DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 7, 2023

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

RE: CCN: 245530
Cycle Start Date: October 28, 2022

Dear Administrator:

On December 12, 2022 and January 9, 2023, we notified you a remedy was imposed. On March 1, 2023 the Minnesota Departments of Health and Public Safety 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 February 3, 2023.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 24, 2023 be discontinued as of February 3, 2023. (42 CFR 488.417 (b))

However, as we notified you in our letter of December 12, 2022, 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 January 24, 2023. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 7, 2023

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

Re: Reinspection Results
Event ID: 7O9F12 and XGXR12

Dear Administrator:

On January 6, 2023 and March 1, 2023 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 surveys completed on December 2, 2022 and December 20, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 9, 2023

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

RE: CCN: 245530
Cycle Start Date: October 28, 2022

Dear Administrator:

On December 12, 2022, we informed you of imposed enforcement remedies.

On December 20, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

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 Region V Office for imposition. The CMS Region V Office 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 January 24, 2023.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 24, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 24, 2023.

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.

As we notified you in our letter of November 18, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 24, 2023.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction

(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.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - 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 Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 28, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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) 565-9462

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/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

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

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Electronically delivered
January 9, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: XGXR11

Dear Administrator:

The above facility was surveyed on December 20, 2022 through December 20, 2022 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	C 12/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 12/20/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H55306975C (MN89493), with a deficiency cited at F684. 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 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		2/3/23

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

Electronically Signed | 01/19/2023

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

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

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F 684	Continued From page 1 Based on interview and document review, the facility failed to follow a physician's order to report elevated blood sugars, and failed to respond to a change in condition of 1 of 3 resident's (R1) reviewed for diabetic care. This resulted in harm when R1's symptoms and significantly elevated blood sugar levels lead to re-hospitalization within five days of admission to the facility. Findings include: R1's admitting diagnosis sheet from 12/13/22 indicated diagnoses that included type 2 diabetes mellitus with hyperglycemia (late on-set diabetes with an associated issue of high blood sugars), a recent case of COVID-19, weakness, a fall and subsequent fractures of pubic bone and left hip socket. The hospital after visit summary of care dated 12/13/22, identified R1 had been admitted to the hospital due to weakness. During hospitalization, R1 was found to have hyperglycemia that required insulin administration during her stay. As R1's condition improved, she required less insulin, and insulin was stopped immediately prior to discharge to the nursing home. The admitting physician orders of 12/13/22, identified that R1 was not receiving insulin at the facility, but was receiving metformin hydrochloride (an oral medication that increases the body's ability to use its own insulin) 500 milligrams (mg), two tablets to be taken twice daily with breakfast and supper. On 12/14/22 an order was added indicating R1's blood sugar was to be checked each morning before breakfast, and the medical provider was to be notified if blood sugar levels were greater than 180 milligrams per deciliter	F 684	F684 Samaritan Bethany strives to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices R1 was sent to the hospital on 12/18/22 and bed was held per conversation with R1 daughter. On 12/22/22 daughter notified facility social services she no longer wished to hold the bed. R1 did not return to the facility. Nurse involved in the incident was educated on 12/20/22 on the process of notification of provider when it’s indicated in the order. R1’s order was reviewed and found to be lacking clear parameters of when to notify the provider. The order stated: Please inform provider if blood glucose is >180 for 3 consecutive days. Discussed order parameters with our medical director and order parameters clarified for all other diabetic order as the following: Urgent provider notification (same day within 4 hours). Routine provider notification (the next following business day). Our standing orders were updated to reflect the clarified parameters as well. Residents residing in the facility that have diabetic orders that are lacking clear parameters were identified and those orders were clarified. All staff education will take place beginning on 1/26 through 2/3 to review F684, changes in the standing orders and all diabetic orders that were clarified. Neighborhood audits will be conducted by	

