review locking of equipment.</p> <p>Transfer Audits will be completed by the Care Coordinator weekly for three months to ensure resident transfers are completed correctly.</p> <p>Clinical Mentor and Assistant Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings.</p> <p>Date of Completion: 4/12/2024</p>	

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 2</p> <p>used walker and wheelchair for mobility. Did not identify any recent falls.</p> <p>R1's Fall risk assessment dated 2/22/24, identified a score of 28 indicating R1 was at moderate risk for falls due to diagnoses of diabetes, cardiovascular disease, and bone weakness or osteoporosis. R1 had chronic bowel and urinary incontinence, unsteady gait, unable to ambulate independently, vision and hearing impairment, cannot safely transfer independently, and was on hypertensive and diuretic medications.</p> <p>R1's care plan dated 2/22/24, identified a focus of an activities of daily living (ADL) self-care performance deficit related to limited mobility, incontinence, cognitive impairment, glaucoma, and diabetes. Intervention for transfer was assist of one staff with front wheeled walker (FWW), gait belt for all transfers with contact guard assist (CGA) at all times. An additional focus identified risk for falls related to limited mobility, incontinence, poor balance, hypertension, glaucoma, osteoporosis, and diabetes. Interventions included: anticipate and meet my needs, typically does not attempt to self-transfer, and use gait belt for all transfers/ambulation with CGA at all times.</p> <p>R1's physician visit dated 2/23/24, identified R1 had functional impairments limited by mobility, increased risk of falls, required full assist with all functional cares, hygiene and reading. Family shares R1 had some mobility, but unable to self-advocate needs, will not hydrate independently, or use the bathroom without prompting and transfers are harder due to higher risk of falls. No behaviors, mood changes or</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 3 concerns with resistance to cares.</p> <p>R1's occupational therapy (OT) note dated 2/28/24, included facilitated bed mobility with moderate to maximum assist. R1 transfers from edge of bed to standing with walker with minimal assist, then trial of stand pivot due to timing and noting fatigue from R1. Stand pivot with gait belt, minimal assist, and pivot to toilet with minimal assist to rise. Moderate assist to ensure turning completely, minimal assist from toilet to the wheelchair. R1 benefited from multisensorial verbal cueing. Noted potential variances due to timing of the session will further assess for safety in upcoming sessions.</p> <p>R1's physical therapy (PT) note dated 3/4/24, indicated R1 required moderate assist with FWW with sit to stand (STS) from recliner, required 100 % verbal/tactile/visual cues for forward trunk flexion, hand placement, foot placement. Stand-sit CGA with cues to reach back armrest. Recliner to wheelchair with FWW, moderate assist to stand, CGA while pivoting with FWW, wheelchair to edge of bed (EOB) with FWW minimal assist to stand, CGA while pivoting with FWW. R1 responded best with multiple forms of cueing. R1 required cues for walker management and occasional minimal assist for navigating walker, cues for increasing step height and step length. R1's gait was discontinuous and varied from step through partial step, primarily would shuffle.</p> <p>R1's progress note dated 3/4/24 at 6:00 p.m., included nurse was notified by a nursing assistant (NA) that R1 had fallen. R1 was observed laying at the foot of her bed on the left side with glasses in front of R1. R1's left arm was parallel to left</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 4</p> <p>side and right arm was behind her. Nurse and two aides used the EZ-lift (full body mechanical lift) to pick R1 up off the floor and place R1 in bed, gait belt was around R1's waist. CNA stated that R1 was pivoting when R1 lost her balance, attempted to catch R1 but was not strong enough or fast enough to catch R1 from falling. ¼ inch superficial abrasion was noted across the bridge of R1's nose, circle of blood blisters on left shoulder and hematoma noted around R1's left elbow, and was transferring with assistance. R1 was alert to self, family member (FM)-A notified of the fall at 7:15 p.m.</p> <p>R1's progress note dated 3/4/24 at 8:22 p.m., was given 500 milligrams (mg) of acetaminophen (pain reliever), due to R1 stated, "I hurt."</p> <p>R1's progress note dated 3/5/24 at 7:30 a.m., identified R1 had bruising on both arms and left shoulder and a small abrasion on the bridge of nose. R1 had some facial grimacing with left arm ROM but was unable to say if the discomfort was in the shoulder or arm. R1 was transferred out of bed with two staff assist and the EZ-lift. Left for appointment at 8:15 a.m., FM-A went with.</p> <p>R1's progress note dated 3/5/24 at 7:51 p.m., a fall follow up: R1 had a witnessed fall in room when transferring via pivot to shower chair with NA using gait belt. Shower chair brakes were on. R1 lost her balance during the transfer, clothing and footwear were appropriate. Care plan was reviewed/followed at the time of the fall. Daughter notified of fall on 3/4/24 at 7:15 p.m. injuries noted to the bridge of nose (abrasion) and left shoulder/left arm bruising. R1 seen in emergency department (ED) on 3/5/24 related to fall.</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 5</p> <p>R1's hospitalization in the intensive care unit (ICU) dated 3/5/24 to 3/12/24 identified R1 sustained a ground level fall at the nursing home resulting in a traumatic brain injury (TBI) to include treatment for a right temporal lobe subdural hemorrhage subarachnoid hemorrhage and intraventricular hemorrhage as well as a second and third left rib fracture and a left clavicle (the bone connecting the breastbone and shoulder) fracture.</p> <p>During a phone interview on 3/13/24 at 4:15 p.m., family member (FM)-A indicated she got a call from a nurse on evening of 3/4/24, R1 fell in the bathroom trying to get to the shower and fell on her left side. Every time R1 has fallen in the past she has broken a bone. FM-A got to the facility on 3/5/24 around 7:30 a.m., staff had R1 up in the chair. FM-A noticed a big bruise on the right arm, a large bruise on the left upper arm, and an abrasion on R1's nose. R1 had her head down and seemed really sleepy, we took the shuttle to the appointment. FM-A indicated when at the appointment R1 had mental status changes, she was unable to remember her name or birth date or who FM-A was. R1 was then sent to the emergency room and admitted to the ICU for eight days where she was diagnosed with bilateral subdural hematoma and a subarachnoid bleed, two left fractured ribs and a left fractured clavicle. R1 did have a seizure a few days into the stay, so now R1 will be on antiseizure meds for a couple months. FM-A stated the last couple days R1 had been alert and talking. FM-A explained R1 transferred by putting both her hands on the walker but the gait belt needed to be on, and "you can't let go or R1 will fall" otherwise she transferred just fine.</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 6</p> <p>During a phone interview on 3/13/24 at 12:40 p.m., nursing assistant (NA)-B indicated working the evening of 3/4/24. NA-B stated it was R1's shower day. NA-B informed NA-A through how to give R1 a shower and went through the care plan. NA-B informed NA-A to make sure to put the brakes on the shower chair, use the gait belt, take R1 to the bathroom, have R1 grab onto the bar on the wall to stand up to take R1's pants off. R1's fall happened right after supper approximately 5:45 p.m. Licensed practical nurse (LPN)-B found NA-B and asked her to grab the lift because R1 was on the floor. NA-B and LPN-B went to R1's room got R1 back into bed, R1 "did not say a thing, no facial grimacing, nothing." R1 did have some "rug burn" on the left shoulder, some "little bruising clusters" down the left arm, then got R1 undressed and in a gown. NA-B stated the rest of her shift she checked on R1 frequently and gave R1 drinks of water, R1 never had any complaints of pain.</p> <p>During an interview on 3/13/24 at 4:03 p.m. NA-A was in R1's room and demonstrated how she had been transferring R1 when she fell on 3/4/24; NC-A was also present. NA-A explained, she was told to give R1 a bath by NA-B and NA-B briefly walked her through how to do it; NA-B left to go answer some call lights on the other side of the facility. NA-A indicated R1 was seated in her wheelchair in front of the recliner next to the bed by the window side of the bed. NA-A put the shower chair directly across from R1's wheelchair, she did not lock the brakes on the shower chair because she did not know the shower chair had brakes. Then NA-A put the gait belt on R1 and asked her to stand up. NA-A hung on to the gait belt and "kind of just pulled her [R1] up". R1 started walking to the right toward the</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 7</p> <p>foot of her bed, lost her balance, and fell to the floor on her left side. NA-A stated R1 was too heavy for her. NA-A stated she did not use a walker during the transfer because she did not realize the care plan directed this. R1 did not make a sound during the fall or after the fall. NA-A checked to make sure R1 was breathing and then left to go get the nurse. NA-A was not sure if R1 had hit her head, "it happened so fast". R1 did have a cut on her left arm and NA-A never heard R1 say anything while she was in the room. NA-A stated LPN-B and NA-B got R1 off the floor with the mechanical lift and she was instructed to go help on the other unit while they finished with R1.