

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 11, 2021

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

RE: CCN: 245530 Cycle Start Date: April 20, 2021

Dear Administrator:

On April 20, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 20, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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In addition, if substantial compliance with the regulations is not verified by October 20, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			1		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	`́сом	E SURVEY IPLETED
		245530	B. WING				C 20/2021
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	E ON EIGHTH			- 8TH STREET NORTHWEST OCHESTER, MN 55901		
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F 000	INITIAL COMMEN	rs	F 0	00			
	abbreviated survey facility. Your facility compliance with the	4/20/2021, a standard was conducted at your was found to be NOT in e requirements of 42 CFR equirements for Long Term					
	SUBSTANTIATED: H55300065C (MN7 (MN56161) with a of F584, and F684	71916) and H55300067C deficiencies cited at F557, 68831) no corresponding					
	The following comp UNSUBSTANTIATI H55300068C (MN6						
	5 1	f correction (POC) will serve of compliance upon the otance.					
	signature is not req page of the CMS-2	nrolled in ePOC, your juired at the bottom of the first 567 form. Your electronic POC will be used as pliance.					
F 550 SS=D	an onsite revisit of to validate substan- regulations has bee Resident Rights/Ex CFR(s): 483.10(a)(rercise of Rights 1)(2)(b)(1)(2)	F 5	50			6/4/21
	§483.10(a) Resider	C C					
		ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE		TITLE		(X6) DATE
Electron	ically Signed						05/21/2021

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

PRINTED: 05/28/2021

		AND HUMAN SERVICES				FORM	: 05/28/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED C
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F 550	The resident has a self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A face with respect and digresident in a manner promotes maintenather quality of life, resident in a manner promote smaintenather quality of life, resident in a manner quality of life, resident the rights of \$483.10(a)(2) The facess to quality caseverity of condition must establish and practices regarding provision of service residents regardless §483.10(b) Exercises The resident has the rights as a resident or resident of the U §483.10(b)(1) The faces from the facility. §483.10(b)(2) The faces of the face of interference interference reprisal from the facility.	right to a dignified existence, and communication with and and services inside and including those specified in cility must treat each resident gnity and care for each er and in an environment that unce or enhancement of his or ecognizing each resident's ucility must protect and of the resident. facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the es under the State plan for all as of payment source. e of Rights. he right to exercise his or her of the facility and as a citizen	F	550			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
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F 550	by: Based on observat review the facility fa 1 resident (R1) who and stained carpet. Findings include During an observat 4/19/2021, at 8:50 a upon entry to the ro present; the odor si her reclining chair of known as a soaker from incontinence); on the floor under F was partially undern the pad had differen R1 was asked why what was underneat underneath, had be admitted, and the fl and picked up the si was more prominent the floor. The pad of approximately 2 fee black that was mois covered the area w stated she did not k carpet was deep cle cleaned it herself. F carpet. During a sul p.m. R1 sat in her of	NT is not met as evidenced tion, interview, and document ailed to ensure dignity for 1 of b had an offensive room odors ion and interview on a.m. R1's door was closed, oom a very strong odor was melt like stale urine. R1 sat in on a washable bed pad (also pad-used to protect mattress there was also a soaker pad R1's feet. The pad on the floor neath the recliner; that area of nt shades of brown markings. the pad was on the floor and ath, R1 stated there was mold een there since she was oor was leaking. R1 bent over soaker off the floor; the odor nt when the pad was lifted off covered a large area that was et in diameter that was dark st. The back of the pad that as yellow and brown. R1 know when the last time her eaned/shampooed, and she R1 indicated she wanted new bsequent interview at 1:45 chair, she was informed ices was going to clean her oh good, I hope they can take	F 5	 F550 F550 Resident Rights/Exercise Samaritan Bethany strive resident has a right to a d existence, self-determinat communication with and a persons and services insi the facility. R1's carpet was cleaned environmental services on carpet cleaning company care team along with the resident agreed on the fol cleaning schedule: R1's r cleaned twice a week with occurring on an as neede as twice a month by envir services. R1's room odor improved. Samaritan Beth with Hillers Flooring to rep carpet. The Carpet Cleaning polia and found appropriate. 5th neighborhood staff wee 4/23 and 4/26 regarding F cares/services and appro approach R1 when care/s declined. All neighborhood staff will 5/27/21 and 5/28/21 on F resident room cleaning pr approaches for residents care/services. Neighborhood audits will 	s to ensure each ignified tion, and access to de and outside by n 4/19/21. R1's oy an outside on 4/28/21. The family and llowing room oom will be n carpet cleaning d basis as well onmental has significantly nany is working blace R1's cy was reviewed ere educated on R1's declining of aches for how to services are l be educated on 550 along with ocedures and who decline		

Facility ID: 00427

TATEMENT		K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
	ST CONNECTION	DENTITIOATION NOMBER.	A. BUILDI	NG_		(
		245530	B. WING				20/2021
NAME OF	PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH			4 - 8TH STREET NORTHWEST OCHESTER, MN 55901		
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F 550	family has told me it really bad." R1 le pad covering the st bad I just can't star embarrassing. R1's face sheet inc generalized anxiety (fear of certain plac person believes is of spaces) R1's quarterly Minit 4/7/2021, indicated impairment and did behaviors. The MD independent ambul hygiene, and toileti was frequently inco occasionally incont R1's care plan inclu room and bathroom know I'm incontiner emesis on any give to it some days. Sta cleaning myself up myself, which in tur which I understand environment." The directed staff to re- During an interview nursing assistant (N stated the soaker p urinary overflow inc	how bad it smells, I can smell aned down and removed the cain and stated, "It gets so very ad it anymore, it's just so Udded diagnoses of disorder and agoraphobia ces and situation that the difficult from such as public mum Data Set (MDS) dated R1 did not have cognitive I not have rejection of care S indicated R1 was lating in her room, personal ng. The MDS identified R1 ontinent of urine and inent of bowel. uded "I allow staff to clean my n about every two weeks. I not of urine, stool, and have en day. My room has an odor aff will offer to assist me in . I usually choose to do it n causes my room to smell and I choose to live in this corresponding intervention approach later if needed. y on 4/19/2021, at 8:57 a.m. NA)-A entered the room. NA-A bad was on the floor for R1	F 5	50	Coordinators for 3 months to ensure carpets are cleaned and rooms are odor. Community Leader and Assistant 0 Mentor will monitor for compliance Findings will be reported at Quality Assurance Committee meetings. Date of completion: 6/4/21	e free of Clinical	

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		AND HUMAN SERVICES				FORM	05/28/2021 APPROVED 0938-0391
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		245530	B. WING	. <u> </u>			20/2021
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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F 550	room had an offens carpets were clean R1 was not in her r to beauty shop app cleaned the carpets the beauty shop. LF product Odor Be G soak up the urine o R1 did not always a R1 liked to do it her During an interview family member (FM very recently; R1's urine/bowel odor, a the floor. FM-A indi- discussed the conc however, didn't thin about it. During an interview registered nurse (R nurse manager for RN-A indicated stat room almost week! RN-A stated there of checklist that was of checklist outlined the each room. RN-A s surveyor; the check room numbers und did not outline spec stated NA's would of carpet cleaner for r environmental serv cleaning.	sive odor and indicated R1's ed whenever they can; when oom such as when she went pointments. LPN-A stated staff is last week when she was at PN-A stated staff used a one/biomatic and towels to on the floor. LPN-A indicated allow staff to clean her carpet;	F	550			

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TATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DA	D. 0938-039 TE SURVEY MPLETED	
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NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	•	•	
SAMARI	TAN BETHANY HOME	E ON EIGHTH	24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901				
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F 550 F 584 SS=D	environmental serv she had not been in ESP-A indicated NA to shampoo the cal unit had their own of R1's room, ESP-A foul odor. ESP-A in stained she couldn observed R1's carp seen it [stain] that b been cleaned in a l chair; there was the R1's chair. ESP-A the carpet cleaner odor/dirty carpet co other residents, and During an interview director of nursing staff to clean the ca often refuse her ca indicated that once but would have to t alternatives. Safe/Clean/Comfor CFR(s): 483.10(i)(1 §483.10(i) Safe En The resident has a comfortable and ho but not limited to re supports for daily li The facility must pr §483.10(i)(1) A safe homelike environm	ice partner (ESP)-A stated in R1's room for a long time. A's on the unit were supposed pet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were 't get the stains out. ESP-A bet and stated, "I've never black, it doesn't look like it has ong time." ESP-A moved R1's e stain extended underneath stated she was going to get now. ESP-A indicated that the buld be a health risk for R1, d staff. (DON) indicated she expected arpets however, R1 would rpets to be cleaned. DON stained, the stains do not lift, alk to maintenance for table/Homelike Environment I)-(7) vironment. right to a safe, clean, omelike environment, including ceiving treatment and ving safely.	F 554			6/4/21	