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F 684	Continued From page 2 (mg/dl) for three consecutive days. R1's care plan dated 12/13/22, indicated: "I have diabetes mellitus; goal-I will have no complications with diabetes mellitus through the review date." The only intervention listed was: "Diabetic medications as ordered. Observe for side-effects and effectiveness." Progress note dated 12/13/22, 12:14 p.m. indicated R1 had previously been independent, was able to communicate her needs, but had some impaired cognition, struggled with some short term memory issues. R1 has some pain on that date. Progress note dated 12/14/22, 2:26 p.m. indicated R1 was confused, but was up and ambulating on her own. Progress note dated 12/16/22, 2:07 p.m. indicated R1 was alert and oriented to person and place, but had some confusion. The note indicated R worked with therapy, but had also been found to self-transfer at times. On that date R1 did not complain of pain or discomfort. Progress note dated 12/17/22, 1:25 p.m. indicated R1 was only oriented to herself, was up walking on her own quite a bit, required more redirection, and complained of pain. Progress note dated 12/18/22, 2:42 p.m. indicated R1 complained of pain, but was unable to describe her pain; she required more assistance and had not been up walking all day. R1 was oriented to herself and surroundings only. Progress note dated 12/18/22, 4:16 p.m.	F 684	Care Coordinators for 3 months to ensure that all diabetic orders received have clear parameters and nurses are following those parameters. Clinical Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of Completion: 2/3/23	

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F 684	Continued From page 3 indicated R1 had requested assistance to the bathroom, but was found unable to stand. Progress note dated 12/18/22, 6:33 p.m. indicated a family member (FM)-A expressed concerns about R1, and stated she "seemed too sleepy, which was not her usual." FM-A also stated R1 seemed to have increased confusion, and FM-A wanted to know what medications had been given. The note indicated the writer, a licensed practical nurse (LPN)-A told FM-A that R1 had needed more help with transfers and had not been up walking that day. FM-A requested R1's blood sugar to be checked. The note indicated R1's blood sugar was 517 mg/dl and vital signs showed a low grade temp of 100.3 F, an increased pulse of 100 beats per minute, a respiratory rate of 18 breaths per minute and a slightly low oxygen level of 93%. The note indicated a call was to be placed to the on-call medical provider. Progress note dated 12/18/22, 7:11 p.m. indicated FM-A asked if the facility was able to give R1 some insulin. The on-call medical provider had returned their call and advised transfer to the emergency department, and R1 was taken to the hospital via ambulance. R1's medication administration record (MAR) for December of 2022 indicated blood sugar monitoring had been done each morning after admission to the facility. On 12/15/22, the level was 134, on 12/16/22, it was 200, on 12/17/22, it was 302 and on 12/18/22, it was 307. The levels on 12/16, 12/17 and 12/18 met the criteria for reporting if levels were greater than 180 mg/dl for three consecutive days. R1's medical record did not contain documentation of these results having	F 684		

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F 684	Continued From page 4 been reported to a medical provider. When interviewed on 12/20/22, at 1:40 p.m. a licsensed practical nurse (LPN)-B stated nurses were responsible to monitor the blood sugar levels of diabetic residents. LPN-B stated a resident's MAR would provide criteria for notification to providers. LPN-B stated a provider should be notified right away if a diabetic resident exhibited changes outside of their norm. LPN-B described symptoms of concern to be unusual sleepiness, shakiness, or getting more confused. LPN-B stated the on-call provider should be notified after hours or on weekends if the primary provider was unavailable. When interviewed on 12/20/22, at 2:04 p.m. a registered nurse (RN)-A stated each diabetic patient would have different orders for when to notify a medical provider of their blood sugar levels. RN-A stated R1 had been on insulin when in the hospital but when discharged from the hospital and admitted to the facility, there were no orders to check her blood sugars. RN-A stated the facility liked to have an order to check blood sugars if a person had changed from insulin to an oral anti-diabetic medication so the provider for the facility had been contacted upon R1's admission to write an order to monitor R1's levels. RN-A stated that even without an order, as a nurse she would have concerns about any blood sugar level higher than 250 or 300 mg/dl; however, because R1's order indicated to call if greater than 180 mg/dl for three consecutive days, she did not expect a nurse should call for a single level higher than 180. RN-A did expect the provider should have been notified of the three consecutive days R1's levels were higher than 180 mg/dl.	F 684		