</p> <p>During an interview on 3/13/24 at 2:37 p.m., LPN-B indicated she was the nurse for the evening shift on 3/4/24 when R1 had fallen. LPN-B stated she was on the other side of the nurses station when NA-A came to get her and told her R1 had fallen. LPN-B explained she went to R1's room, R1 was lying on her left side at the foot of her bed, and R1 still had the gait belt around her. R1's walker was not in sight, so LPN-B guessed it was not used during the transfer. NA-B and LPN-B transferred R1 back into bed using the full body mechanical lift. LPN-B completed an assessment and notified family. R1 did not have any facial grimacing or indicators of pain until a little after 8:00 p.m. which LPN-B gave R1 some acetaminophen. LPN-B stated "this fall was 100 % preventable, it was a simple pivot transfer." LPN-B could not understand how R1 could have fallen R1 took "commands well" and never got up without help. LPN-B indicated she had not completed a causal analysis of the fall and/or interviewed NA-A after R1's fall to determine the root cause.</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 8</p> <p>During an interview on 3/13/24 at 3:17 p.m., neighborhood coordinator (NC)-A indicated on the day of R1's fall on 3/4/24, NA-A was still in orientation and that NA-A did not have any supervision when NA-A transferred R1 and had fallen.</p> <p>During a phone interview on 3/13/24 at 1:01 p.m., NA-C indicated working the night shift on 3/4/24 and had heard during report R1 had fallen on the evening shift. NA-C stated, she heard that R1 was being transferred from her recliner to the bathroom. R1's baseline was very unsteady on her feet. R1 did not move unless she was asked by staff to do so NA-C was confused how R1 could have fallen.</p> <p>During a phone interview on 3/13/24 at 1:19 p.m., LPN-C indicated working the night shift on 3/4/24 and had gotten report from LPN-B. LPN-C was told in shift report R1 had hit her left side, her face, her shoulder, and her elbow and given acetaminophen for the pain. LPN-C indicated she assessed R1 for pain and changes throughout the night, with no changes or signs of pain noted.</p> <p>During an interview on 3/13/24 at 11:30 a.m., licensed practical nurse (LPN)-A indicated she worked the day shift of 3/5/24. LPN-A stated that morning she informed the aides to not get R1 up until she could do an assessment from the fall. R1 had grimacing with left shoulder range of motion (ROM) so staff got R1 up with an EZ-lift to try and protect that arm, R1 was brought to the dining room where she was fed breakfast. R1 had an eye appointment that morning and FM-A assisted R1 to the appointment. LPN-A stated, she got a phone call from the nurse at the eye</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 9</p> <p>clinic mid-morning that R1 was not recognizing FM-A had a change in condition and was brought to the emergency department (ED).</p> <p>During an interview on 3/14/24 at 8:24 a.m., registered nurse (RN)-A stated R1's care plan for transfers was to use a gait belt with CGA at all times and FWW. The wheeled walker would be important to use for R1's balance that was what R1 used prior to coming here when R1 was at home with FM-A. R1 was very unsteady on her feet and would lose her balance very easily. RN-A indicated being involved in the investigation of R1's fall on 3/4/24 and stated, we never checked to see if the FWW was being used during the fall, we were more focused on if the gait belt was used and to make sure the neuro assessments were being completed per policy.</p> <p>During an interview on 3/14/24 at 8:52 a.m., therapy program director (TPD)-A indicated if a resident had an order to use a gait belt with CGA at all times and FWW with transfers this would be used for strength and balance for the resident. TDP-A verified R1 had this order for transfers and was seen by OT and PT for strengthening and balance. TDP-A stated it was very important to follow the care plan exactly for transfers to prevention falls.</p> <p>R4's quarterly MDS dated 2/22/24, identified R4 to have moderate cognitive impairment and had diagnoses of dementia, anemia, and hypertension. No recent falls.</p> <p>R4's care plan dated 11/30/23, identified a focus of ADL self-care performance deficit related to limited mobility and incontinence, dementia, and</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 10</p> <p>diabetes. Intervention to transfer was assist of one staff using CGA to pivot transfer with FWW and gait belt.</p> <p>R4's Fall risk assessment dated 2/18/24, identified a score of 22 indicating 4 was at moderate risk for falls due to diagnoses of diabetes, cardiovascular disease, and anemia. R1 had chronic bowel and urinary incontinence, unable to ambulate independently, cannot safely transfer independently, and was on hypertensive medications.</p> <p>During an observation and interview on 3/14/24 at 8:41 a.m., R4 was seated on his bed with the gait belt around the waist, the wheelchair was directly across from R4. R4's walker was noted to be on the other side of the room. NA- D was standing to the right of R4 holding the gait belt. R4 had his hands on the arms of the wheelchair in front of him, wheelchair brakes were locked. R4 stood with the help of NA-D pulling up on the gait belt, R4 did not fully standup and tried to sit before reaching the wheelchair. NA-D had to physical lift and guided R4 to the wheelchair with difficulty of ensuring R4 was in a safe position to sit down squarely in the wheelchair. NA-D reviewed R4's care plan on the door and stated, "I didn't realize R4 should have used the walker to standup with the transfer, I suppose that would have been easier."</p> <p>During an interview on 3/14/24 at 11:27 a.m. director of nursing (DON) stated an investigation was completed for R1's fall on 3/4/24 at 6:00 p.m. and they were not able to come up with a true root cause to the fall. The investigation focused on the gait belt being used and making sure neuro assessments were being completed per</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	<p>Continued From page 11</p> <p>facility policy. The interdisciplinary team (IDT) did not check to see if the walker was used for the transfer with R1's fall. DON was notified of R4's transfer with NA-D not using a walker to transfer R4 to the wheelchair as directed by the care plan. DON stated, the care plan should be followed with all resident transfers.</p> <p>Facility policy, "Resident Transfer Policy," revised 6/2023 identified It is Samaritan Bethany's policy to transfer residents from one location to another following the residents individualized care plan to prevent resident and staff injuries from occurring. PROCEDURE: 1. Residents will be evaluated for transfers at the time of move-in to the facility and is noted is the residents care plan. 2. The resident care plan will be updated as changes occur. 3. If a resident has fallen a two assist with EZ Lift equipment will be used. 4. When a resident transfer occurs, the staff member assisting must follow the care plan. 5. Resident's arms and pants are not used as a lifting device. 6. Samaritan Bethany Types of Transfers include: a. Independent: Resident can transfer independently from sitting to standing positioning or from a standing to sitting position and does not require assistance from staff. b. One-staff Assist: Resident can bear weight on one or both legs and requires a gait belt with all transfers, which helps to provide support and balance for the resident. i. A walker, cane, or other support equipment may be used.</p> <p>Facility policy, "Fall Protocol," revised 3/2024, identified when a fall occurs, it will be Samaritan Bethany's practice to investigate the contributing factors/circumstances surrounding the fall, looking for patterns, etc. to prevent further falls and/or minimize the risk of injury. PROCEDURE:</p>	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 1. When a resident sustains a fall he or she will not be moved until a licensed nurse has evaluated their condition. 2. Pulse, respirations, and blood pressure, o2 saturation, and temperature obtained and recorded. 3. If an injury has occurred, it will be evaluated by the licensed nurse. Skin tears, bruises, abrasions, etc. will be treated using the facility standing orders. 4. If the fall was not witnessed and/or the resident hit their head, neuro checks will be initiated. 5. The nurse practitioner / MD will be notified immediately when there is need for further evaluation, emergency room visit or hospitalization. 6. A huddle is conducted, with staff present at the time of the fall, to determine contributing factors and what immediate intervention is to be put in place, to prevent further falls. These contributing factors and interventions will be documented in the electronic medical record. 7. A comprehensive assessment will be completed after each fall by the Care Coordinator looking for patterns, contributing factors, resident observation, fall history, physical limitations, medications, environment, and diagnoses. 8. IDT (Inter Disciplinary Team) meetings are held for 2 falls in 24 hours, 3 falls in a month, or after a fall with significant injury. Documentation of the IDT meeting will be entered in the progress notes in the resident's electronic medical record, including interventions put in place to prevent further falls. 9. Care Plan and Kardex are reviewed and updated when changes occur. 10. Resident falls are reported at stand-up meetings. A meeting is conducted with the Care Coordinators after stand-up after each fall to review fall and new intervention. 11. Fall Investigation Reports will be kept for one year. This report is a quality assurance investigation and is not part of the residents' record. 12. Falls are reviewed, and	F 689		