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		AND HUMAN SERVICES				FORM	05/28/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	E SURVEY PLETED
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SAMARI	TAN BETHANY HOME	ON EIGHTH			- 8TH STREET NORTHWEST OCHESTER, MN 55901		
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F 584	 (i) This includes ensireceive care and sephysical layout of the independence and (ii) The facility shall the protection of the or theft. §483.10(i)(2) House services necessary orderly, and comfore §483.10(i)(3) Clean in good condition; §483.10(i)(3) Clean in good condition; §483.10(i)(4) Private resident room, as segual areas; §483.10(i)(5) Adequation and the evels in all areas; §483.10(i)(6) Comfore levels. Facilities inite 1990 must maintain 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observate review the facility far was free from offent (R1) Findings include 	suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary,	F 5	.84	F584 Safe/Clean/Comfortable/Homelike Environment Samaritan Bethany strives to ensur resident has right to a safe, clean, comfortable and homelike environn including but not limited to receiving treatment and supports for daily livi	nent, g	

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED	
		245530	B. WING _			C 20/2021	
	PROVIDER OR SUPPLIER	E ON EIGHTH		STREET ADDRESS, CITY, STATE, ZIP 24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	CODE		
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F 584	 4/19/2021, at 8:50 a upon entry to the ropresent; the odor wher reclining chair, floor under R1's fee partially underneath pad had different slasked why the pad was underneath, R underneath and the over and picked up odor was more provided off the floor. T that was approximate was dark black that pad that covered the R1 stated she did r her carpet was dee she cleaned it hers new carpet. During an interview licensed practical n room had an offense carpets were clean R1 was not in her room had R1 was not in hero R1 was not in her room had R1 was not i	a.m. R1's door was closed, bom a very strong odor was vas like stale urine. R1 sat in there was also a pad on the et. The pad on the floor was in the recliner; that area of the hades of brown. R1 was was on the floor and what 1 stated there was mold e floor was leaking. R1 bent the soaker off the floor; the minent when the pad was The pad covered a large area ately 2 feet in diameter that t was moist. The back of the he area was yellow and brown. not know when the last time ep cleaned/shampooed, and elf. R1 indicated she wanted on 4/19/2021, at 8:57 a.m. NA)-A entered the room. NA-A on the floor for R1 urinary nee. NA-A stated R1 toileted ed she did not want staff to of 00 4/19/2021, at 10:04 a.m. nurse (LPN)-A confirmed R1's sive odor and indicated R1's ed whenever they can; when oom such as when she went	F 58	 safely. R1's carpet was cleaned be environmental services on carpet was also cleaned be carpet cleaning company of care team along with the faresident agreed on the foll cleaning schedule: R1's roce cleaned twice a week with occurring on an as needed as twice a month by envirous services. R1's room odor here to the foll of the services. R1's room odor here to the services and the services and the services and approved. Samaritan Beth with Hillers Flooring to reprearpet. The Carpet Cleaning policies and found appropriate. 5th neighborhood staff were 4/23 and 4/26 regarding R cares/services and approach R1 when care/services and approach R1 when care/services. All neighborhood staff will 5/27/21 and 5/28/21 on F5 resident room cleaning proceare/services. Neighborhood audits will be reported and roodor. Community Leader and As Mentor will monitor for com Findings will be reported a Assurance Committee me Date of completion: 6/4/2* 	4/19/21. R1's y an outside on 4/28/21. The amily and owing room oom will be carpet cleaning d basis as well onmental has significantly any is working lace R1's y was reviewed re educated on 1's declining of thes for how to ervices are be educated on 84 along with ocedures and who decline be conducted by rs and Care to ensure boms are free of esistant Clinical npliance. t Quality etings.		

Facility ID: 00427

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		AND HUMAN SERVICES				FORM	: 05/28/2021 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COM	E SURVEY IPLETED C
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F 584	there was a soaker indicated she had h concern with the nu- think anything had During an interview registered nurse (R nurse manager for RN-A indicated staf room almost weekly RN-A stated there w checklist that was of checklist that was of checklist outlined th each room. RN-A s carpet using the ca cleaning and enviro the deep carpet cle During an interview environmental serv she had not been in ESP-A indicated NA to shampoo the car unit had their own of R1's room, ESP-A in stained she couldn' observed R1's carp seen it [stain] that b been cleaned in a la chair; there was the R1's chair. ESP-A s the carpet cleaner n odor/dirty carpet co other residents, and During an observat R1 had been move	 pad on the floor. FM-A instorically discussed the urse manager however, didn't been done about it. on 4/19/2021, at 10:45 a.m. cN)-A stated she was the the unit where R1 resided. ff would attempt to clean R1's y and when R1 would allow. was a daily and a weekly completed by NA's; the ne cleaning schedules for tated NA's would clean the rpet cleaner for routine onmental services would do aning. on 4/19/2021, at 2:30 p.m. ice partner (ESP)-A stated in R1's room for a long time. A's on the unit were supposed rpet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were 't get the stains out. ESP-A bet and stated, "I've never black, it doesn't look like it has ong time." ESP-A moved R1's e stain extended underneath stated she was going to get now. ESP-A indicated that the buld be a health risk for R1, 	F	584			

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		AND HUMAN SERVICES				FORM	: 05/28/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	`´CO№	E SURVEY IPLETED
		245530	B. WING				20/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH			4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 584	after cleaned. R1's odor was now notic of R1's room; inside unchanged from 4/ the area of carpet to black. During an interview neighborhood coord was responsible for checklist for comple manager. NC-A sta shampoo carpets a once per month. W checklist when was shampooed, NC-A the last time the car cleaned/shampooe indicated that just to informed environme responsible for the stock the supplies f During an interview director of nursing (staff to clean the car often refuse her car indicated that once but would have to to alternatives. Facility policy Carpe included: Samaritan to ensure carpet in and maintained. 1. Household carpe each neighborhood	room door was opened, the ceable in the hallway outside e R1's room the odor was 19, industrial fans pointed at hat continued to be a dark of on 4/20/2021, at 8:35 a.m. dinator (NC)-A indicated she r reviewing and auditing etion along with the unit nurse ted NA's were supposed to as needed and deep cleaned hen asked, Based on the s the last time the carpets were stated she could not tell when	F	584			

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER	240000		STREET ADDRESS, CITY, STATE, ZIP COI		20/2021
	TAN BETHANY HOME	ON EIGHTH		24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 584	- 1	ea needs further cleaning by	F 58	34		
F 684 SS=D			F 68	34		6/4/21
	applies to all treatm facility residents. Ba assessment of a re- that residents recei accordance with pro- practice, the compri- care plan, and the re- This REQUIREMEN by: Based on observat review the facility fa comprehensively as behaviors of self-ne- behaviors for 1 of 1 worsening non-press resided in a room w unmanaged inconti Findings include R1's quarterly Minina assessment dated of have cognitive impare rejection of care be R1 was independer personal hygiene, a identified R1 was fr and occasionally in also indicated R1 h	NT is not met as evidenced tion, interview, and document ailed to identify, ssess, monitor, and manage eglect and/or rejection of care residents (R1) who had ssure related wounds and <i>v</i> ith odors as a result of		F684 Quality of Care Quality of care is a fundamer that applies to all treatment a provided to residents. Based comprehensive assessment the facility must ensure that r receive treatment and care ir with professional standards of the comprehensive person-or plan, and the residents' choid Several areas of self-neglect reviewed and the following its implemented based on R1's R1's care plan for Mood/Beh updated on 4/23/21 and the of plan was updated on 5/21/21 shower was changed to Tues mornings per R1's request or 5/18/21 a skin assessment w completed. On 5/21/21 a blad assessment was initiated. Or	nd care on the of a resident, esidents a accordance of practice, entered care ces. for R1 were ems preferences: avior was overall care . R1's cay o 5/4/21. On as dder	

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245530	B. WING _			C 20/2021
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE
F 684	ointments/medication R1's face sheet inc agoraphobia (extreme entering open or cre- one's own home, of escape is difficult), dependence, venous chronic ulcer of low and morbid obesity During an interview family member (FM to the long term car assisted living when incontinence, woun which caused healt required long term self-neglect behavion making good decisi and didn't have the R1 had a strong pe redirect. FM-1 state R1 could not be giv cares because she to be direct with he dressing change" n change?", stated st FM-1 indicated the interventions with h refusals. FM-1 state recently; R1's room urine/bowel odor, a the floor. FM-1 indic discussed the conc	ans other than to feet. Iuded diagnoses of me or irrational fear of owded places, of leaving r of being in places from which anxiety disorder, opioid us insufficiency, non-pressure rer leg left leg, diabetes type II, r on 4/19/2021, at 10:16 a.m. I)-1 stated prior to admission re facility she had been in a re she was not managing her d care, and medications h problems. FM-1 stated R1 care to manage harmful ors. FM-1 stated R1 was not ions for her own well-being capacity to. FM-1 indicated rsonality, and was difficult to ad she has informed the facility would not do it, staff needed r and say "It's time to do your ot "Is it ok to do your dressing aff also have to be persistent. facility had not discussed new er in order to manage R1's ed she had visited R1 very	F 68	 3x/week per NP. An order on 5/20 to conduct ST for 5/14/21 the LacHydrin treachanged from evenings to Treatments to R1's lower was changed from evenin 4/23/21. R1's skin check w from evenings to days on wraps and elevation of low order was changed to PR NP dictation was received outlining R1's choices of of choice to reject or decline reviewing the risks of thos is scheduled to visit R1 or review overall goals of car bladder incontinence and order changes as a result implemented. All neighborhood staff will 5/27/21 and 5/28/21 on F6 comprehensive assessme approaches for residents pattern of self-neglect and care. Care Coordinators will be education on 6/3/21 on the comprehensively assessing display a pattern of self-neglect rejection of care. Neighborhood audits will I Care Coordinators and As Mentor for 3 months to en comprehensive assessme completed for those reside a pattern of self-neglect and care. 	a MOCA. On atment was o days. extremity wound gs to days on was changed 5/4/21. R1's leg ver extremity N on 5/20/21. on 5/19/21 care including care as well as se choices. NP o 5/21/21 to re including orders. Any will be be educated on 684 including ents and that display a l/or rejection of provided e process of ng residents that eglect and/or be conducted sistant Clinical sure ents are ents that display	