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

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F 684	Continued From page 5 When interviewed on 12/20/22, 3:25 p.m. a certified nurse practitioner (NP)-A stated a nurse should have reported R1's three consecutive days of blood sugars greater than 180 mg/dl within 1-2 hours of the findings. NP-A stated the results showed rising levels, but they were not of an emergent level at that time, and a provider could have decided on whether treatment should have been initiated and/or if further monitoring should have been started. NP-A stated a blood sugar of greater than 500 mg/dl was concerning as this could indicate the person was progressing to diabetic Ketoacidosis (DKA) or hyperosmolar hyperglycemic state (HHS) [both of these can be life threatening and require prompt treatment]. NP-A stated the symptoms of hyperglycemia frequently noted are: complaints of not feeling well and increasing confusion. When interviewed on 12/20/22, 4:04 p.m. LPN-A stated she first met R1 on 12/17/22, when she obtained her morning blood sugar level. LPN-A stated R1 had been up on 12/17/22, without the need of a wheel chair. On 12/18/22, LPN-A remembered a nursing assistant (NA) had brought R1 to the breakfast table in a wheelchair rather than walking her, stating R1 wanted to eat. LPN-A proceeded to check R1's blood sugar and noted it was around 300. LPN-A stated she had looked at R1's chart and saw there was not an insulin order, but instead R1 took metformin. LPN-A also noted the order to notify the provider of blood sugar levels greater than 180 mg/dl for three consecutive days, and stated R1 had had elevated blood sugars meeting that criteria. LPN-A said she wrote herself a note to write an SBAR (a notification form used to describe a resident's change in condition) to "notify the nurse	F 684		

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	245530	A. BUILDING _____ B. WING _____	C 12/20/2022

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F 684	Continued From page 6 practitioner of the blood sugars on Monday [the next morning]". LPN-A stated she did not see R1 again until later in the morning when she needed assist to the bathroom. LPN-A attempted to assist R1, but discovered she was unable to stand on her own and a lift was needed which was a change from the day before. LPN-A said R1 complained of pain, but was very vague. LPN-A did not see R1 again until around 3:00 p.m. when an NA asked if they could lay R1 down as a visitor had reported she was "not herself and could not sit up any more." LPN-A assisted with cares and said R1 complained of pain, but again was not really able to describe her discomfort. LPN-A stated, "I was really focused on her comfort at that time." Several hours later, LPN-A went to R1's room to give a medication. FM-A was present and asking to have her check R1's blood sugar which is when she got the result of 517 mg/dl. LPN-A stated she assured FM-A that R1 had received all ordered medications and thought they should call the on-call provider. LPN-A said she notified the facility charge nurse and then LPN-A obtained a set of vital signs while the charge nurse called the provider. LPN-A stated the symptoms of hyperglycemia (high blood sugar) were confusion and lethargy, and was able to state, left untreated, a diabetic could progress into a coma. LPN-A stated, "looking back, I should have notified the charge nurse and called the provider right away that morning." When interviewed on 12/20/22, 5:02 p.m. RN-B stated a nurse should contact a provider when a diabetic resident's blood sugar was out of their normal range. RN-B stated the provider often designated a number and if the resident was out	F 684		

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F 684	Continued From page 7	F 684		

of that range a notification should be made right away as "you don't know what is going on with that person, or what might be needed." RN-B stated the provider might choose to monitor the blood sugar more frequently or may order a change in medications.

When interviewed on 12/20/22, 5:08 p.m. the facility director of nursing (DON) stated she had been notified of R1 being sent to the hospital and about the order to report the elevated blood sugars not having been followed on 12/19/22. The DON stated nursing leadership met to discuss the incident, and had reported it to the state entity to be on the safe side. The DON said they try to do interviews with the persons involved as soon as possible when there is a significant event at the facility, and they had started interviews on 12/20/22. The DON stated they had identified the original order had not had specific parameters for when the notifications were to be made, but DON stated, if a nurse observed a blood sugar greater than 300 mg/dl and no other parameters were defined, the nurse should notify the provider as soon as possible. DON stated an SBAR for the provider to review the next day was not soon enough when the person was symptomatic. The DON stated she had talked with the nurses involved about the situation with R1, but had not yet started training any other nurses on other shifts, or other units.

