Electronically Submitted
June 16, 2019

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

RE: Project Numbers S5530031, H5530044C, H5530046C

Dear Administrator:

On May 3, 2019, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 15, 2019 that included an investigation of complaint number H5530044C. 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), whereby corrections were required.

On May 28, 2019, an extended standard 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 and to investigate complaint number H5530046C.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On May 26, 2019, the situation of immediate jeopardy to potential health and safety cited at F600 was removed. However, continued non-compliance remains at the lower scope and severity of G.

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 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 effective July 4, 2019.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 4, 2019, (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 4, 2019, (42 CFR 488.417 (b)).

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.

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 $10,483; 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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 28, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80 Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and

1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

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.

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown
Rochester Survey Team
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
Phone: (507) 206-2731
Fax: (507) 206-2711

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 October 15, 2019 (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 DENIAL OF PAYMENT

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:

Tamika.Brown@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 Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

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 05/28/2019

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 5/23/19, 5/24/19, 5/26/19 and 5/28/19, an onsite abbreviated survey was completed by surveyors from the Minnesota Department of Health (MDH) to investigate complaint(s) Samaritan Bethany Home on Eighth was found not to be in compliance with 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. Complaint H5530046C were substantiated and related deficiencies were issued at : F600. The immediate jeopardy began on 5/11/19, when the facility failed to protect and investigate an allegation of abuse for R1 who was noted to have scratches and bruising of unknown origin. The IJ was identified on 5/24/19, and the assistant director of nursing, director of nursing and administrator were notified at 5:36 p.m. The immediate jeopardy was removed on 5/26/19, at 1:20 p. m., after it could be verified the facility had implemented an acceptable removal plan however, noncompliance remained at the lower scope and severity level of G, isolated with actual harm for R1, who experienced injuries to the face and leg of unknown source. An extended survey was completed on 5/28/19. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/26/2019

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively investigate and ensure resident protections for 1 of 2 residents (R1) reviewed for an allegation of abuse. The facility's failure to protect residents resulted in an immediate jeopardy situation. The immediate jeopardy began on 5/11/19, when the facility failed to protect and investigate an allegation of abuse for R1 who was noted to have scratches and bruising of unknown origin. The IJ was identified on 5/24/19, and the assistant	F 600	F 600 Samaritan Bethany strives to ensure that each resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident’s medical symptoms. On 5/11/19 the facility submitted a VA report on the allegation of abuse of the	7/2/19

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F 600	Continued From page 2 director of nursing, director of nursing and administrator were notified at 5:36 p.m. The immediate jeopardy was removed on 5/26/19, at 1:20 p. m., after it could be verified the facility had implemented an acceptable removal plan however, noncompliance remained at the lower scope and severity level of G, isolated with actual harm for R1, who experienced injuries to the face and leg of unknown source. Findings include: During observation on 5/23/19, at 10:40 a.m., R1 laid in bed sleeping. There were no staff present in R1's room or within eye sight outside of R1's room. At 10:46 a.m., unit coordinator (UC)-A looked into R1's room and then stood outside of R1's room by a piece of wooden furniture along a wall. At 10:48 a.m., R1 sat up on the side of the bed. R1 had one shoe on and held the other shoe in her hand while standing holding onto her walker. UC-A informed an unidentified staff person to go into R1's room and help her. R1's progress note (PN) identified on 5/7/19, at 11:02 a.m., a 1:1(staff present with resident 24/7) had been initiated due to R1's increase in wandering. The note indicated R1 had also been added to the facility's wanderguard list, and indicated R1's care plan would be reviewed and updated. An undated sheet of paper located outside R1's room in a drawer identified 1:1 Tracking: "Do not leave resident unattended for any reason. If you are going on break you need to find the nurse, let them know you are leaving and who is covering while you are gone. You are not to leave unless there is someone to cover 1:1 hours. If you are	F 600	unexplained injury for R1. NA-C and NA-E were removed from the schedule until the investigation was completed. The facility conducted a thorough 5 day investigation including 18 interviews (11 staff members and 7 residents – including R1). The Rochester Police Department was called on 5/11/19. After their investigation they found the case to be unfounded. Although the facility did not substantiate abuse, R1's care plan was updated on 5/25 to include additional interventions when caring for R1. R1 continues on 1:1 staffing for her wandering and to prevent adverse outcomes to other residents, not for falls. Social Worker met with R1 on 6/21/19. R1 stated the care received was good and had no concerns. NA-C no longer works at the facility. NA-E was re-educated on person-centered care, working with residents who have dementia specifically regarding toileting and aggression, the importance of resident choice when providing cares, reporting to the nurse any skin injuries of unknown and vulnerable adult on 5/25/19. All residents' individual abuse prevention plans will be reviewed and updated as needed. All-staff meetings took place from 5/25/19 – 5/28/19 to review person-centered care, the importance of resident choice when providing cares, vulnerable adult and reporting to the nurse any skin injuries of unknown origin. All-staff in-services will be held on June 27th and 28th 2019 to review F600 and the plan of correction. The same	