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 F 755 SS=D	Continued From page 13 trends reported at Quality Assurance meetings. Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility	F 689 F 755	Samaritan Bethany strives to provide	4/12/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	<p>Continued From page 14</p> <p>failed to accurately transcribe physician's orders into the electronic health record (EHR) for 1 of 3 residents (R1) who received 14 wrong doses of aspirin.</p> <p>Findings include:</p> <p>R1's physician visit dated 2/23/24, identified R1 to have quite a bit of drainage from her nose, constant in nature and many times is bloody/serosanguinous (yellowish with small amounts of blood) from history of recurring nose bleeds was receiving aspirin (medication to thin the blood) 325 milligrams (mg) daily. New orders to discontinue aspirin 325 mg daily and change to aspirin 81 mg daily due to frequent nose bleeds.</p> <p>R1's order summary dated 2/23/24, identified an order of aspirin 325 mg daily for permanent atrial fibrillation.</p> <p>R1's admission Minimum Data Set (MDS) dated 2/28/24, identified R1 to have severe cognitive impairment and diagnoses of atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), thrombocytopenia (low platelets) and hypertension (high blood pressure).</p> <p>R1's February and March 2024 medication administration records (MAR) identified R1 received aspirin 325 mg daily from 2/23/24 through 3/5/24. R1 received the wrong dose of aspirin for 14 days.</p> <p>During a phone interview on 3/13/24, at 4:15 p.m., family member (FM)-A reported a concern that on 2/23/24 R1 was seen by the physician and had ordered a change in R1's aspirin dosage from 325 mg to 81 mg due to frequent nose</p>	F 755	<p>pharmaceutical services to meet the needs of each resident.</p> <p>R1 was hospitalized at the time the medication error was identified. Upon R1 returning from the hospital on 3/19/2024, the AVS indicated Aspirin 325mg PO daily. R1's medication orders were reviewed by the provider on 3/20/2024 and updated to Aspirin 81mg PO daily on 3/20/2024. Upon investigation, DON identified that the provider did not send the change in Aspirin dosage of 81mg order to the facility after R1 was seen on 2/23/2024. The facility never received the order for the Aspirin 81mg for R1 but did receive the Aspirin 81mg medication from the pharmacy on 2/23/24. The facility did not question the Aspirin 81mg medication and continued giving 325mg. The Medical Director will be consulted to improve communication regarding order process for physicians. Receiving Medication Policy and Transcribing Medication Orders Policy was reviewed and updated regarding receiving medications from the pharmacy and transcription of medication. Neighborhood Meetings will be held with licensed nurses and trained medication aides April 5th through 12th regarding receiving medications from the pharmacy and transcription of orders. Medication transcription audits will be conducted for three months to ensure medications that were prescribed were transcribed correctly into the resident's electronic medical record. Clinical Mentor and Assistant Clinical Mentor will monitor for compliance.</p>	