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TATEMEN	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED		
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		245530		STREET ADDRESS, CITY, STATE, ZIP CODE	•	/20/2021	
	PROVIDER OR SUPPLIER	ON EIGHTH		24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901			
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F 684	R1's urinary inconti (CAA) dated 7/13/2 actual problem with CAA indicated cont psychological/psyc restricted mobility. is able to ask for as MDS note 7/7/2020 transfers and ambu alerting staff. Staff a as needed." R1's p 7/13/2020, included venous ulcers bilate treatments and are [registered nurse]. skin breakdown an ulcers related to im incontinence, obes Physician orders in -Lasix 40 milligram bilateral lower extre 1/25/2021) -lac-hydrin 12% lott calloused/thickened shift (start date 7/12 -Bilateral knee-higf until stockingettes a 9/24/2020) -To bilateral venous normal saline, pat of dressing cut to wou wound with barrier non-adherent gauz and as needed for -Left foot ulcer: size	nence Care Area Assessment 2020, identified R1 had an a urinary incontinence. The ributing modifiable factors as hiatric problems, pain, and The CAA included, "Resident asistance as needed but her b she chooses to initiate alation in her room without assist with incontinence care ressure ulcer/injury CAA dated d "Resident has 3 chronic erally that have daily assessed periodically by RN Resident is at risk for further d the development of pressure paired mobility and ity, other diagnosis" cluded: s (mg) one time a day for emity edema (start date ton apply daily to d skin on toes every evening 8/2020) n stretch compression wraps arrive twice per day (start date s ulcers cleanse daily with dry, apply calcium alginate and bed size, spray around the spray to dry, cover with e and secure with kerlix daily soiling (start date 5/2/2020) e unknown. Depth than 0.2 cm. Cleansed daily	F 684	4 Mentor will monitor for complia Findings will be reported at Qu Assurance Committee meeting Date of completion: 6/4/21	ality		

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245530			04	C / 20/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		20/2021
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F 684	Continued From page 13 with non-adherent gauze, and secure with kerlix one time a day (start date 9/11/2020) R1's March and April medication/treatment administration records were reviewed in combination with nursing progress notes; the records identified multiple refusals/rejection of physician ordered treatments without consistent or sufficient documentation of attempted interventions. The records also lacked evidence R1 was consistently provided with education of risks versus benefits and lacked evidence the physician was notified of the rejection/refusals of care. In addition, R1's record lacked evidence of analysis of R1's rejection/refusal behaviors in order to determine if R1's behavior was worsening/increasing in frequency or improving/decreasing in frequency and what if any impact the rejection/refusal behaviors had on meeting R1's care plan goals for safety, dignity, urinary incontinence and wound management.			84		
	March MAR identified the following: -Daily weights; 3/5/2021 was left blank and indicated R1 refused to be weighed 28 times (weighed only twice) -Lac-Hydrin; R1 refused/rejected the medication 11 times March TAR identified the following: -Left foot ulcer treatment: 3/10 and 3/11/2021 boxes were left blank, R1 refused/rejected treatment 12 times. -Lower extremity venous treatment orders: 3/10 and 3/11/2021 boxes were left blank, R1 refused/rejected treatment 11 times. -Knee high stretch compression wraps: R1 refused/rejected treatment 25 times out of 31					

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		245530	B. WING				_ 20/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SAMARI	TAN BETHANY HOME	ON EIGHTH			4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From pa opportunities.	ge 14	F	684			
	was left blank and r which totaled 18 da -low extremity veno 9 out of 20 opportur -Left foot ulcer treat out of 20 opportunit April MAR identified	compression wraps; R1 4/9/21 refused/rejected all other days ys. us ulcers: R1 refused/rejected nities tment; R1 refused/rejected 8 ies					
	opportunities -Daily weights; R1 r weighed twice, 4/9/	refused/rejected 18 times, was 2021 was left blank. 7/8/20202, 10/7/2020, and					
	1/5/2021 did not ide and despite docume multiple rejection/re	entify R1 rejected refused care entation in R1's record of fusals the MDS dated refusals behaviors was not					
	included "resident h extremity] edema b wraps when offered independent with to bowel and bladder i accept help from ca "Resident chooses ambulation in her ro understands the ris refuses wound care give her a shower s	a note dated 4/5/2021, has BLE [bilateral lower ut declines compression " and "Resident is hileting but has episodes of incontinence but will not aregivers for peri care." and to initiate self-transfers and bom without alerting staff and ks." and Resident often and does not allow staff to stating that she gives herself a and does not need us to look					

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F 684	Continued From pa	ge 15	F	684			
	Shared Risk Agreer representative on 4 1/19/2021, indicated benefits of refusing transfer. The asses understood the pote this choice that inclu- dislocation of bones R1's care plan date exercise my right to sometimes chosen offer. I have decline R1's goal was not to consequences relat Corresponding inter- continue to offer ca date 7/12/2019) -Do not judge me [F 7/12/2019) -Explain the need to consequences to sk bathing (start date 7 -I allow staff to clea about every two we urine, stool, and ha My room has an od offer to assist me in choose to do it mys room to smell which live in this environm -Re-approach later 7/12/2019) Bathing	ential negative outcomes of uded falls fracture, cuts, s, up to death. ed 7/12/2021, included "[R1] o make decisions. I have to not accept cares that staff ed a shower or bath at times. o experience adverse ted to her decisions. rventions included: ares and bath/showers (start R1] for my decision (start date o be clean and the kin integrity and self due to not					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/28/2021 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		245530	B. WING				20/2021	
NAME OF	PROVIDER OR SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE			
SAMARI	TAN BETHANY HOME	ON EIGHTH			4 - 8TH STREET NORTHWEST COCHESTER, MN 55901			
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F 684	weekly bathing in M lacked evidence R1 lacked attempts ma interventions. -Bath/Skin note dat "resident was offere evening shift and re was not completed, extremity} treatmen -Bath/Skin note dat "Resident refused s well as skin check" refused dressing ch -Bath/skin note date went to see if reside assess skin head a this time "no" Will c and any other day i -Bath/skin note date shower/bath was gi dressing changes. -Bath/skin note date shower/bath was gi dressing changes. -Bath/skin note date want to be disturbed Wound Care R1's skin care plan R1 had wounds to k R1's goal was to ha wounds. Correspon keep skin clean and monitor and report a to physician.	larch and April. The record was provided education and ide to attempt new ed 3/2/2021, included ad her regular shower this efused. A skin assessment however, BLE [bilateral lower ts were completed." ed 3/9/2021, included shower evening of 3/9/2021 as The note also indicated R1 hanges to her leg wounds. ed 3/22/2021, included "Writer ent would allow writer to nd toes. Resident chose at ontinue to try on bath days f resident allows." ed 3/28/2021, did not identify if ven, however R1 refused ed 4/6/2021, included bath/shower. She also refused ound dressing change. She o her stomach and does not	F	584				

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/28/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	Сом	E SURVEY PLETED C
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F 684	treatments. The not interventions aside education and risk not include/identify evidence of new rea attempted and/or of additional wound to 3/19 to 4/15 and incleg wound had dete R1's Wound/Pressu 3/19/2021, included 8.7 cm area, 5.2 cm bottom wound mea length, and 1.1 cm measured 4.2 cm a width, right inner wo 0.9 cm length, 0.5 c odor with a tan drai is pink/red in color. the wounds were cl The note also includ lumpy today. Little I leg with no drainage R1's Wound/Pressu included; Left out lo 8.0 cm area, 4.7 cm 20% granulation an Bottom wound on le 1.6 cm area, 2.3 cm 90% slough and 10 leg measured 6.0 c width, 50% granula lower legs still red a pitting edema noted	that R1 had rejected/refused tes did not identify from R1 was provided versus benefits; the record did root cause of refusals and/or visions to the care plan were ffered. The notes identified an the left lower extremity from dicated the wounds to the right eriorated between those dates. are Injury Note dated d; Left top wound measured h length, 2.0 cm width, left sured 1.9 cm area, 2.2 cm width. Right lower outer leg rea, 4.1 cm length, 1.4 cm bund measured 0.3 cm area, cm width. All wounds had an nage except inner right wound The note indicated that after eaned there was more odor. ded, "Surrounding skin is very ump nodules all over lower	F	584			