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F 600	Continued From page 3 covering someone's break, your are to sit with the resident in full view and not move. Please carry a radio so you can call for assistance with coverage." An initial report to the State Agency (SA) dated 5/11/19, at 1:13 p.m. identified an allegation of physical abuse of unexplained injury. Details on the report included: 2 abrasions to forehead and purplish bruise to left lateral leg occurred in the resident's (R1) room. A description of incident included: Family notified nursing that resident had abrasions to forehead. Staff completed an assessment and talked with nursing staff on duty as well as the resident. Resident reported, "[Staff name] was hitting the hell out of me and then was scared when I saw blood." Resident had also stated to daughter, "Have you ever seen blood on a black person before." Nursing asked if she had fallen and she stated "No." Nursing reviewed report sheets and did not find a staff named [name]. Review of the facility's internal investigation regarding R1's allegation, included a panel interview with possible witnesses, alleged perpetrators (AP), and residents. The investigation panel included the director of nursing (DON), administrator, social worker, assistant DON, unit coordinator and registered nurse (RN). Although the facility claimed no wrongdoing occurred, the investigation indicated R1 had made similar comments to that of a police report, such as: "It was like a girl getting raped and someone beating her, hitting the hell out of her and scared once the [AP] saw blood." The investigation also included an interview with nursing assistant (NA)-C. The investigation indicated NA-C had verified R1 was agitated and	F 600	information will be provided for staff review in each neighborhood. Audits will be conducted by the Community Leader, Clinical Mentor and Social Services Mentor for 3 months to ensure that any allegation of abuse, neglect, misappropriation or exploitation are reported timely and thoroughly investigated. Community Leader, Clinical Mentor and Social Services Mentor will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 7/2/19	

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F 600	Continued From page 4	F 600		

was refusing to go to bed to be changed. NA-C stated R1 had said, "do not touch me." The interview with NA-C also indicated she had to get another staff [NA-E] to put R1 to bed because R1 was refusing cares. The facility's investigation report also included an interview from NA-E which confirmed R1 was very agitated, and had taken 15-20 minutes to lay R1 down. NA-E had stated R1 was grabbing at her (NA-E) so she'd allowed R1 to hold her hands the whole time. NA-E had reported trying to calm R1 down while NA-C changed her. R1 was talking of random things such as car, house, blue car. Both NA-C and NA-E stated they'd noticed a bump on R1's forehead and claimed they'd updated the nurse on duty.

R1's 30-day Minimum Data Set (MDS) assessment dated 4/22/19, included diagnoses of Alzheimer's disease and fractures. The MDS also indicated R1 had moderate cognitive impairment, did not have any verbal, physical, or rejection of care behaviors, and indicated wandering had occurred during 1 to 3 days out of 7 days in the assessment period. The MDS further indicated R1 required extensive assistance from one staff for dressing and limited assistance for transfers, bed mobility, toileting and personal hygiene.

R1's vulnerable adult care plan dated 4/12/19, included: "I am considered a vulnerable adult due to my need for inpatient therapy and some assistance with my daily care needs. I am at risk for elopement. I am not at risk of harming others or myself. I would not be able to report maltreatment d/t (due to) dx (diagnosis) of dementia." The care plan directed all staff to keep her safe, upon notification of possible/actual Vulnerable Adult incident; immediately assess,

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F 600	Continued From page 5	F 600		

prevent further harm and notify the Community Leader [administrator], and Remove me from an actual or potentially dangerous situations. The care plan also indicated R1 had cognitive impairment and indicated staff were to speak in a calm voice, reorient as needed/appropriate, allow resident choices offering no more than 2 at a time to prevent overwhelming with decision making. Reproach if resident becomes overly anxious and keep her informed of what is happening. [R1] would like staff to allow her to express herself because [R1] is at risk for both receptive and expressive communication problems. The care plan also indicated R1 had impaired visual function and can see objects/shapes/light/dark; required assistance with one caregiver for dressing and toilet use; Uses a FWW (front wheeled walker) to ambulate to and from the bathroom; Had a potential for disruptive behaviors, and would like staff to be aware of when she may be becoming more agitated/distressed. Care plan approaches indicated staff were to reassure and reproach the resident as necessary and to explain the reasons for both care and other interventions.