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	<p>Continued From page 15</p> <p>bleeds. FM-A stated, this was never changed and R1 received 325 mg daily when she should have been getting 81 mg daily.</p> <p>During an interview on 3/14/24 at 2:20 p.m., director of nursing (DON) indicated when a medication error occurs, the nurse would document the error of a medication error report form, assess, and monitor the resident and notify the doctor. DON indicated an unawareness of the transcription medication error with R1's aspirin.</p> <p>Facility policy Medication error, dated 11/23, identified It is Samaritan Bethany's policy to evaluate medication and treatment errors that occur at the facility and provide education/corrective action to the person making the error. A medication error is the observed or identified preparation or administration of medications or biologicals which is not in accordance with: The prescriber order, Manufacturers specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. The Licensed nurse that identifies the error initiates the Medication Error Report. The error must be determined as significant or non-significant. A significant error is one that causes the resident discomfort or jeopardizes the residents health or safety and follows these three general guidelines: Resident condition, Drug category, and Frequency of the error. Any significant medication error or resident reaction must be reported to the following: MD/NP, Resident or the residents representative, an explanation must be made in the residents record for a significant error. If the medication error is</p>	F 755	Findings will be reported at Quality Assurance Committee meetings. Date of Completion: 4/12/2024	

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

PRINTED: 04/15/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245530	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 03/14/2024
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 16 significant, it will be reported under Vulnerable Adult guidelines. The medication error is reviewed with the individual making the error looking at any potential contributing factors	F 755		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: XCVQ11

Dear Administrator:

The above facility was surveyed on March 13, 2024 through March 14, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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

Please feel free to call me with any questions.