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TATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIO		(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245530				C 04/20/2021		
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS	S, CITY, STATE, ZIP COI		20/2021	
SAMARI	TAN BETHANY HOME	ON EIGHTH		24 - 8TH STREE ROCHESTER,				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH C	/IDER'S PLAN OF CORR CORRECTIVE ACTION S EFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 684	take part in wrappir them. "I have done help. I been to wou what to do for me." encouraged resider legs by following or educate, encourage healing her own leg treatments. Nutrition R1's nutrition note of physician decline to related to ongoing a gastrointestinal disc included, "Resident per preference and symptoms of nause not. She has margin vegetables and also Nutrition services for Incontinence R1's activities of da 1/16/2021, indicate assist with toileting initiate self- transfer also identified R1 re two wheeled walker identified R1 had bl impaired mobility ar medication. R1's go skin breakdown due Corresponding inte assistance alert nur are wet or soiled so date 1/22/2021), R ⁻	all that before and it does not all that before and it does not nd clinic and they cannot find Staff and CNP has int to take part in healing lower ders. Staff will continue to e resident to take part in gs along with present dated 4/9/2021, indicated the prescribe a multivitamin and intermittent comfort. The note also t continues to self-select food according to [gastrointestinal ea/vomiting] being present or nal intake of fruits and o declines nutritional support. blowing."	F	584				

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F 684	when she needed lepisodes. The care assist with toileting decrease episodes R1's record lacked assessment to deter incontinent episoder refusing/rejecting st bathroom. Room cleaning/offer staining. Progress note date night shift, resident herself. She was var around in her room she said she could assistant] helped in Resident insisted o she wasn't stable o on her until she we Progress note date reported that reside to kneel toward rec the seat of the chai incontinent episode staff assist with the and able to voice ho one assist with ADL Staff try to educate voice, staff to leave seen by staff vacuu "Will continue to ha and offer staff assist	ed herself and called for help ots of help with incontinent plan also instructed staff to at 6:30 a.m. and 10:00 p.m. to of incontinence. evidence of bladder ermine if R1's had increases in	F	584			

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F 684	Continued From pa	ige 20	F 684			
	rejection/refusals of toileting/ambulation environment that su control. The physici on going behaviora refusal/rejections at involvement or refe R1's physician prog indicated R1 was ca regions and had an The overview section included; Edema Sa recurrent cellulitis in Intermittently comp (multiple compression uncomfortable for huicers bilateral; dail sometimes refuse (weekends/with unfa disorder-Primary (Comissed all short-ter in drawing o'clock. In represents mild coord dementia. Function prior to cognitive dis (long-term skilled ni physical limitations) ascertain if she is fu cognitive basis. Iter importantFluctuation During an observatt 4/19/2021, at 8:50 at	nd/or professional psychiatry errals. gress notes dated 4/9/2021, allus formation to both ankle n order for lac-hydrin lotion. on of the progress note tasis bilateral (chronic) with n context of edema. liant with compression ion strategies have been her. Hyper venous chronic ly dressing- she will (per report more on amiliar staff. Cognitive Chronic) "6/2020 MOCA 14/30, m recall, declined participation Not clear at this time if this gnitive impairment or hally, she was already impaired sorder to coming to light ursing facility resident due to), so it is somewhat difficult to unctionally impaired on rative [sic] re-evaluation will be tions in cognition also likely				

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F 684	R1 sat in her reclinipad (also known as mattress from incorsoaker pad on the formal sector of the pad on the floor was pathat area of the pad brown markings. For the floor and whethere was mold under since she was admileaking. R1 bent ow off the floor; the odd the pad was lifted of large area that was diameter diameter that was diamet	vas consistent with stale urine. ing chair on a washable bed s a soaker pad-used to protect ntinence); there was also a floor under R1's feet. The pad rtially underneath the recliner; d had different shades of R1 was asked why the pad was hat was underneath, R1 stated derneath, had been there hitted, and the floor was ver and picked up the soaker or was more prominent when off the floor. The pad covered a capproximately 2 feet in dark black that was moist. The t covered the area was yellow ed she did not know when the t was deep d, and she cleaned it herself. ranted new carpet. R1 stated neerns with her care however, nges to the staff schedule and oble providing her cares. During view at 1:45 p.m. R1 sat in her rmed environmental services her carpet. R1 stated, "oh can take of the carpet, the arrassing, I can't have friends has told me how bad it smells, bad." R1 leaned down and overing the stain and stated, I I just can't stand it anymore,	F 6				

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		AND HUMAN SERVICES				FORM	05/28/2021 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245530	B. WING				20/2021
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH			24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	urinary overflow inc "was completely de R1 would say that t "she has to come u odor." NA-A stated toileting without pro- skin was checked of however R1 refused liked to do things in would refuse cares her. During an interview licensed practical n refused showers th evening. LPN-A rev indicated that it did extremities dressing 4/18/2021. During an interview LPN-A indicated R1 changes, refused s assistance, refused she would have a fa them. LPN-A stated to the facility she us LPN-A did not know showers or why. LF re-approach when s education. LPN-A c offensive odor and cleaned whenever th her room such as w appointments. LPN	continence. NA-A stated R1 elusional", and didn't know why there was mildew on the floor, p with another motive for the R1 was independent with ompting. NA-A indicated R1's on shower days by the nurse, d showers. NA-A stated R1 idependently and when she she would "conversate" with on 4/19/2021, at 9:01 a.m. urse (LPN)-A stated R1 at were scheduled in the viewed R1's record and not look like R1's lower gs were changed on on 4/19/2021, at 10:04 a.m. sometimes refused dressing howers, refused staff to allow staff to clean her to go to clinic appointments; amily member call and cancel when R1 was first admitted sed to take shower/bath; w when R1 started refusing	F	584			

Facility ID: 00427

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		AND HUMAN SERVICES			FORM	05/28/2021 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	СОМ	E SURVEY IPLETED C
		245530	B. WING			20/2021
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH		24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Gone/biometric and on the floor. LPN-A allow staff to clean herself. During an interview registered nurse (R nurse manager for RN-A stated staff g allows us to. RN-A treatment, the staff of completing the ta the staff would re-a RN-A stated R1 ref were scheduled to stated she didn't the treatment had been wounds were gettin social worker and N psych services was unawareness if R1' assessed and analy would attempt to cle and when R1 would a daily and a weekl completed by NA's; cleaning schedules the checklist to the days of the week w the day of the week cleaning tasks. RN- carpet using the ca cleaning and enviro the deep carpet cle During an interview environmental serv	d towels to soak up the urine indicated R1 did not always her carpet; R1 liked to do it on 4/19/2021, at 10:45 a.m. RN)-A stated she was the the unit where R1 resided. o into assist R1 when she stated when it's time for a would nicely present options ask now or later. RN-A stated approach if she would refuse. used dressing changes that be completed in the evening; ink changing the wound n attempted. RN-A stated R1's ng worse. RN-A stated the NP were involved, did not think is involved. RN-A indicated an 's rejection/refusals were yzed. RN-A indicated staff ean R1's room almost weekly d allow. RN-A stated there was ly checklist that was ; the checklist outlined the for each room. RN-A showed surveyor; the checklist had rith room numbers underneath k, it did not outline specific -A stated NA's would clean the rpet cleaner for routine onmental services would do	F 684	,		

Facility ID: 00427

If continuation sheet Page 24 of 27

STATEMEN	T OF DEFICIENCIES DF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245530	B. WING		C 04/20/2021		
NAME OF	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COL	-		
SAMARITAN BETHANY HOME ON EIGHTH			24 - 8TH STREET NORTHWEST ROCHESTER, MN 55901				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 684	ESP-A indicated N/ to shampoo the car unit had their own of R1's room, ESP-A in stained she couldn' observed R1's carp seen it [stain] that b been cleaned in a l chair; there was the R1's chair. ESP-A s the carpet cleaner n odor/dirty carpet co other residents, and During an interview MDS coordinator re confirmed rejection identified on the MI she was informed t a resident choice th identified on the as also indicated staff information for the the MDS. During an interview licensed social wor would complete be and implement card indicated it would b what the repercuss decisions or refusa re-approach to mar rejection/refusal. LS use indirect approa after R1 refused. LS	A's on the unit were supposed rpet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were 't get the stains out. ESP-A bet and stated, "I've never black, it doesn't look like it has ong time." ESP-A moved R1's e stain extended underneath stated she was going to get now. ESP-A indicated that the buld be a health risk for R1,	F 6				

Facility ID: 00427

If continuation sheet Page 25 of 27

		AND HUMAN SERVICES				FORM	: 05/28/2021 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	CON	E SURVEY IPLETED
		245530	B. WING				/20/2021
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH			4 - 8TH STREET NORTHWEST ROCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684		on 4/20/2021, at 1:49 p.m.	F 6	84			
	indicated R1 had th treatment/care and rejection/refusals as DON indicated she carpets however, R carpets to be clean	looked at R1's s a choice and not a behavior. expected staff to clean the the would often refuse her ed. DON indicated that once do not lift, but would have to					
	nurse practitioner s	on 4/20/2021, at 3:00 p.m. tated she was not aware that ssistance for toileting and					
	Tracking dated 12/2 presence of mood a management in ord maintain the highes and psychosocial w prevention and trea -Behavior and moor recorded in the elec chart behaviors in the occur. -The information ga resident behavioral addressed in the M upon move in, quar change. -This information is resident's provider of as needed.	avior and Mood Symptom 2020 included, To identify the and behavioral symptoms for ler for the resident to attain or st practical physical, mental, vell-being. This includes atment of mental disorders. d symptom tracking is ctronic health record. Nurses he progress notes as they athered is used to assess health needs and is DS, CAA, and the care plan terly, and with significant communicated with the during recertification visits and y approach including resident,					

Facility ID: 00427

If continuation sheet Page 26 of 27

		AND HUMAN SERVICES				FORM	05/28/2021 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COM	E SURVEY PLETED
		245530	B. WING	i			C 20/2021
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON EIGHTH			4 - 8TH STREET NORTHWEST COCHESTER, MN 55901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	their family or repre	age 26 esentative is used to address od, and psychosocial needs of	F	684			

Facility ID: 00427



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 11, 2021

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

Re: State Nursing Home Licensing Orders Event ID: CM4L11

Dear Administrator:

The above facility was surveyed on April 19, 2021 through April 20, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

<u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

Samaritan Bethany Home On Eighth May 11, 2021 Page 2

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

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

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

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

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

Please feel free to call me with any questions.