R1's Visual/Bedside Kardex Report (used by nursing staff), hung outside the resident's room. Information on the Kardex indicated staff are to speak in calm clear voice, reorient as needed/appropriate, allow resident choices- offer no more than 2 at a time, to prevent problems with decision-making. Re-approach if resident becomes overly agitated and keep her informed of what is happening. In addition, the Kardex indicated R1's toileting would be done by one caregiver, and use of gait belt with FWW to ambulate to/from bathroom.

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F 600	Continued From page 6	F 600		

A Police Department event report dated 5/11/19 regarding an incident for R1, indicated an officer had been dispatched to the facility on 5/11/19 at 3:15 p.m. to respond to an allegation of assault. After interviews, the officer's conclusion indicated there was "no evidence to indicate an assault occurred. Case status is unfounded." The police report included interviews with family members, staff and residents:

Family member (FM)-A interview indicated FM-A had last seen R1 5/9/19, and R1 had been fine. FM-A reported when visiting R1 today [5/11/19], there were "beating marks" on R1's forehead and face. FM-A was alarmed because the marks hadn't been there Thursday [5/9/19], and no one called FM-A to update about any injuries to R1. FM-A had also reported a "softball sized" bruise on R1's left shin. FM-A was concerned R1 had been kicked. The interview documentation indicated FM-A had stated R1 had her own room and someone was assisting her 24/7. FM-A had reported not feeling the injuries were consistent with a fall. FM-A had reported, "A few years ago a similar incident with [R1]'s husband occurred."

Licensed practical nurse (LPN)-A had reported to the police officer that R1 was normally 1:1 to make sure R1 does not wander or fall. LPN-A had reported if there was a shortage, staff members would check in R1's room frequently because "[R1] is quick." LPN-A had also reported R1 made frequent trips to the bathroom although she was supposed to press the call button for staff to assist. LPN-A reported during the police interview R1 yells often and will aggressively yell when she doesn't want something. LPN-A said she had been at work at 5:50 a.m. on date of allegation and R1 was already up walking around.

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

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Registered nurse (RN)-A had reported to the police officer she'd seen R1 the night prior and had not noticed any marks on the resident at that time even when she was helping with R1's neck brace. RN-A had reported to the police she understood R1's family was upset because of an incident that happened a few years ago with R1's husband. RN-A also reported R1 was supposed to be on 1 to 1 because she would wander into other residents' rooms. RN-A had further reported there was insufficient staff the previous day to ensure a 1-to-1. RN-A reported an employee who came in that morning [5/11/19] had noticed the marks on R1's forehead and had asked night shift nursing assistant (NA)-C about it. RN-A reported NA-C had told that employee she did not know how it had happened, and NA-C had told the employee she'd been with R1 all night. RN-A said R1 made a comment at the lunch table asking another resident, "Have you ever seen blood on a black person before." [NA-C and NA-E are both black.] RN-A had reported R1's injuries must have happened sometime overnight. Finally, RN-A verified NA-C and NA-E had been placed on leave until the investigation is completed.

The police officer's report indicated all R1's scratches were scabbed over, but were still slightly red in color. R1 had a softball sized bruise on her left shin, which was purple and blue in color. The officer documented R1's answers to the officer's questions were inconsistent, although when the officer had asked R1, "Did someone give you those scratches?" R1 answered, "like if there was a girl getting raped, that was it." R1 had stated not knowing how it had ever gotten to that point. The officer asked, "Can you describe the

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person who gave you the marks on your forehead?" R1 answered, "He was kind of "starky [starkly]" and thinks they were both there. They were so, "hard fisting back and forth." Officer asked, "They were fighting?" R1 said, yes with her. A guy in the back was twisting arms and legs. The officer asked R1, "Did you fight with someone last night?" R1 said, "between the two of them they 'beat the hell outta me"

Documentation indicated NA-E had also been interviewed by the police officer. NA-E had reported to the officer R1 was "antsy" that night, did not have a good day according to the day shift, and was rather agitated. NA-E reported having helped R1 to bed around 2:00 a.m. at which time NA-E reported having noticed the small bump on R1's forehead when they [NA-C and NA-E] put R1 to bed. NA-E also told the police officer R1 was supposed to be 1 to 1 during the day, but did not think they had someone with her that day due to staff shortages.