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>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.</p> <p>INITIAL COMMENTS: On 3/13/24 qnd 3/14/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.</p>	2 000		
-------	--	-------	--	--

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE 	(X6) DATE 04/04/24
---	---------------	----------------------------------

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>The following complaints were reviewed. H55301646C (MN101437 and MN101365) with a licensing order issued at (0830 and 1545). 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.</p> <p>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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>PLEASE DISREGARD THE HEADING OF THE</p>	2 000		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	<p>MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General</p> <p>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the care plan for transfers to prevent or mitigate risk for falls and/or falls with major injury for 2 of 4 residents (R1 and R4) reviewed for falls. This resulted in actual harm for R1 who experienced a witnessed ground level fall resulting in a subdural, subarachnoid, and intraventricular hemorrhages, two left rib fractures, and a left clavicle fracture, requiring intensive care unit (ICU) hospitalization for eight days.</p> <p>Findings include:</p>	2 830	Corrected	4/12/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	<p>Continued From page 3</p> <p>Subdural hemorrhage is a serious medical condition where blood collects beneath the dura mater, the outermost membrane surrounding the brain. This accumulation of blood puts pressure on the brain, potentially causing life-threatening consequences.</p> <p>Subarachnoid hemorrhage is bleeding in the space between the brain and the tissue covering the brain.</p> <p>Intraventricular hemorrhage is bleeding inside or around the ventricles-spaces in the brain that contain the cerebral spinal fluid. Bleeding in the brain can put pressure on the nerve cells and damage them. If the nerve cells are severely damaged, it can result in irreversible brain injury.</p> <p>R1's admission Minimum Data Set (MDS) dated 2/28/24, identified R1 had severe cognitive impairment and had diagnoses of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), thrombocytopenia (low platelets) and hypertension (high blood pressure). R1 had impairment in bilateral (both) upper extremities, required extensive assist of one staff with bed mobility, transfers, eating and toilet use, used walker and wheelchair for mobility. Did not identify any recent falls.</p> <p>R1's Fall risk assessment dated 2/22/24, identified a score of 28 indicating R1 was at moderate risk for falls due to diagnoses of diabetes, cardiovascular disease, and bone weakness or osteoporosis. R1 had chronic bowel and urinary incontinence, unsteady gait, unable to ambulate independently, vision and hearing impairment, cannot safely transfer independently, and was on hypertensive and diuretic medications.</p>	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 830	<p>Continued From page 4</p> <p>R1's care plan dated 2/22/24, identified a focus of an activities of daily living (ADL) self-care performance deficit related to limited mobility, incontinence, cognitive impairment, glaucoma, and diabetes. Intervention for transfer was assist of one staff with front wheeled walker (FWW), gait belt for all transfers with contact guard assist (CGA) at all times. An additional focus identified risk for falls related to limited mobility, incontinence, poor balance, hypertension, glaucoma, osteoporosis, and diabetes. Interventions included: anticipate and meet my needs, typically does not attempt to self-transfer, and use gait belt for all transfers/ambulation with CGA at all times.</p> <p>R1's physician visit dated 2/23/24, identified R1 had functional impairments limited by mobility, increased risk of falls, required full assist with all functional cares, hygiene and reading. Family shares R1 had some mobility, but unable to self-advocate needs, will not hydrate independently, or use the bathroom without prompting and transfers are harder due to higher risk of falls. No behaviors, mood changes or concerns with resistance to cares.</p> <p>R1's occupational therapy (OT) note dated 2/28/24, included facilitated bed mobility with moderate to maximum assist. R1 transfers from edge of bed to standing with walker with minimal assist, then trial of stand pivot due to timing and noting fatigue from R1. Stand pivot with gait belt, minimal assist, and pivot to toilet with minimal assist to rise. Moderate assist to ensure turning completely, minimal assist from toilet to the wheelchair. R1 benefited from multisensorial verbal cueing. Noted potential variances due to timing of the session will further assess for safety</p>	2 830		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	<p>Continued From page 5</p> <p>in upcoming sessions.</p> <p>R1's physical therapy (PT) note dated 3/4/24, indicated R1 required moderate assist with FWW with sit to stand (STS) from recliner, required 100 % verbal/tactile/visual cues for forward trunk flexion, hand placement, foot placement. Stand-sit CGA with cues to reach back armrest. Recliner to wheelchair with FWW, moderate assist to stand, CGA while pivoting with FWW, wheelchair to edge of bed (EOB) with FWW minimal assist to stand, CGA while pivoting with FWW. R1 responded best with multiple forms of cueing. R1 required cues for walker management and occasional minimal assist for navigating walker, cues for increasing step height and step length. R1's gait was discontinuous and varied from step through partial step, primarily would shuffle.</p> <p>R1's progress note dated 3/4/24 at 6:00 p.m., included nurse was notified by a nursing assistant (NA) that R1 had fallen. R1 was observed laying at the foot of her bed on the left side with glasses in front of R1. R1's left arm was parallel to left side and right arm was behind her. Nurse and two aides used the EZ-lift (full body mechanical lift) to pick R1 up off the floor and place R1 in bed, gait belt was around R1's waist. CNA stated that R1 was pivoting when R1 lost her balance, attempted to catch R1 but was not strong enough or fast enough to catch R1 from falling. ¼ inch superficial abrasion was noted across the bridge of R1's nose, circle of blood blisters on left shoulder and hematoma noted around R1's left elbow, and was transferring with assistance. R1 was alert to self, family member (FM)-A notified of the fall at 7:15 p.m.</p> <p>R1's progress note dated 3/4/24 at 8:22 p.m.,</p>	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 830	<p>Continued From page 6</p> <p>was given 500 milligrams (mg) of acetaminophen (pain reliever), due to R1 stated, "I hurt."</p> <p>R1's progress note dated 3/5/24 at 7:30 a.m., identified R1 had bruising on both arms and left shoulder and a small abrasion on the bridge of nose. R1 had some facial grimacing with left arm ROM but was unable to say if the discomfort was in the shoulder or arm. R1 was transferred out of bed with two staff assist and the EZ-lift. Left for appointment at 8:15 a.m., FM-A went with.</p> <p>R1's progress note dated 3/5/24 at 7:51 p.m., a fall follow up: R1 had a witnessed fall in room when transferring via pivot to shower chair with NA using gait belt. Shower chair brakes were on. R1 lost her balance during the transfer, clothing and footwear were appropriate. Care plan was reviewed/followed at the time of the fall. Daughter notified of fall on 3/4/24 at 7:15 p.m. injuries noted to the bridge of nose (abrasion) and left shoulder/left arm bruising. R1 seen in emergency department (ED) on 3/5/24 related to fall.</p> <p>R1's hospitalization in the intensive care unit (ICU) dated 3/5/24 to 3/12/24 identified R1 sustained a ground level fall at the nursing home resulting in a traumatic brain injury (TBI) to include treatment for a right temporal lobe subdural hemorrhage subarachnoid hemorrhage and intraventricular hemorrhage as well as a second and third left rib fracture and a left clavicle (the bone connecting the breastbone and shoulder) fracture.