A facility policy titles Diabetic Protocol and last reviewed on August 2021, indicated "blood sugar levels will be checked per provider order and as needed if a resident is experiencing a change in condition." The policy referred to standing orders "diabetic management for treatment of hypoglycemia and hyperglycemia episodes

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F 684	Continued From page 8 unless specified by a provider order." A document titled Standing Orders for Samaritan Bethany Home on 8th, dated 5/8/22 indicated: "diabetic management - initiate QID [4 times daily] blood glucose (BG) [blood sugar]monitoring upon admission for three days for all diabetic patients unless the orders specify otherwise. -notify provider if two BG results are [less than]70 or [greater than] 400 in a 24 hour period and/or change in condition; if no condition change, notify provider on the next business day."	F 684		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/20/22, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found 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.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H55306975C (MN89493) with a licensing order issued at STAG 0830. 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. 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	2 000		

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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow a physician's order to report elevated blood sugars, and failed to respond to a change in condition of 1 of 3 resident's (R1) reviewed for diabetic care. This resulted in harm when R1's symptoms and significantly elevated blood sugar levels lead to re-hospitalization within five days of admission to the facility. Findings include:	2 830	Corrected	2/3/23

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2 830	Continued From page 3 R1's admitting diagnosis sheet from 12/13/22 indicated diagnoses that included type 2 diabetes mellitus with hyperglycemia (late on-set diabetes with an associated issue of high blood sugars), a recent case of COVID-19, weakness, a fall and subsequent fractures of pubic bone and left hip socket. The hospital after visit summary of care dated 12/13/22, identified R1 had been admitted to the hospital due to weakness. During hospitalization, R1 was found to have hyperglycemia that required insulin administration during her stay. As R1's condition improved, she required less insulin, and insulin was stopped immediately prior to discharge to the nursing home. The admitting physician orders of 12/13/22, identified that R1 was not receiving insulin at the facility, but was receiving metformin hydrochloride (an oral medication that increases the body's ability to use its own insulin) 500 milligrams (mg), two tablets to be taken twice daily with breakfast and supper. On 12/14/22 an order was added indicating R1's blood sugar was to be checked each morning before breakfast, and the medical provider was to be notified if blood sugar levels were greater than 180 milligrams per deciliter (mg/dl) for three consecutive days. R1's care plan dated 12/13/22, indicated: "I have diabetes mellitus; goal-I will have no complications with diabetes mellitus through the review date." The only intervention listed was: "Diabetic medications as ordered. Observe for side-effects and effectiveness." Progress note dated 12/13/22, 12:14 p.m. indicated R1 had previously been independent,	2 830		

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2 830	Continued From page 4 was able to communicate her needs, but had some impaired cognition, struggled with some short term memory issues. R1 has some pain on that date. Progress note dated 12/14/22, 2:26 p.m. indicated R1 was confused, but was up and ambulating on her own. Progress note dated 12/16/22, 2:07 p.m. indicated R1 was alert and oriented to person and place, but had some confusion. The note indicated R worked with therapy, but had also been found to self-transfer at times. On that date R1 did not complain of pain or discomfort. Progress note dated 12/17/22, 1:25 p.m. indicated R1 was only oriented to herself, was up walking on her own quite a bit, required more redirection, and complained of pain. Progress note dated 12/18/22, 2:42 p.m. indicated R1 complained of pain, but was unable to describe her pain; she required more assistance and had not been up walking all day. R1 was oriented to herself and surroundings only. Progress note dated 12/18/22, 4:16 p.m. indicated R1 had requested assistance to the bathroom, but was found unable to stand. Progress note dated 12/18/22, 6:33 p.m. indicated a family member (FM)-A expressed concerns about R1, and stated she "seemed too sleepy, which was not her usual." FM-A also stated R1 seemed to have increased confusion, and FM-A wanted to know what medications had been given. The note indicated the writer, a licensed practical nurse (LPN)-A told FM-A that R1 had needed more help with transfers and had	2 830		