Documentation indicated NA-C was interviewed by the police officer. NA-C said there was a "lady" that was up all night and refused to go to bed. NA-C reported she'd been with the "lady" the whole night walking around and being out in the common area. NA-C described the "lady" as wearing a neck brace and walking with her head down a lot. NA-C further identified the "lady" as R1, and reported R1 had been screaming about not wanting to go to bed and had not wanted NA-C or NA-E to check to see if she had peed herself. NA-C told the police officer she had finally grabbed a wheelchair and they helped R1 back to her room. NA-C stated they'd put R1 to bed around 1:49 a.m. and NA-C reported she'd noticed a bruise on R1's forehead when she put

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her to bed. The documentation indicated NA-C did not remember seeing a bruise on R1's forehead when she'd arrived for work at 6:00 p.m.

R1 skin observation record was reviewed from 4/16/19-5/28/19. NA-B who worked on R1's unit documented:
-5/10/19 none of the above observed
-5/11/19 scratched
-5/15/19 scratched

R1's PN reviewed from 4/16/19-5/24/19, included:

A PN from 5/9/19, indicated R1's skin inspection was completed that evening after a shower; "[R1's] skin is pink, warm, dry and intact overall. Scab over right elbow, small older bruise turning yellow on hip, no other concerns."

R1's PN dated on 5/11/19, at 11:30 a.m. included, "There is a bruise on her left lateral leg that is black is 5 x 2 inches. The abrasion on the left side of the head is 0.5 x 0.5 cm (centimeters). The abrasion in the middle of the forehead is 4 cm x 1 cm. The lacerations on the right side of the head, one is 1 cm, and the other is 2.5 cm.

NA-E was interviewed on 5/23/19 at 1:49 pm. NA-E verified having worked the overnight shift on Friday 5/10-Saturday 5/11/19. NA-E stated she'd been told not to come back to work until an investigation related to R1's injuries had been completed. NA-E said she'd seen the scratches on R1's forehead but had not reported them because she'd only gone over to help NA-C get R1 to bed. NA-E reiterated she'd been working on the other side, and did not report because she thought other staff had reported it already. When

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asked how R1 had acted the night she'd assisted her to bed, NA-E said R1 had been agitated, confused, not making sense, and had been walking around up and down the halls from what she could see from her unit. NA-E stated she'd assisted NA-C with getting R1 to bed and once in bed they had changed R1. NA-E said R1 was holding her (NA-E)'s hands and said R1 was talking about random things such as blue car and billing. NA-E stated when they had provided pericare the light was on low but she had noticed a scratch on R1's forehead and had asked R1 what had happened, but R1did not know. NA-E stated, "This happened about 1-2 a.m." when NA-E helped NA-C with R1 and noticed the forehead, NA-E stated no blood was noticed.

During an interview on 5/23/19, at 2:13 p.m. FM-A acknowledged having visited R1 on 5/11/19, at 11:30 a.m. FM-A stated R1's face was messed up and that she'd taken pictures. FM-A stated NA-D had reported to her she'd started her day at 6:00 a. m. and had helped R1 get ready for the day, but there was no communication to the nurses regarding R1 injuries to her face. FM-A said, "I would have thought someone would have noticed." FM-A stated R1 "would have to have fallen several times to get those injuries." FM-A also said she'd received a call from staff the Monday before the incident (5/6/19), letting her know they were going to place R1 on one to one (1:1) supervision because R1 was wandering, and stated they also placed an ankle bracelet on R1. FM-A said staff have since told her no one is aware why there was no 1:1 with R1 the night of the incident.