</p> <p>During a phone interview on 3/13/24 at 4:15 p.m., family member (FM)-A indicated she got a call from a nurse on evening of 3/4/24, R1 fell in the bathroom trying to get to the shower and fell on her left side. Every time R1 has fallen in the past</p>	2 830		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 830	<p>Continued From page 7</p> <p>she has broken a bone. FM-A got to the facility on 3/5/24 around 7:30 a.m., staff had R1 up in the chair. FM-A noticed a big bruise on the right arm, a large bruise on the left upper arm, and an abrasion on R1's nose. R1 had her head down and seemed really sleepy, we took the shuttle to the appointment. FM-A indicated when at the appointment R1 had mental status changes, she was unable to remember her name or birth date or who FM-A was. R1 was then sent to the emergency room and admitted to the ICU for eight days where she was diagnosed with bilateral subdural hematoma and a subarachnoid bleed, two left fractured ribs and a left fractured clavicle. R1 did have a seizure a few days into the stay, so now R1 will be on antiseizure meds for a couple months. FM-A stated the last couple days R1 had been alert and talking. FM-A explained R1 transferred by putting both her hands on the walker but the gait belt needed to be on, and "you can't let go or R1 will fall" otherwise she transferred just fine.</p> <p>During a phone interview on 3/13/24 at 12:40 p.m., nursing assistant (NA)-B indicated working the evening of 3/4/24. NA-B stated it was R1's shower day. NA-B informed NA-A through how to give R1 a shower and went through the care plan. NA-B informed NA-A to make sure to put the brakes on the shower chair, use the gait belt, take R1 to the bathroom, have R1 grab onto the bar on the wall to stand up to take R1's pants off. R1's fall happened right after supper approximately 5:45 p.m. Licensed practical nurse (LPN)-B found NA-B and asked her to grab the lift because R1 was on the floor. NA-B and LPN-B went to R1's room got R1 back into bed, R1 "did not say a thing, no facial grimacing, nothing." R1 did have some "rug burn" on the left shoulder, some "little bruising clusters" down the left arm,</p>	2 830		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	<p>Continued From page 8</p> <p>then got R1 undressed and in a gown. NA-B stated the rest of her shift she checked on R1 frequently and gave R1 drinks of water, R1 never had any complaints of pain.</p> <p>During an interview on 3/13/24 at 4:03 p.m. NA-A was in R1's room and demonstrated how she had been transferring R1 when she fell on 3/4/24; NC-A was also present. NA-A explained, she was told to give R1 a bath by NA-B and NA-B briefly walked her through how to do it; NA-B left to go answer some call lights on the other side of the facility. NA-A indicated R1 was seated in her wheelchair in front of the recliner next to the bed by the window side of the bed. NA-A put the shower chair directly across from R1's wheelchair, she did not lock the brakes on the shower chair because she did not know the shower chair had brakes. Then NA-A put the gait belt on R1 and asked her to stand up. NA-A hung on to the gait belt and "kind of just pulled her [R1] up". R1 started walking to the right toward the foot of her bed, lost her balance, and fell to the floor on her left side. NA-A stated R1 was too heavy for her. NA-A stated she did not use a walker during the transfer because she did not realize the care plan directed this. R1 did not make a sound during the fall or after the fall. NA-A checked to make sure R1 was breathing and then left to go get the nurse. NA-A was not sure if R1 had hit her head, "it happened so fast". R1 did have a cut on her left arm and NA-A never heard R1 say anything while she was in the room. NA-A stated LPN-B and NA-B got R1 off the floor with the mechanical lift and she was instructed to go help on the other unit while they finished with R1.</p> <p>During an interview on 3/13/24 at 2:37 p.m., LPN-B indicated she was the nurse for the</p>	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 830	<p>Continued From page 9</p> <p>evening shift on 3/4/24 when R1 had fallen. LPN-B stated she was on the other side of the nurses station when NA-A came to get her and told her R1 had fallen. LPN-B explained she went to R1's room, R1 was lying on her left side at the foot of her bed, and R1 still had the gait belt around her. R1's walker was not in sight, so LPN-B guessed it was not used during the transfer. NA-B and LPN-B transferred R1 back into bed using the full body mechanical lift. LPN-B completed an assessment and notified family. R1 did not have any facial grimacing or indicators of pain until a little after 8:00 p.m. which LPN-B gave R1 some acetaminophen. LPN-B stated "this fall was 100 % preventable, it was a simple pivot transfer." LPN-B could not understand how R1 could have fallen R1 took "commands well" and never got up without help. LPN-B indicated she had not completed a causal analysis of the fall and/or interviewed NA-A after R1's fall to determine the root cause.</p> <p>During an interview on 3/13/24 at 3:17 p.m., neighborhood coordinator (NC)-A indicated on the day of R1's fall on 3/4/24, NA-A was still in orientation and that NA-A did not have any supervision when NA-A transferred R1 and had fallen.</p> <p>During a phone interview on 3/13/24 at 1:01 p.m., NA-C indicated working the night shift on 3/4/24 and had heard during report R1 had fallen on the evening shift. NA-C stated, she heard that R1 was being transferred from her recliner to the bathroom. R1's baseline was very unsteady on her feet. R1 did not move unless she was asked by staff to do so NA-C was confused how R1 could have fallen.</p> <p>During a phone interview on 3/13/24 at 1:19 p.m.,</p>	2 830		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	<p>Continued From page 10</p> <p>LPN-C indicated working the night shift on 3/4/24 and had gotten report from LPN-B. LPN-C was told in shift report R1 had hit her left side, her face, her shoulder, and her elbow and given acetaminophen for the pain. LPN-C indicated she assessed R1 for pain and changes throughout the night, with no changes or signs of pain noted.</p> <p>During an interview on 3/13/24 at 11:30 a.m., licensed practical nurse (LPN)-A indicated she worked the day shift of 3/5/24. LPN-A stated that morning she informed the aides to not get R1 up until she could do an assessment from the fall. R1 had grimacing with left shoulder range of motion (ROM) so staff got R1 up with an EZ-lift to try and protect that arm, R1 was brought to the dining room where she was fed breakfast. R1 had an eye appointment that morning and FM-A assisted R1 to the appointment. LPN-A stated, she got a phone call from the nurse at the eye clinic mid-morning that R1 was not recognizing FM-A had a change in condition and was brought to the emergency department (ED).</p> <p>During an interview on 3/14/24 at 8:24 a.m., registered nurse (RN)-A stated R1's care plan for transfers was to use a gait belt with CGA at all times and FWW. The wheeled walker would be important to use for R1's balance that was what R1 used prior to coming here when R1 was at home with FM-A. R1 was very unsteady on her feet and would lose her balance very easily. RN-A indicated being involved in the investigation of R1's fall on 3/4/24 and stated, we never checked to see if the FWW was being used during the fall, we were more focused on if the gait belt was used and to make sure the neuro assessments were being completed per policy.</p> <p>During an interview on 3/14/24 at 8:52 a.m.,</p>	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 830	<p>Continued From page 11</p> <p>therapy program director (TPD)-A indicated if a resident had an order to use a gait belt with CGA at all times and FWW with transfers this would be used for strength and balance for the resident. TDP-A verified R1 had this order for transfers and was seen by OT and PT for strengthening and balance. TDP-A stated it was very important to follow the care plan exactly for transfers to prevention falls.</p> <p>R4's quarterly MDS dated 2/22/24, identified R4 to have moderate cognitive impairment and had diagnoses of dementia, anemia, and hypertension. No recent falls.</p> <p>R4's care plan dated 11/30/23, identified a focus of ADL self-care performance deficit related to limited mobility and incontinence, dementia, and diabetes. Intervention to transfer was assist of one staff using CGA to pivot transfer with FWW and gait belt.</p> <p>R4's Fall risk assessment dated 2/18/24, identified a score of 22 indicating 4 was at moderate risk for falls due to diagnoses of diabetes, cardiovascular disease, and anemia. R1 had chronic bowel and urinary incontinence, unable to ambulate independently, cannot safely transfer independently, and was on hypertensive medications.</p> <p>During an observation and interview on 3/14/24 at 8:41 a.m., R4 was seated on his bed with the gait belt around the waist, the wheelchair was directly across from R4. R4's walker was noted to be on the other side of the room. NA- D was standing to the right of R4 holding the gait belt. R4 had his hands on the arms of the wheelchair in front of him, wheelchair brakes were locked. R4 stood</p>	2 830		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