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2 830	Continued From page 5 not been up walking that day. FM-A requested R1's blood sugar to be checked. The note indicated R1's blood sugar was 517 mg/dl and vital signs showed a low grade temp of 100.3 F, an increased pulse of 100 beats per minute, a respiratory rate of 18 breaths per minute and a slightly low oxygen level of 93%. The note indicated a call was to be placed to the on-call medical provider. Progress note dated 12/18/22, 7:11 p.m. indicated FM-A asked if the facility was able to give R1 some insulin. The on-call medical provider had returned their call and advised transfer to the emergency department, and R1 was taken to the hospital via ambulance. R1's medication administration record (MAR) for December of 2022 indicated blood sugar monitoring had been done each morning after admission to the facility. On 12/15/22, the level was 134, on 12/16/22, it was 200, on 12/17/22, it was 302 and on 12/18/22, it was 307. The levels on 12/16, 12/17 and 12/18 met the criteria for reporting if levels were greater than 180 mg/dl for three consecutive days. R1's medical record did not contain documentation of these results having been reported to a medical provider. When interviewed on 12/20/22, at 1:40 p.m. a licsensed practical nurse (LPN)-B stated nurses were responsible to monitor the blood sugar levels of diabetic residents. LPN-B stated a resident's MAR would provide criteria for notification to providers. LPN-B stated a provider should be notified right away if a diabetic resident exhibited changes outside of their norm. LPN-B described symptoms of concern to be unusual sleepiness, shakiness, or getting more confused. LPN-B stated the on-call provider should be	2 830		

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2 830	Continued From page 6 notified after hours or on weekends if the primary provider was unavailable. When interviewed on 12/20/22, at 2:04 p.m. a registered nurse (RN)-A stated each diabetic patient would have different orders for when to notify a medical provider of their blood sugar levels. RN-A stated R1 had been on insulin when in the hospital but when discharged from the hospital and admitted to the facility, there were no orders to check her blood sugars. RN-A stated the facility liked to have an order to check blood sugars if a person had changed from insulin to an oral anti-diabetic medication so the provider for the facility had been contacted upon R1's admission to write an order to monitor R1's levels. RN-A stated that even without an order, as a nurse she would have concerns about any blood sugar level higher than 250 or 300 mg/dl; however, because R1's order indicated to call if greater than 180 mg/dl for three consecutive days, she did not expect a nurse should call for a single level higher than 180. RN-A did expect the provider should have been notified of the three consecutive days R1's levels were higher than 180 mg/dl. When interviewed on 12/20/22, 3:25 p.m. a certified nurse practitioner (NP)-A stated a nurse should have reported R1's three consecutive days of blood sugars greater than 180 mg/dl within 1-2 hours of the findings. NP-A stated the results showed rising levels, but they were not of an emergent level at that time, and a provider could have decided on whether treatment should have been initiated and/or if further monitoring should have been started. NP-A stated a blood sugar of greater than 500 mg/dl was concerning as this could indicate the person was progressing to diabetic Ketoacidosis (DKA) or hyperosmolar	2 830		