· Ping

Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

Minnesc	ota Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
,		Image: Second				
		00427	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	<u>.</u>	
CAMADI		24 - 8TH 9				
SAWARI		ROCHES	TER, MN 55	901		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defice herein are not corrected shall with a schedule of f the Minnesota Depart Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health. hether a violation has been compliance with all e rule provided at the tag ule number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon iny item of multi-part rule will ment of a fine even if the item				
	that may result fron orders provided tha the Department wit	n non-compliance with these it a written request is made to hin 15 days of receipt of a				
	was conducted at y the Minnesota Dep facility was found N State Licensure. Pl electronic plan of co these orders, and is	4/20/2021, a complaint survey rour facility by surveyors from artment of Health (MDH). Your IOT in compliance with the MN ease indicate in your prrection you have reviewed				
Minnesota D LABORATOR`	epartment of Health Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
	ically Signed					05/21/21

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If continuation sheet 1 of 27

STATEMEN	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	СОМ (°СОМ	E SURVEY PLETED
	00427 B. V		B. WING			C 20/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	ge 1	2 000			
	be completed.	-				
	SUBSTANTIATED: H55300065C (MN7 (MN56161) with lice and 1805. H55300066C (MN6 were issued					
	the State Licensing Federal software. T assigned to Minness Nursing Homes. The appears in the far le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." For findings are the Sug and Time Period for You have agreed to receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf licensing orders are				

CM4L11

PRINTED: 05/28/2021 FORM APPROVED

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		PLETED
		00427	B. WING		C 04/20/2021	
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
AMARIT	TAN BETHANY HOME	· ON FIGHTH	STREET NOR TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 000	Continued From pa	age 2	2 000			
2 830	is necessary for Sta enter the word "CC available for text. Y electronic State lice heading completion will be corrected pr to the Minnesota D facility is enrolled ir signature is not req page of state form. PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA MN Rule 4658.052 Proper Nursing Ca Subpart 1. Care in receive nursing car custodial care, and individual needs ar the comprehensive plan of care as des and 4658.0405. A be out of bed as m is a written order fro	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. 0 Subp. 1 Adequate and re; General general. A resident must re and treatment, personal and supervision based on nd preferences as identified in resident assessment and scribed in parts 4658.0400 nursing home resident must uch as possible unless there om the attending physician ust remain in bed or the	2 830			6/4/21
	by:	ent is not met as evidenced		Corrected		
nesota De	Based on observat	ion, interview, and document		Corrected		

CM4L11

PRINTED: 05/28/2021 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00427	B. WING			C 20/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR	-		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTI						
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 3	2 830			
	review the facility fa					
		ssess, monitor, and manage				
		eglect and/or rejection of care residents (R1) who had				
		ssure related wounds and				
	resided in a room with odors as a result of					
	unmanaged incontinence.					
	Findings include					
	R1's quarterly Minimum Data Set (MDS)					
	assessment dated 4/7/2021, indicated R1 did not					
		airment and did not have				
		haviors. The MDS indicated nt ambulating in her room,				
		and toileting. The MDS				
		equently incontinent of urine				
		continent of bowel. The MDS ad 3 venous or arterial ulcers				
		onal intervention, nonsurgical				
	dressings and appl	ication of				
	ointments/medication	ons other than to feet.				
	R1's face sheet inc	luded diagnoses of				
	agoraphobia (extre	me or irrational fear of				
		owded places, of leaving				
		r of being in places from which anxiety disorder, opioid	1			
		us insufficiency, non-pressure				
		ver leg left leg, diabetes type II	,			
	and morbid obesity	'.				
	During an interview	/ on 4/19/2021, at 10:16 a.m.				
	family member (FM	1)-1 stated prior to admission				
		re facility she had been in a re she was not managing her				
		nd care, and medications				
	which caused healt	th problems. FM-1 stated R1				
	required long term	care to manage harmful				

CM4L11
	IT OF DEFICIENCIES					
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00427	B. WING			C 20/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	TAN BETHANY HOME	24 - 8TH		THWEST		
		ROCHES	TER, MN 5590)1		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 4	2 830			
	and didn't have the R1 had a strong per redirect. FM-1 state R1 could not be giv cares because she to be direct with he dressing change" in change?", stated st FM-1 indicated the interventions with h refusals. FM-1 state recently; R1's room urine/bowel odor, a the floor. FM-1 indi discussed the cond	ions for her own well-being capacity to. FM-1 indicated ersonality, and was difficult to ed she has informed the facility ven a choice to complete daily would not do it, staff needed r and say "It's time to do your not "Is it ok to do your dressing taff also have to be persistent. facility had not discussed new her in order to manage R1's ed she had visited R1 very in had a very strong and there was a soaker pad on cated she had historically cern with the nurse manager is anything had been done				
	(CAA) dated 7/13/2 actual problem with CAA indicated cont psychological/psyc restricted mobility. is able to ask for as MDS note 7/7/2020 transfers and ambu alerting staff. Staff as needed." R1's p 7/13/2020, included venous ulcers bilate treatments and are [registered nurse]. skin breakdown an ulcers related to im	inence Care Area Assessment 2020, identified R1 had an a urinary incontinence. The tributing modifiable factors as hiatric problems, pain, and The CAA included, "Resident assistance as needed but her b she chooses to initiate ulation in her room without assist with incontinence care ressure ulcer/injury CAA dated d "Resident has 3 chronic erally that have daily assessed periodically by RN Resident is at risk for further d the development of pressure upaired mobility and ity, other diagnosis"	I			

Minnesc	ta Department of He	alth			FORM	APPROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		00427	B. WING		C 04/20/202 ²	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	••••••••••••••••	•	2 830			
	bilateral lower extre 1/25/2021) -lac-hydrin 12% loti calloused/thickened shift (start date 7/18 -Bilateral knee-high until stockingettes a 9/24/2020) -To bilateral venous normal saline, pat of dressing cut to wou wound with barrier non-adherent gauze and as needed for -Left foot ulcer: size approximately less with normal saline, with non-adherent g one time a day (sta R1's March and Ap administration reco combination with nu records identified m physician ordered t or sufficient docume interventions. The r R1 was consistently risks versus benefit physician was notific care. In addition, R analysis of R1's reje order to determine worsening/increasin improving/decreasin any impact the reje	s (mg) one time a day for emity edema (start date on apply daily to d skin on toes every evening 3/2020) a stretch compression wraps arrive twice per day (start date s ulcers cleanse daily with dry, apply calcium alginate and bed size, spray around the spray to dry, cover with e and secure with kerlix daily soiling (start date 5/2/2020) e unknown. Depth than 0.2 cm. Cleansed daily pat dry, apply iodosorb, cover gauze, and secure with kerlix rt date 9/11/2020) ril medication/treatment rds were reviewed in ursing progress notes; the bultiple refusals/rejection of reatments without consistent entation of attempted ecords also lacked evidence y provided with education of is and lacked evidence the red of the rejection/refusals of 1's record lacked evidence of ection/refusal behaviors in if R1's behavior was				

STATEMEN	ota Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:			E SURVEY PLETED
		00427	B. WING			C 20/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 6	2 830			
	urinary incontinence	e and wound management.				
	March MAR identified the following: -Daily weights; 3/5/2021 was left blank and indicated R1 refused to be weighed 28 times (weighed only twice) -Lac-Hydrin; R1 refused/rejected the medication 11 times					
	boxes were left blan treatment 12 times. -Lower extremity ve and 3/11/2021 boxe refused/rejected tre -Knee high stretch	tment: 3/10 and 3/11/2021 hk, R1 refused/rejected enous treatment orders: 3/10 es were left blank, R1				
	was left blank and r which totaled 18 da -low extremity veno 9 out of 20 opportu	compression wraps; R1 4/9/21 refused/rejected all other days lys. lus ulcers: R1 refused/rejected nities tment; R1 refused/rejected 8				
	opportunities -Daily weights; R1 i	d the following: used/rejected 5 out of 20 refused/rejected 18 times, was 2021 was left blank.	3			
	1/5/2021 did not ide and despite docum	7/8/20202, 10/7/2020, and entify R1 rejected refused care entation in R1's record of fusals the MDS dated				