2 830	<p>Continued From page 12</p> <p>with the help of NA-D pulling up on the gait belt, R4 did not fully standup and tried to sit before reaching the wheelchair. NA-D had to physical lift and guided R4 to the wheelchair with difficulty of ensuring R4 was in a safe position to sit down squarely in the wheelchair. NA-D reviewed R4's care plan on the door and stated, "I didn't realize R4 should have used the walker to standup with the transfer, I suppose that would have been easier."</p> <p>During an interview on 3/14/24 at 11:27 a.m. director of nursing (DON) stated an investigation was completed for R1's fall on 3/4/24 at 6:00 p.m. and they were not able to come up with a true root cause to the fall. The investigation focused on the gait belt being used and making sure neuro assessments were being completed per facility policy. The interdisciplinary team (IDT) did not check to see if the walker was used for the transfer with R1's fall. DON was notified of R4's transfer with NA-D not using a walker to transfer R4 to the wheelchair as directed by the care plan. DON stated, the care plan should be followed with all resident transfers.</p> <p>Facility policy, "Resident Transfer Policy," revised 6/2023 identified It is Samaritan Bethany's policy to transfer residents from one location to another following the residents individualized care plan to prevent resident and staff injuries from occurring. PROCEDURE: 1. Residents will be evaluated for transfers at the time of move-in to the facility and is noted is the residents care plan. 2. The resident care plan will be updated as changes occur. 3. If a resident has fallen a two assist with EZ Lift equipment will be used. 4. When a resident transfer occurs, the staff member assisting must follow the care plan. 5. Resident's arms and pants are not used as a lifting device.</p>	2 830		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	<p>Continued From page 13</p> <p>6. Samaritan Bethany Types of Transfers include: a. Independent: Resident can transfer independently from sitting to standing positioning or from a standing to sitting position and does not require assistance from staff. b. One-staff Assist: Resident can bear weight on one or both legs and requires a gait belt with all transfers, which helps to provide support and balance for the resident. i. A walker, cane, or other support equipment may be used.</p> <p>Facility policy, "Fall Protocol," revised 3/2024, identified when a fall occurs, it will be Samaritan Bethany's practice to investigate the contributing factors/circumstances surrounding the fall, looking for patterns, etc. to prevent further falls and/or minimize the risk of injury. PROCEDURE: 1. When a resident sustains a fall he or she will not be moved until a licensed nurse has evaluated their condition. 2. Pulse, respirations, and blood pressure, o2 saturation, and temperature obtained and recorded. 3. If an injury has occurred, it will be evaluated by the licensed nurse. Skin tears, bruises, abrasions, etc. will be treated using the facility standing orders. 4. If the fall was not witnessed and/or the resident hit their head, neuro checks will be initiated. 5. The nurse practitioner / MD will be notified immediately when there is need for further evaluation, emergency room visit or hospitalization. 6. A huddle is conducted, with staff present at the time of the fall, to determine contributing factors and what immediate intervention is to be put in place, to prevent further falls. These contributing factors and interventions will be documented in the electronic medical record. 7. A comprehensive assessment will be completed after each fall by the Care Coordinator looking for patterns, contributing factors, resident observation, fall history, physical limitations, medications,</p>	2 830		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	<p>Continued From page 14</p> <p>environment, and diagnoses. 8. IDT (Inter Disciplinary Team) meetings are held for 2 falls in 24 hours, 3 falls in a month, or after a fall with significant injury. Documentation of the IDT meeting will be entered in the progress notes in the resident's electronic medical record, including interventions put in place to prevent further falls. 9. Care Plan and Kardex are reviewed and updated when changes occur. 10. Resident falls are reported at stand-up meetings. A meeting is conducted with the Care Coordinators after stand-up after each fall to review fall and new intervention. 11. Fall Investigation Reports will be kept for one year. This report is a quality assurance investigation and is not part of the residents' record. 12. Falls are reviewed, and trends reported at Quality Assurance meetings.</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 830		
21545	<p>MN Rule 4658.1320 A.B.C Medication Errors</p> <p>A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title</p>	21545		4/12/24