During an interview on 5/24/19, at 8:05 a. m. NA-C stated, "Unfortunately the incident

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happened on my shift. [R1] was supposed to be on 1:1, but no one was available." NA-C said she had noticed the bruise on R1's forehead at about 1:45 a.m. NA-C added, "She [R1] is usually continent, but she was incontinent that night and does not like people touching her. [R1] was walking around with her walker when another resident called her (NA-C) to tell her [R1] had to go to the bathroom." NA-C said she'd said to R1 "Let's go to the bathroom." NA-C said she could tell R1 was incontinent because she'd felt R1's disposable underwear over her pants. NA-C said R1 had stated, "No, no, no, no, no" when NA-C took R1 to her the room. NA-C stated she'd tried to put R1 in bed but R1 kept saying " no no" when NA-C tried to lay R1 down. NA-C then said if she could not get R1 to bed, she couldn't change her and stated it was hard to put R1 to bed. When NA-C was asked what R1 was doing while she was trying to get her in her room, NA-C said R1 was pushing her away, but stated R1was not strong enough to hurt her (NA-C). NA-C also stated R1 was moving her arms and kept saying "no, I don't want to go with you." NA-C said when R1 wouldn't go to bed, she (NA-C) had called NA-E from the other unit to help her. When asked how the two of them got R1 to bed, NA-C said, "With one in back and one in front." NA-C said they completed it fast and flipped her in bed. NA-C added, "[R1] is not normally a two people assist." NA-C said when she first started; R1 had required limited assist, but did not like people doing stuff for her. NA-C said, "When [R1] gets like she did that night, she needs 2 assist." When questioned about the 1:1, NA-C said she did not know why R1 did not have a 1:1 that night. NA-C also stated she did not know how the bruise happened because she hadn't heard any screaming. NA-C said, "If she hurt herself, I

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would have heard her screaming, I did not hear any screaming that night, but I was not with her the whole night." NA-C said although she'd noticed the marks on R1's head, she couldn't recall whom she told. NA-C added, "It would be neglect if I kept her wet." NA-C was asked about what training she'd had to care for R1. NA-C said she had not been working at the facility long, and stated, "It's a learn as you go, depends on the residents. [R1] does not like people to do stuff for her or touch her. [R1] has no behaviors if she's in a good mood, but if she's in a bad mood, she will not let anyone touch her." NA-C said, "If I know she is dry and in a safe place, I let her be."

During a follow-up interview with NA-E on 5/24/19 at 9:14 a.m., NA-E again said she'd helped NA-C put R1 to bed. NA-E said R1 was already in her room sitting on her bed when she'd arrived on the unit. NA-E said both she and NA-C had tried to get R1 to roll [over], and R1 "got a hold of my hands." NA-E said R1 was saying a lot of random things. When asked how they got R1 to lay down NA-E said, "We assisted with two people, one had the shoulders and the other had the legs. NA-E said it took them about 10 minutes to lay R1 down because she was very confused. R1 walked around and stood up, sat down. When asked whether they had left the room when R1 was confused and didn't want to lay down, NA-E said no, they stayed in the room. NA-E said they finally got R1 to lay down. When asked what the resident did after she laid down, NA-E said, "We would roll her over and she (R1) would roll her self back onto her back saying, "NO". We would try to roll over again, and R1 would not roll over. NA-E stated she had held onto NA-E hands, because she [R1] kept moving over onto her back and would not move onto the other side so they

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could change her pants. When asked how R1 had acted while they were changing her, NA-E said, "She calmed down after we changed her but was still agitated during it and was saying random things." NA-E said, "[R1] would not roll over, she grabbed my hands hard, before that she was moving her hands and arms around." NA-E said R1 was talking and mumbling and NA-E said at one time she thought R1 was going to hit herself in the face. NA-E verified during interview she had received training to let residents calm down. When asked whether she'd done this for R1, NA-E confirmed she had not left R1 alone to calm down, but had stayed in the room until the cares were done. NA-E said she'd stayed with R1 because R1 had ahold of her (NA-E) arms. NA-E said NA-C had stepped away from the bed but remained in the room.