	NT OF DEFICIENCIES	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NOMBER.	A. BUILDING:			
		00427	B. WING		04/2	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	F ON FIGHTH	STREET NOR STER, MN 5590	-		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 7	2 830			
		4/7/2021, rejection/refusals behaviors was not identified and or assessed.				
	included "resident I extremity] edema b wraps when offered independent with to bowel and bladder accept help from ca "Resident chooses ambulation in her re understands the ris refuses wound care give her a shower s	s note dated 4/5/2021, has BLE [bilateral lower but declines compression d" and "Resident is bileting but has episodes of incontinence but will not aregivers for peri care." and to initiate self-transfers and boom without alerting staff and sks." and Resident often e and does not allow staff to stating that she gives herself a and does not need us to look				
	Shared Risk Agree representative on 4 1/19/2021, indicate benefits of refusing transfer. The asses understood the pot	ed on risk assessment. R1's ment first signed by R1 and l/30/2019 and reviewed on ed R1 understood the risks and one staff assist with all esment indicated R1 ential negative outcomes of luded falls fracture, cuts, s, up to death.				
	exercise my right to sometimes chosen offer. I have decline R1's goal was not t consequences rela Corresponding inte -continue to offer ca date 7/12/2019)	ed 7/12/2021, included "[R1] o make decisions. I have to not accept cares that staff ed a shower or bath at times. o experience adverse ted to her decisions. erventions included: ares and bath/showers (start R1] for my decision (start date				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COM	E SURVEY PLETED C
		00427	B. WING		04/	20/2021
AME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
AMARI	TAN BETHANY HOME		STREET NOR ⁻ TER, MN 559(
(X4) ID PREFIX	(EACH DEFICIENC)		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT	ION SHOULD BE	(X5) COMPLE DATE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC		DATE
2 830	Continued From pa	ige 8	2 830			
	bathing (start date -I allow staff to clear about every two we urine, stool, and ha My room has an or offer to assist me in choose to do it mys room to smell which live in this environm	kin integrity and self due to not				
	weekly bathing in N lacked evidence R lacked attempts ma interventions. -Bath/Skin note dat "resident was offere evening shift and re was not completed extremity} treatmer -Bath/Skin note dat "Resident refused s well as skin check" refused dressing ch -Bath/skin note dat this time "no" Will c and any other day i -Bath/skin note dat shower/bath was g dressing changes. -Bath/skin note dat	ted 3/2/2021, included ed her regular shower this efused. A skin assessment , however, BLE [bilateral lower its were completed." red 3/9/2021, included shower evening of 3/9/2021 as The note also indicated R1 nanges to her leg wounds. ed 3/22/2021, included "Writer ent would allow writer to ind toes. Resident chose at ontinue to try on bath days				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00427	B. WING			C)4/20/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR TER, MN 559	-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE	
2 830	Continued From pa	ge 9	2 830				
		ound dressing change. She o her stomach and does not d."					
	R1 had wounds to l R1's goal was to ha wounds. Correspor keep skin clean and	dated 1/22/2021, indicated both calves and top of feet, ave no complications to the ading interventions included: d dry, use lotion on dry skin, abnormalities or failure to heal					
	to 4/15/2021; the reasessments, and to treatments. The nor- interventions aside education and risk not include/identify evidence of new re- attempted and/or or additional wound to 3/19 to 4/15 and into	were reviewed from 3/19/2021 ecord identified weekly wound that R1 had rejected/refused tes did not identify from R1 was provided versus benefits; the record did root cause of refusals and/or visions to the care plan were ffered. The notes identified an the left lower extremity from dicated the wounds to the right eriorated between those dates.	:				
	3/19/2021, included 8.7 cm area, 5.2 cm bottom wound mea length, and 1.1 cm measured 4.2 cm a width, right inner wo 0.9 cm length, 0.5 c odor with a tan drai is pink/red in color. the wounds were cl The note also include	ure Injury Note dated d; Left top wound measured n length, 2.0 cm width, left sured 1.9 cm area, 2.2 cm width. Right lower outer leg irea, 4.1 cm length, 1.4 cm ound measured 0.3 cm area, cm width. All wounds had an nage except inner right wound The note indicated that after leaned there was more odor. ded, "Surrounding skin is very lump nodules all over lower					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		00427	B. WING		C 04/20/	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR STER, MN 5590	-		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 10	2 830			
	leg with no drainage from them."					
	included; Left out lo 8.0 cm area, 4.7 cm 20% granulation an Bottom wound on lo 1.6 cm area, 2.3 cm 90% slough and 10 leg measured 6.0 c width, 50% granula lower legs still red a pitting edema noted hard when touch. S take part in wrappir them. "I have done help. I been to wou what to do for me." encouraged resider legs by following or educate, encourage	ure Note dated 4/15/2021, ower top wound bed measured in length, 2.2 cm width with ad 80% slough in wound bed. eft outer lower leg measured in length, 0.9 cm width, with 0% granulation. The right outer is area, 4.7 cm length, 1.5 cm tion and 50% slough. Both and scaly foot to knees. No d except both lower legs feels Staff encourage resident to ing lower legs to help heal all that before and it does not ind clinic and they cannot find Staff and CNP has int to take part in healing lower iders. Staff will continue to e resident to take part in gs along with present				
	physician decline to related to ongoing a gastrointestinal disc included, "Resident per preference and symptoms of nause not. She has margi	comfort. The note also t continues to self-select food according to [gastrointestinal ea/vomiting] being present or nal intake of fruits and o declines nutritional support.				
		ily living care plan dated d R1 required one staff to				

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00427	B. WING			C 20/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE	•	
		24 - 8TH	STREET NOR			
AMARI	TAN BETHANY HOME	ROCHES	TER, MN 5590	01		
X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 11	2 830			
	initiate self- transfe also identified R1 rd two wheeled walke identified R1 had bl impaired mobility at medication. R1's go skin breakdown du Corresponding inte assistance alert nu are wet or soiled so date 1/22/2021), R incontinence care, daily that she clean when she needed I episodes. The care assist with toileting decrease episodes R1's record lacked assessment to dete	rvention included: nursing rse when lower leg dressings o they can be replaced (start 1 was one assistant with R1 had incontinent episodes ned herself and called for help ots of help with incontinent e plan also instructed staff to at 6:30 a.m. and 10:00 p.m. to of incontinence. evidence of bladder ermine if R1's had increases in				
	bathroom. Room cleaning/offe staining. Progress note date	taff assistance to the ensive odor and carpet ed 4/1/2021, included "During was cleaning her room by				
	herself. She was va around in her room she said she could assistant] helped in Resident insisted o she wasn't stable o	was cleaning her room by acuuming and moving boxes . Staff offered to help her, but do it herself. NAR [nursing n moving the boxes for her. on doing the cleaning although on her own. Staff kept checking nt back in her chair.				
		d 4/14/2021, included "It was ent had put herself on the floor				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00427	B. WING			C 20/2021
AME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
SAMARI	TAN BETHANY HOME	F ON FIGHTH	STREET NORT			
			TER, MN 5590			()(7)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 12	2 830			
	the seat of the chai incontinent episode staff assist with the and able to voice h one assist with ADI Staff try to educate voice, staff to leave seen by staff vacuu "Will continue to ha and offer staff assis resident to allow sta R1's physician note rejection/refusals o toileting/ambulatior environment that su control. The physic on going behaviora refusal/rejections a involvement or refe	nd/or professional psychiatry errals.				
	indicated R1 was c regions and had an The overview sector included; Edema S recurrent cellulitis in Intermittently comp (multiple compress uncomfortable for h ulcers bilateral; dai sometimes refuse (weekends/with unfa disorder-Primary (C missed all short-ter in drawing o'clock. represents mild cog	gress notes dated 4/9/2021, allus formation to both ankle order for lac-hydrin lotion. on of the progress note tasis bilateral (chronic) with n context of edema. Jiant with compression ion strategies have been her. Hyper venous chronic ly dressing- she will (per report more on amiliar staff. Cognitive Chronic) "6/2020 MOCA 14/30, rm recall, declined participation Not clear at this time if this gnitive impairment or hally, she was already impaired				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00427	B. WING			C 20/2021
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
		24 - 8TH	STREET NORT			
AMARI	AN BETHANY HOME	CON EIGHTH ROCHES	STER, MN 5590)1		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	THE APPROPRIATE	COMPLE DATE
0.000	0 11 15		0.000	DEFICIENC	,Y)	
2 830	Continued From pa	ige 13	2 830			
	prior to cognitive dis	sorder to coming to light				
	(long-term skilled n	ursing facility resident due to				
), so it is somewhat difficult to				
		unctionally impaired on				
		rative [sic] re-evaluation will b	e			
		tions in cognition also likely				
	complicated by chro	onic opioid use.				
	During on charming	ion and interview on				
		ion and interview on				
		a.m. R1's door was closed,				
		oom a very strong odor was as consistent with stale urine				
	•	ing chair on a washable bed	•			
		a soaker pad-used to protec	t			
		ntinence); there was also a	·			
		floor under R1's feet. The pad				
		rtially underneath the recliner				
		had different shades of	,			
		R1 was asked why the pad wa	s			
	on the floor and wh	at was underneath, R1 stated	1			
	there was mold und	derneath, had been there				
		itted, and the floor was				
	0	ver and picked up the soaker				
		or was more prominent when				
		off the floor. The pad covered	а			
		approximately 2 feet in				
		dark black that was moist. The				
		t covered the area was yellow				
		ed she did not know when the	*			
	last time her carpet	d, and she cleaned it herself.				
		anted new carpet. R1 stated				
		icerns with her care however,				
		nges to the staff schedule and				
		ble providing her cares. During				
		view at 1:45 p.m. R1 sat in he				
						1
	chair, she was more	rmed environmental services				
		rmed environmental services her carpet. R1 stated, "oh				