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 15</p> <p>42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means:</p> <p>(1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or</p> <p>(2) the administration of expired medications.</p> <p>B. It is free of any significant medication error. A significant medication error is:</p> <p>(1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or</p> <p>(2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.</p> <p>C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record.</p>	21545		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

21545	<p>Continued From page 16</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to accurately transcribe physician's orders into the electronic health record (EHR) for 1 of 3 residents (R1) who recieved 14 wrong doses of aspirin.</p> <p>Findings include:</p> <p>R1's physician visit dated 2/23/24, identified R1 to have quite a bit of drainage from her nose, constant in nature and many times is bloody/serosanguinous (yellowish with samll amounts of blood) from history of recurring nose bleeds was receiving aspirin (medication to thin the blood) 325 milligrams (mg) daily. New orders to discontinue aspirin 325 mg daily and change to aspirin 81 mg daily due to frequent nose bleeds.</p> <p>R1's order summary dated 2/23/24, identified an order of aspirin 325 mg daily for permanent atrial fibrillation.</p> <p>R1's admission Minimum Data Set (MDS) dated 2/28/24, identified R1 to have severe cognitive impairment and diagnoses of atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), thrombocytopenia (low platelets) and hypertension (high blood pressure).</p> <p>R1's February and March 2024 medication administration records (MAR) identified R1 received aspirin 325 mg daily from 2/23/24 through 3/5/24. R1 received the wrong dose of aspirin for 14 days.</p> <p>During a phone interview on 3/13/24, at 4:15</p>	21545	Corrected	
-------	--	-------	-----------	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

21545	<p>Continued From page 17</p> <p>p.m., family member (FM)-A reported a concern that on 2/23/24 R1 was seen by the physician and had ordered a change in R1's aspirin dosage from 325 mg to 81 mg due to frequent nose bleeds. FM-A stated, this was never changed and R1 received 325 mg daily when she should have been getting 81 mg daily.</p> <p>During an interview on 3/14/24 at 2:20 p.m., director of nursing (DON) indicated when a medication error occurs, the nurse would document the error of a medication error report form, assess, and monitor the resident and notify the doctor. DON indicated an unawareness of the transcription medication error with R1's aspirin.</p> <p>Facility policy Medication error, dated 11/23, identified It is Samaritan Bethany's policy to evaluate medication and treatment errors that occur at the facility and provide education/corrective action to the person making the error. A medication error is the observed or identified preparation or administration of medications or biologicals which is not in accordance with: The prescriber order, Manufacturers specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. The Licensed nurse that identifies the error initiates the Medication Error Report. The error must be determined as significant or non-significant. A significant error is one that causes the resident discomfort or jeopardizes the residents health or safety and follows these three general guidelines: Resident condition, Drug category, and Frequency of the error. Any significant medication error or resident reaction must be reported to the following: MD/NP,</p>	21545		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00427	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/14/2024
--	--	---	---

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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21545	<p>Continued From page 18</p> <p>Resident or the residents representative, an explanation must be made in the residents record for a significant error. If the medication error is significant, it will be reported under Vulnerable Adult guidelines. The medication error is reviewed with the individual making the error looking at any potential contributing factors</p> <p>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures for medication errors. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure medications were correctly transcribed. The quality assurance committee could monitor these measures to ensure compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty One (21) days</p>	21545		