During an interview on 5/24/19 at 2:22 p.m., the director of nurses (DON) said she was aware of the incident with R1. The DON said they had investigated the incident and found there was no indication someone hurt R1. The DON said most likely R1 hit a corner or scratched herself. The facility found no evidence of wrongdoing. When asked about training provided for staff to deal with resident with behaviors, the DON said, "During interviews about incidents we take the opportunity to educate staff during the interviews". The DON said the alleged perpetrators (AP)'s were taken off the schedule during the investigation, but verified there had been no monitoring put in place for the two NA's and confirmed they had been allowed to come back and work with R1 without any additional monitoring. The DON stated she was unaware of R1 refusals of care that night (5/10-5/11/19), until the investigation of the incident was completed. The DON said she would

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expect staff to document refusals, not to pressure the resident, and to give the resident a little time to calm down if the resident continued to refuse. In addition, the DON said she would not expect staff to force a resident to be changed even if they were incontinent, if the resident had refused to be changed initially. The DON said R1's 1:1 supervision had started 5/7/19, because she was falling and had begun wandering. The DON was updated about staff indicating R1 was made to roll back and forth to change her, even though the resident had refused. The DON said she was surprised to hear that, and said residents would only have 2 staff instead of 1 in a unsafe situation. The DON also stated she wouldn't expect anyone to be forced to have his or her pants changed.

During interview on 5/24/19, at 2:55 p.m., the DON stated, "We cannot neglect the other residents because of having to have a one to one for R1. We would always try to have a person in sight of the resident requiring one to one and if we do not have the staff, we have someone check on the resident frequently. I do not always have staff to provide one to one. It is kind of a tuff thing."

In a follow up interview on 5/24/19 at 4:12 p.m., the DON provided documentation to verify there had been no 1:1 scheduled for the night shift 5/10-5/11/19.

The IJ was removed on 5/26/19, at 1:20 p.m. when implementation of an acceptable removal plan could be verified: NA-C and NA-E were removed from the schedule to complete additional training and education, and monitoring was identified to be completed each shift worked

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F 600	Continued From page 15 for one month. In addition, all staff on the unit were retrained about how to respect resident choices, and staff received education to confirm the use of force during provision of care would be unacceptable. The facility's policy and procedures related to Skin Injury and Abuse Prevention were reviewed for adequacy, and staff were provided training. All residents on the unit were assessed and interviewed as able to help determine the impact, or any concerns about harm related to care provided by NA-C and NA-E.	F 600		
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under	F 843		7/2/19

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F 843	Continued From page 16 §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a written agreement with a hospital approved for participation under Medicare or Medicaid programs, which reasonably ensured that residents would be transferred to the hospital and ensured timely admission. This had potential to affect all 153 residents in the facility who could require hospitalization on an emergent basis. Findings include: During the extended survey on 5/28/19, evidence was requested from the community leader to demonstrate the facility had a transfer agreement in place with a local Medicare/Medicaid participating hospital entity. During interview on 5/28/19 at 10:48 a.m., the community leader stated the facility did not have a hospital transfer agreement in place.	F 843	F843 Samaritan Bethany strives to ensure that we have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs. A transfer agreement with executed with Mayo Clinic with Olmsted Medical Center. All staff in-services will be held on June 27th and 28th 2019 to review F843 and the plan of correction. The same information will be provided for staff review in each neighborhood. Community Leader will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 7/2/19	
F 846 SS=C	Facility Closure CFR(s): 483.70(m) §483.70(m) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility	F 846		7/2/19

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F 846	Continued From page 17 closure, as required at paragraph (l) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a facility closure policy and procedure had been developed. This had the potential to effect all residents residing in the building. Findings include: A policy and procedure covering facility closure was requested from the facility but facility failed to provide such documentation. According to an interview 5/29/19, 3:10 p.m. Administrator stated, "We don't have a policy related to that, I'm sorry."	F 846	F 846 Samaritan Bethany strives to have policies and procedures in place to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure. A Facility Closure Policy was created on 6/25/19. All staff in-services will be held on June 27th and 28th 2019 to review F846 and the plan of correction. The same information will be provided for staff review in each neighborhood. Community Leader will monitor for compliance. Findings will be reported at Quality Assurance Committee meetings. Date of completion: 7/2/19	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 16, 2019

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

Re: Project Number H553946C

Dear Administrator:

The above facility survey was completed on May 28, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H553946C. Complaint H5530046C was substantiated with no corresponding licensing order issued.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
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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 05/28/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 5/23, 5/24, 5/26 and 5/28/19 an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found not to be in compliance with the MN state licensure. Complaint H5530046C was substantiated with no corresponding licensing order issued.	2 000		

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2 000	Continued From page 1 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		