Minnesota Department of Health STATE FORM

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00427	B. WING		C 04/20/2021	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
AMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 830	smell is really emba in here. My family f I can smell it really removed the pad co "It gets so very bad it's just so embarra During an interview nursing assistant (f stated the soaker p urinary overflow ind "was completely de R1 would say that f "she has to come u odor." NA-A stated toileting without pro skin was checked o however R1 refuse liked to do things in	arrassing, I can't have friends has told me how bad it smells, bad." R1 leaned down and overing the stain and stated, I just can't stand it anymore,				
	licensed practical n refused showers th evening. LPN-A rev indicated that it did extremities dressin 4/18/2021. During an interview	on 4/19/2021, at 9:01 a.m. hurse (LPN)-A stated R1 at were scheduled in the viewed R1's record and not look like R1's lower gs were changed on				
	changes, refused s assistance, refused room, and refused she would have a f them. LPN-A stated to the facility she us	1 sometimes refused dressing howers, refused staff I to allow staff to clean her to go to clinic appointments; amily member call and cancel d when R1 was first admitted sed to take shower/bath; v when R1 started refusing				

CM4L11

If continuation sheet 15 of 27

	NT OF DEFICIENCIES	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00427	B. WING	VING		2021
IAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
		24 - 8TH	STREET NORT	HWEST		
AWARI	TAN BETHANY HOME	ROCHES	TER, MN 5590)1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE C THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 15	2 830			
	showers or why. LF re-approach when education. LPN-A co offensive odor and cleaned whenever her room such as w appointments. LPN carpets last week w shop. LPN-A stated Gone/biometric and on the floor. LPN-A	PN-A indicated staff she refuses care and provide confirmed R1's room had an indicated R1's carpets were they can; when R1 was not in when she went to beauty shop I-A stated staff cleaned the when she was at the beauty I staff used a product Odor Be d towels to soak up the urine indicated R1 did not always her carpet; R1 liked to do it				
	registered nurse (R nurse manager for RN-A stated staff g allows us to. RN-A treatment, the staff of completing the ta the staff would re-a RN-A stated R1 ref were scheduled to stated she didn't th treatment had beer wounds were gettir social worker and N psych services was unawareness if R1' assessed and anal would attempt to cl and when R1 would a daily and a week completed by NA's cleaning schedules the checklist to the	on 4/19/2021, at 10:45 a.m. (N)-A stated she was the the unit where R1 resided. o into assist R1 when she stated when it's time for a would nicely present options ask now or later. RN-A stated pproach if she would refuse. used dressing changes that be completed in the evening; ink changing the wound n attempted. RN-A stated R1's ng worse. RN-A stated the NP were involved, did not think is rejection/refusals were yzed. RN-A indicated staff ean R1's room almost weekly d allow. RN-A stated there was y checklist that was ; the checklist outlined the 6 for each room. RN-A showed surveyor; the checklist had rith room numbers underneath	5			

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00427	B. WING			C 20/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AMARI	TAN BETHANY HOME	· ON FIGHTH	STREET NORT			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 16	2 830			
	carpet using the ca	A stated NA's would clean the rpet cleaner for routine onmental services would do aning.				
	environmental serv she had not been in ESP-A indicated N/ to shampoo the car unit had their own of R1's room, ESP-A in stained she couldn' observed R1's carp seen it [stain] that b been cleaned in a l chair; there was the R1's chair. ESP-A s the carpet cleaner	on 4/19/2021, at 2:30 p.m. ice partner (ESP)-A stated n R1's room for a long time. A's on the unit were supposed pet as needed because each carpet cleaner. ESP-A entered confirmed the presence of the dicated once the carpets were t get the stains out. ESP-A bet and stated, "I've never black, it doesn't look like it has ong time." ESP-A moved R1's e stain extended underneath stated she was going to get now. ESP-A indicated that the buld be a health risk for R1, d staff.				
	MDS coordinator re confirmed rejection identified on the MI she was informed t a resident choice th identified on the as also indicated staff	on 4/20/2021, at 8:46 a.m. eviewed the MDS's and /refusal behaviors were not DS. MDS coordinator stated, hat if the rejection/refusal was hen it did not have to be sessment. MDS coordinator did not document enough behavior to be identified on				
	licensed social wor would complete be and implement care	on 4/20/2021, at 12:43 p.m. ker (LSW)-A indicated nursing havior assessments, develop e plan interventions. LSW-A e the nursing side of things				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00427	B. WING			C 20/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	ON FIGHTH	STREET NORT	-		
			TER, MN 5590		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	decisions or refusa re-approach to mar rejection/refusal. LS use indirect approa after R1 refused. LS recognized the righ own decisions. During an interview director of nursing indicated R1 had th treatment/care and rejection/refusals a DON indicated she carpets however, F carpets to be clean stained, the stains talk to maintenance During an interview nurse practitioner s	looked at R1's s a choice and not a behavior. expected staff to clean the R1 would often refuse her ed. DON indicated that once do not lift, but would have to				
	cleaning her room. Facility policy Beha Tracking dated 12/2 presence of mood a management in orc maintain the highes and psychosocial w prevention and trea -Behavior and moo recorded in the elec chart behaviors in to occur. -The information ga resident behavioral	avior and Mood Symptom 2020 included, To identify the and behavioral symptoms for der for the resident to attain or st practical physical, mental, vell-being. This includes atment of mental disorders. d symptom tracking is ctronic health record. Nurses the progress notes as they athered is used to assess health needs and is IDS, CAA, and the care plan				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
		00427	B. WING			C 20/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR STER, MN 559			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	age 18	2 830			
	change. -This information is resident's provider as needed. -An interdisciplinary their family or repres	rterly, and with significant communicated with the during recertification visits and y approach including resident, esentative is used to address od, and psychosocial needs of				
	director of nursing/ and procedure for the self-neglect/rejection DON/designee cour rejection/refusals of management of. The develop an auditing	THOD OF CORRECTION: The designee could review policies behavioral management for on/refusals of care. The ld then re-educate staff on f care and behavioral he DON/designee could then g system as part of the surance activities to ensure e.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21695	MN Rule 4658.141 Housekeeping, Ope	5 Subp. 4 Plant eration, & Maintenance	21695			6/4/21
	provide housekeep necessary to maint comfortable interior	eeping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting,				
	This MN Requiremost	ent is not met as evidenced				

STATE FORM

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		DENTIFICATION NONDER.	A. BUILDING	:		
		00427	B. WING			C 20/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	FON FIGHTH	STREET NO TER, MN 55			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
21695	Continued From pa	ige 19	21695			
	Based on observation, interviews, and document review the facility failed to ensure resident room was free from offensive odors for 1 of 3 residents (R1)			Corrected		
	Findings include					
	4/19/2021, at 8:50 a upon entry to the re- present; the odor w her reclining chair, floor under R1's fee partially underneath pad had different sl asked why the pad was underneath, R underneath and the over and picked up odor was more pro- lifted off the floor. T that was approximate was dark black that pad that covered th R1 stated she did r her carpet was dee she cleaned it hers new carpet.	ion and interview on a.m. R1's door was closed, oom a very strong odor was vas like stale urine. R1 sat in there was also a pad on the et. The pad on the floor was in the recliner; that area of the hades of brown. R1 was was on the floor and what 1 stated there was mold e floor was leaking. R1 bent the soaker off the floor; the minent when the pad was the pad covered a large area ately 2 feet in diameter that t was moist. The back of the he area was yellow and brown. Not know when the last time up cleaned/shampooed, and elf. R1 indicated she wanted				
	nursing assistant (I stated the pad was overflow incontinen	on 4/19/2021, at 8:57 a.m. NA)-A entered the room. NA-A on the floor for R1 urinary ice. NA-A stated R1 toileted ed she did not want staff to				

С	COMP		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		ND PLAN OF CORRECTION IDENTIFICATION NUMBER:	
/20/2021			B. WING	00427		
		ATE, ZIP CODE	DRESS, CITY, S	STREET AD	PROVIDER OR SUPPLIER	NAME OF F
			STREET NOR FER, MN 559	FIGHTH	TAN BETHANY HOME ON	SAMARIT
(X5) COMPLE DATE	N SHOULD BE E APPROPRIATE	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ID PREFIX TAG	ENT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	(EACH DEFICIENCY MUST	(X4) ID PREFIX TAG
		DEFICIENCY)	21695	whenever they can; when such as when she went ments. 4/19/2021, at 10:16 a.m. stated she had visited R1 offensive odors, and on the floor. FM-A rically discussed the manager however, didn't n done about it. 4/19/2021, at 10:45 a.m. A stated she was the unit where R1 resided. uld attempt to clean R1's d when R1 would allow. a daily and a weekly bleted by NA's; the eaning schedules for d NA's would clean the cleaner for routine ental services would do g. 4/19/2021, at 2:30 p.m. bartner (ESP)-A stated 's room for a long time. on the unit were supposed as needed because each et cleaner. ESP-A entered irmed the presence of the	R1 was not in her room to beauty shop appointm During an interview on 4 family member (FM)-A s very recently; R1's had of there was a soaker pad indicated she had histor concern with the nurse r think anything had been During an interview on 4 registered nurse (RN)-A nurse manager for the u RN-A indicated staff wou room almost weekly and RN-A stated there was a checklist that was compl checklist outlined the cle each room. RN-A stated carpet using the carpet of cleaning and environme the deep carpet cleaning During an interview on 4 environmental service p she had not been in R1's ESP-A indicated NA's or to shampoo the carpet a unit had their own carpe R1's room, ESP-A confir	21695
				manager however, didn't a done about it. 4/19/2021, at 10:45 a.m. A stated she was the unit where R1 resided. uld attempt to clean R1's d when R1 would allow. a daily and a weekly bleted by NA's; the eaning schedules for d NA's would clean the cleaner for routine ental services would do g. 4/19/2021, at 2:30 p.m. bartner (ESP)-A stated 's room for a long time. on the unit were supposed as needed because each et cleaner. ESP-A entered irmed the presence of the ted once the carpets were t the stains out. ESP-A	concern with the nurse r think anything had been During an interview on A registered nurse (RN)-A nurse manager for the u RN-A indicated staff wou room almost weekly and RN-A stated there was a checklist that was comp checklist outlined the cle each room. RN-A stated carpet using the carpet of cleaning and environme the deep carpet cleaning During an interview on A environmental service p she had not been in R1's ESP-A indicated NA's or to shampoo the carpet a unit had their own carpet R1's room, ESP-A confir foul odor. ESP-A indicate stained she couldn't get observed R1's carpet ar seen it [stain] that black,	