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2 830	Continued From page 7 hyperglycemic state (HHS) [both of these can be life threatening and require prompt treatment]. NP-A stated the symptoms of hyperglycemia frequently noted are: complaints of not feeling well and increasing confusion. When interviewed on 12/20/22, 4:04 p.m. LPN-A stated she first met R1 on 12/17/22, when she obtained her morning blood sugar level. LPN-A stated R1 had been up on 12/17/22, without the need of a wheel chair. On 12/18/22, LPN-A remembered a nursing assistant (NA) had brought R1 to the breakfast table in a wheelchair rather than walking her, stating R1 wanted to eat. LPN-A proceeded to check R1's blood sugar and noted it was around 300. LPN-A stated she had looked at R1's chart and saw there was not an insulin order, but instead R1 took metformin. LPN-A also noted the order to notify the provider of blood sugar levels greater than 180 mg/dl for three consecutive days, and stated R1 had had elevated blood sugars meeting that criteria. LPN-A said she wrote herself a note to write an SBAR (a notification form used to describe a resident's change in condition) to "notify the nurse practitioner of the blood sugars on Monday [the next morning]". LPN-A stated she did not see R1 again until later in the morning when she needed assist to the bathroom. LPN-A attempted to assist R1, but discovered she was unable to stand on her own and a lift was needed which was a change from the day before. LPN-A said R1 complained of pain, but was very vague. LPN-A did not see R1 again until around 3:00 p.m. when an NA asked if they could lay R1 down as a visitor had reported she was "not herself and could not sit up any more." LPN-A assisted with cares and said R1 complained of pain, but again was not really able to describe her discomfort. LPN-A stated, "I was really focused on her comfort at	2 830		

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2 830	Continued From page 8 that time." Several hours later, LPN-A went to R1's room to give a medication. FM-A was present and asking to have her check R1's blood sugar which is when she got the result of 517 mg/dl. LPN-A stated she assured FM-A that R1 had received all ordered medications and thought they should call the on-call provider. LPN-A said she notified the facility charge nurse and then LPN-A obtained a set of vital signs while the charge nurse called the provider. LPN-A stated the symptoms of hyperglycemia (high blood sugar) were confusion and lethargy, and was able to state, left untreated, a diabetic could progress into a coma. LPN-A stated, "looking back, I should have notified the charge nurse and called the provider right away that morning." When interviewed on 12/20/22, 5:02 p.m. RN-B stated a nurse should contact a provider when a diabetic resident's blood sugar was out of their normal range. RN-B stated the provider often designated a number and if the resident was out of that range a notification should be made right away as "you don't know what is going on with that person, or what might be needed." RN-B stated the provider might choose to monitor the blood sugar more frequently or may order a change in medications. When interviewed on 12/20/22, 5:08 p.m. the facility director of nursing (DON) stated she had been notified of R1 being sent to the hospital and about the order to report the elevated blood sugars not having been followed on 12/19/22. The DON stated nursing leadership met to discuss the incident, and had reported it to the state entity to be on the safe side. The DON said they try to do interviews with the persons involved	2 830		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 as soon as possible when there is a significant event at the facility, and they had started interviews on 12/20/22. The DON stated they had identified the original order had not had specific parameters for when the notifications were to be made, but DON stated, if a nurse observed a blood sugar greater than 300 mg/dl and no other parameters were defined, the nurse should notify the provider as soon as possible. DON stated an SBAR for the provider to review the next day was not soon enough when the person was symptomatic. The DON stated she had talked with the nurses involved about the situation with R1, but had not yet started training any other nurses on other shifts, or other units. A facility policy titles Diabetic Protocol and last reviewed on August 2021, indicated "blood sugar levels will be checked per provider order and as needed if a resident is experiencing a change in condition." The policy referred to standing orders "diabetic management for treatment of hypoglycemia and hyperglycemia episodes unless specified by a provider order." A document titled Standing Orders for Samaritan Bethany Home on 8th, dated 5/8/22 indicated: "diabetic management - initiate QID [4 times daily] blood glucose (BG) [blood sugar]monitoring upon admission for three days for all diabetic patients unless the orders specify otherwise. -notify provider if two BG results are [less than]70 or [greater than] 400 in a 24 hour period and/or change in condition; if no condition change, notify provider on the next business day." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could initiate an updated training program for nursing	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00427	A. BUILDING: _____ B. WING _____	C 12/20/2022

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2 830	Continued From page 10 staff on the care of a diabetic patients, including signs and symptoms of hypo/hyperglycemia, and the consequences of unmanaged blood sugars. This training could include when to report, following physician orders and seeking clarity when needed. DON or designee could initiate audits of diabetic resident charts to ensure orders are clear and being followed up on promptly. TIME PERIOD FOR CORRECTION: twenty-one (21) days.	2 830		