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00427	B. WING			C 20/2021
AME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
AMARI	TAN BETHANY HOME	ON FIGHTH	STREET NOR	-		
			STER, MN 5590			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21695	Continued From pa	ige 21	21695			
	the carpet cleaner i odor/dirty carpet co other residents, and During an observat R1 had been move to an adjoining roor after cleaned. R1's odor was now notic of R1's room; inside unchanged from 4/ the area of carpet t black. During an interview neighborhood coor was responsible for checklist for comple manager. NC-A sta shampoo carpets a once per month. W checklist when was shampooed, NC-A the last time the ca cleaned/shampooe indicated that just tl informed environmer responsible for the stock the supplies for During an interview director of nursing of staff to clean the ca often refuse her can indicated that once	now. ESP-A indicated that the buld be a health risk for R1, d staff. ion on 4/20/2021, at 8:15 a.m. d temporarily out of her room m so that the carpet could dry room door was opened, the eable in the hallway outside e R1's room the odor was 19, industrial fans pointed at hat continued to be a dark of on 4/20/2021, at 8:35 a.m. dinator (NC)-A indicated she r reviewing and auditing etion along with the unit nurse ted NA's were supposed to as needed and deep cleaned then asked, Based on the a the last time the carpets were stated she could not tell when				
		et Cleaning dated 11/2020, n Bethany makes every effort				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
			A. BUILDING: _			
		00427	B. WING			C 20/2021
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AMARI	TAN BETHANY HOME	ON FIGHTH		-		
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
21695	Continued From pa	ge 22	21695			
	and maintained. 1. Household carpe each neighborhood Use to clean soils, s	the neighborhoods is cleaned at cleaners are available on for neighborhood staff use. spills, odorous areas. Fill out a ea needs further cleaning by ices.				
	The administrator, in designee could ensign maintenance progra accurately reflect of maintenance scheor on a routine basis. policies and proced changes and perfor rounds/audits perio maintenance is ade facility could report assurance performation committee for furthe ongoing compliance	am was developed to ngoing preventative Juled or needed in the facility The facility could create Jures, educate staff on these m environmental dically to ensure preventative equately completed. The those findings to the quality ance improvement (QAPI) er recommendations to ensure				
21805	Residents of HC Fa Subd. 5. Courteouresidents have the	.651 Subd. 5 Patients & ac.Bill of Rights us treatment. Patients and right to be treated with ct for their individuality by	21805			6/4/21
		rsons providing service in a				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		00427	B. WING			C 20/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
SAMARI	TAN BETHANY HOME	· ON FIGHTH	STREET NO STER, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
21805	Continued From pa	ge 23	21805			
	by: Based on observat review the facility fa	ent is not met as evidenced ion, interview, and document ailed to ensure dignity for 1 of b had an offensive room odors		Corrected		
	4/19/2021, at 8:50 a upon entry to the ro present; the odor s her reclining chair of known as a soaker from incontinence); on the floor under F was partially under the pad had differe R1 was asked why what was undernea underneath, had be admitted, and the fl and picked up the s was more prominent the floor. The pad of approximately 2 fee black that was mois covered the area w stated she did not F carpet was deep cl cleaned it herself. F	ion and interview on a.m. R1's door was closed, oom a very strong odor was melt like stale urine. R1 sat in on a washable bed pad (also pad-used to protect mattress there was also a soaker pad R1's feet. The pad on the floor neath the recliner; that area of nt shades of brown markings. the pad was on the floor and ath, R1 stated there was mold een there since she was oor was leaking. R1 bent over soaker off the floor; the odor nt when the pad was lifted off covered a large area that was et in diameter that was dark st. The back of the pad that as yellow and brown. R1 know when the last time her eaned/shampooed, and she R1 indicated she wanted new bsequent interview at 1:45 chair, she was informed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND PLAIN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	PLETED
		00427	B. WING			C 20/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
	TAN BETHANY HOME	24 - 8TH	STREET NOR	THWEST		
		ROCHES	TER, MN 559	01		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
21805	Continued From pa	age 24	21805			
	family has told me it really bad." R1 le pad covering the st bad I just can't star embarrassing. R1's face sheet inc generalized anxiety (fear of certain plac person believes is of spaces) R1's quarterly Minin 4/7/2021, indicated impairment and did behaviors. The MD	h't have friends in here. My how bad it smells, I can smell aned down and removed the ain and stated, "It gets so very d it anymore, it's just so udded diagnoses of disorder and agoraphobia ces and situation that the difficult from such as public mum Data Set (MDS) dated R1 did not have cognitive I not have rejection of care S indicated R1 was				
	hygiene, and toileti was frequently inco occasionally incont R1's care plan inclu room and bathroom know I'm incontiner emesis on any give	uded "I allow staff to clean my n about every two weeks. I nt of urine, stool, and have en day. My room has an odor				
	cleaning myself up myself, which in tur which I understand environment." The directed staff to re- During an interview nursing assistant (N	aff will offer to assist me in . I usually choose to do it in causes my room to smell and I choose to live in this corresponding intervention approach later if needed. v on 4/19/2021, at 8:57 a.m. NA)-A entered the room. NA-A bad was on the floor for R1 continence.				
		/ on 4/19/2021, at 10:04 a.m. hurse (LPN)-A confirmed R1's				

		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED
		00427	B. WING			C 20/2021
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
	TAN BETHANY HOME	ON FIGHTH 24 - 8TH	STREET NOR	THWEST		
		ROCHES	STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ige 25	21805			
	carpets were clean R1 was not in her r to beauty shop app cleaned the carpets the beauty shop. Lf product Odor Be G soak up the urine o R1 did not always a R1 liked to do it her During an interview family member (FM very recently; R1's urine/bowel odor, a the floor. FM-A indi discussed the cond	sive odor and indicated R1's ed whenever they can; when oom such as when she went oointments. LPN-A stated staff is last week when she was at PN-A stated staff used a one/biomatic and towels to on the floor. LPN-A indicated allow staff to clean her carpet; rself. o on 4/19/2021, at 10:16 a.m. 1)-A stated she had visited R1 room had a very strong and there was a soaker pad on cated she had historically tern with the nurse manager ak anything had been done				
	registered nurse (R nurse manager for RN-A indicated stat room almost week! RN-A stated there we checklist that was of checklist outlined the each room. RN-A s surveyor; the check room numbers und did not outline spect stated NA's would of carpet cleaner for r	on 4/19/2021, at 10:45 a.m. N)-A stated she was the the unit where R1 resided. ff would attempt to clean R1's y and when R1 would allow. was a daily and a weekly completed by NA's; the ne cleaning schedules for howed the checklist to the clist had days of the week with erneath the day of the week, it cific cleaning tasks. RN-A clean the carpet using the outine cleaning and ices would do the deep carpet	t			
		on 4/19/2021, at 2:30 p.m. ice partner (ESP)-A stated				

	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION OF CORRECTION IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
IND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:			
		00427	B. WING			C 20/2021
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	ATE, ZIP CODE		
	TAN BETHANY HOME	ON FIGHTH	STREET NOR	-		
	-	ROCHES	STER, MN 5590			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 26	21805			
	ESP-A indicated NA to shampoo the car unit had their own of R1's room, ESP-A of foul odor. ESP-A in- stained she couldn' observed R1's carp seen it [stain] that b been cleaned in a lo chair; there was the R1's chair. ESP-A s the carpet cleaner r odor/dirty carpet co other residents, and During an interview	on 4/20/2021, at 1:49 p.m.				
	director of nursing (staff to clean the ca often refuse her can indicated that once	(DON) indicated she expected arpets however, R1 would rpets to be cleaned. DON stained, the stains do not lift, alk to maintenance for				
	The administrator, of designee could device by the interdist residents dignity is could update policies staff on these change resident(s) dignity at these audits will be	HOD OF CORRECTION: director of nursing (DON), or velop and implement a plan of ciplinary team to ensure being maintained. The facility es and procedures, educate ges, and audit to ensure are maintained. The results of reviewed by the quality ee to ensure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				