STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. Building B. Wing	03/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Samaritan Bethany Home on Eighth	24 8th Street Northwest Rochester, MN 55901

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on observation, interview, and document review the facility failed to follow the care plan for transfers to prevent or mitigate risk for falls and/or falls with major injury for 2 of 4 residents (R1 and R4) reviewed for falls. This resulted in actual harm for R1 who experienced a witnessed ground level fall resulting in a subdural, subarachnoid, and intraventricular hemorrhages, two left rib fractures, and a left clavicle fracture, requiring intensive care unit (ICU) hospitalization for eight days. Findings include: Subdural hemorrhage is a serious medical condition where blood collects beneath the dura mater, the outermost membrane surrounding the brain. This accumulation of blood puts pressure on the brain, potentially causing life-threatening consequences. Subarachnoid hemorrhage is bleeding in the space between the brain and the tissue covering the brain. Intraventricular hemorrhage is bleeding inside or around the ventricles-spaces in the brain that contain the cerebral spinal fluid. Bleeding in the brain can put pressure on the nerve cells and damage them. If the nerve cells are severely damaged, it can result in irreversible brain injury. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had severe cognitive impairment and had diagnoses of atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), thrombocytopenia (low platelets) and hypertension (high blood pressure). R1 had impairment in bilateral (both) upper extremities, required extensive assist of one staff with bed mobility, transfers, eating and toilet use, used walker and wheelchair for mobility. Did not identify any recent falls. R1's Fall risk assessment dated [DATE], identified a score of 28 indicating R1 was at moderate risk for falls due to diagnoses of diabetes, cardiovascular disease, and bone weakness or osteoporosis. R1 had chronic bowel and urinary incontinence, unsteady gait, unable to ambulate independently, vision and hearing impairment, cannot safely transfer independently, and was on hypertensive and diuretic medications. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's care plan dated 2/22/24, identified a focus of an activities of daily living (ADL) self-care performance deficit related to limited mobility, incontinence, cognitive impairment, glaucoma, and diabetes. Intervention for transfer was assist of one staff with front wheeled walker (FWW), gait belt for all transfers with contact guard assist (CGA) at all times. An additional focus identified risk for falls related to limited mobility, incontinence, poor balance, hypertension, glaucoma, osteoporosis, and diabetes. Interventions included: anticipate and meet my needs, typically does not attempt to self-transfer, and use gait belt for all transfers/ambulation with CGA at all times. R1's physician visit dated 2/23/24, identified R1 had functional impairments limited by mobility, increased risk of falls, required full assist with all functional cares, hygiene and reading. Family shares R1 had some mobility, but unable to self-advocate needs, will not hydrate independently, or use the bathroom without prompting and transfers are harder due to higher risk of falls. No behaviors, mood changes or concerns with resistance to cares. R1's occupational therapy (OT) note dated 2/28/24, included facilitated bed mobility with moderate to maximum assist. R1 transfers from edge of bed to standing with walker with minimal assist, then trial of stand pivot due to timing and noting fatigue from R1. Stand pivot with gait belt, minimal assist, and pivot to toilet with minimal assist to rise. Moderate assist to ensure turning completely, minimal assist from toilet to the wheelchair. R1 benefited from multisensorial verbal cueing. Noted potential variances due to timing of the session will further assess for safety in upcoming sessions. R1's physical therapy (PT) note dated 3/4/24, indicated R1 required moderate assist with FWW with sit to stand (STS) from recliner, required 100 % verbal/tactile/visual cues for forward trunk flexion, hand placement, foot placement. Stand-sit CGA with cues to reach back armrest. Recliner to wheelchair with FWW, moderate assist to stand, CGA while pivoting with FWW, wheelchair to edge of bed (EOB) with FWW minimal assist to stand, CGA while pivoting with FWW. R1 responded best with multiple forms of cueing. R1 required cues for walker management and occasional minimal assist for navigating walker, cues for increasing step height and step length. R1's gait was discontinuous and varied from step through partial step, primarily would shuffle. R1's progress note dated 3/4/24 at 6:00 p.m., included nurse was notified by a nursing assistant (NA) that R1 had fallen. R1 was observed laying at the foot of her bed on the left side with glasses in front of R1. R1's left arm was parallel to left side and right arm was behind her. Nurse and two aides used the EZ-lift (full body mechanical lift) to pick R1 up off the floor and place R1 in bed, gait belt was around R1's waist. CNA stated that R1 was pivoting when R1 lost her balance, attempted to catch R1 but was not strong enough or fast enough to catch R1 from falling. 1/4 inch superficial abrasion was noted across the bridge of R1's nose, circle of blood blisters on left shoulder and hematoma noted around R1's left elbow, and was transferring with assistance. R1 was alert to self, family member (FM)-A notified of the fall at 7:15 p.m. R1's progress note dated 3/4/24 at 8:22 p.m., was given 500 milligrams (mg) of acetaminophen (pain reliever), due to R1 stated, I hurt. R1's progress note dated 3/5/24 at 7:30 a.m., identified R1 had bruising on both arms and left shoulder and a small abrasion on the bridge of nose. R1 had some facial grimacing with left arm ROM but was unable to say if the discomfort was in the shoulder or arm. R1 was transferred out of bed with two staff assist and the EZ-lift. Left for appointment at 8:15 a.m., FM-A went with. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's progress note dated 3/5/24 at 7:51 p.m., a fall follow up: R1 had a witnessed fall in room when transferring via pivot to shower chair with NA using gait belt. Shower chair brakes were on. R1 lost her balance during the transfer, clothing and footwear were appropriate. Care plan was reviewed/followed at the time of the fall. Daughter notified of fall on 3/4/24 at 7:15 p.m. injuries noted to the bridge of nose (abrasion) and left shoulder/left arm bruising. R1 seen in emergency department (ED) on 3/5/24 related to fall. R1's hospitalization in the intensive care unit (ICU) dated 3/5/24 to 3/12/24 identified R1 sustained a ground level fall at the nursing home resulting in a traumatic brain injury (TBI) to include treatment for a right temporal lobe subdural hemorrhage subarachnoid hemorrhage and intraventricular hemorrhage as well as a second and third left rib fracture and a left clavicle (the bone connecting the breastbone and shoulder) fracture. During a phone interview on 3/13/24 at 4:15 p.m., family member (FM)-A indicated she got a call from a nurse on evening of 3/4/24, R1 fell in the bathroom trying to get to the shower and fell on her left side. Every time R1 has fallen in the past she has broken a bone. FM-A got to the facility on [DATE] around 7:30 a.m., staff had R1 up in the chair. FM-A noticed a big bruise on the right arm, a large bruise on the left upper arm, and an abrasion on R1's nose. R1 had her head down and seemed really sleepy, we took the shuttle to the appointment. FM-A indicated when at the appointment R1 had mental status changes, she was unable to remember her name or birth date or who FM-A was. R1 was then sent to the emergency room and admitted to the ICU for eight days where she was diagnosed with bilateral subdural hematoma and a subarachnoid bleed, two left fractured ribs and a left fractured clavicle. R1 did have a seizure a few days into the stay, so now R1 will be on antiseizure meds for a couple months. FM-A stated the last couple days R1 had been alert and talking. FM-A explained R1 transferred by putting both her hands on the walker but the gait belt needed to be on, and you can't let go or R1 will fall otherwise she transferred just fine. During a phone interview on 3/13/24 at 12:40 p.m., nursing assistant (NA)-B indicated working the evening of 3/4/24. NA-B stated it was R1's shower day. NA-B informed NA-A through how to give R1 a shower and went through the care plan. NA-B informed NA-A to make sure to put the brakes on the shower chair, use the gait belt, take R1 to the bathroom, have R1 grab onto the bar on the wall to stand up to take R1's pants off. R1's fall happened right after supper approximately 5:45 p.m. Licensed practical nurse (LPN)-B found NA-B and asked her to grab the lift because R1 was on the floor. NA-B and LPN-B went to R1's room got R1 back into bed, R1 did not say a thing, no facial grimacing, nothing. R1 did have some rug burn on the left shoulder, some little bruising clusters down the left arm, then got R1 undressed and in a gown. NA-B stated the rest of her shift she checked on R1 frequently and gave R1 drinks of water, R1 never had any complaints of pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/13/24 at 4:03 p.m. NA-A was in R1's room and demonstrated how she had been transferring R1 when she fell on [DATE]; NC-A was also present. NA-A explained, she was told to give R1 a bath by NA-B and NA-B briefly walked her through how to do it; NA-B left to go answer some call lights on the other side of the facility. NA-A indicated R1 was seated in her wheelchair in front of the recliner next to the bed by the window side of the bed. NA-A put the shower chair directly across from R1's wheelchair, she did not lock the brakes on the shower chair because she did not know the shower chair had brakes. Then NA-A put the gait belt on R1 and asked her to stand up. NA-A hung on to the gait belt and kind of just pulled her [R1] up. R1 started walking to the right toward the foot of her bed, lost her balance, and fell to the floor on her left side. NA-A stated R1 was too heavy for her. NA-A stated she did not use a walker during the transfer because she did not realize the care plan directed this. R1 did not make a sound during the fall or after the fall. NA-A checked to make sure R1 was breathing and then left to go get the nurse. NA-A was not sure if R1 had hit her head, it happened so fast. R1 did have a cut on her left arm and NA-A never heard R1 say anything while she was in the room. NA-A stated LPN-B and NA-B got R1 off the floor with the mechanical lift and she was instructed to go help on the other unit while they finished with R1. During an interview on 3/13/24 at 2:37 p.m., LPN-B indicated she was the nurse for the evening shift on 3/4/24 when R1 had fallen. LPN-B stated she was on the other side of the nurses station when NA-A came to get her and told her R1 had fallen. LPN-B explained she went to R1's room, R1 was lying on her left side at the foot of her bed, and R1 still had the gait belt around her. R1's walker was not in sight, so LPN-B guessed it was not used during the transfer. NA-B and LPN-B transferred R1 back into bed using the full body mechanical lift. LPN-B completed an assessment and notified family. R1 did not have any facial grimacing or indicators of pain until a little after 8:00 p.m. which LPN-B gave R1 some acetaminophen. LPN-B stated this fall was 100 % preventable, it was a simple pivot transfer. LPN-B could not understand how R1 could have fallen R1 took commands well and never got up without help. LPN-B indicated she had not completed a causal analysis of the fall and/or interviewed NA-A after R1's fall to determine the root cause. During an interview on 3/13/24 at 3:17 p.m., neighborhood coordinator (NC)-A indicated on the day of R1's fall on 3/4/24, NA-A was still in orientation and that NA-A did not have any supervision when NA-A transferred R1 and had fallen. During a phone interview on 3/13/24 at 1:01 p.m., NA-C indicated working the night shift on 3/4/24 and had heard during report R1 had fallen on the evening shift. NA-C stated, she heard that R1 was being transferred from her recliner to the bathroom. R1's baseline was very unsteady on her feet. R1 did not move unless she was asked by staff to do so NA-C was confused how R1 could have fallen. During a phone interview on 3/13/24 at 1:19 p.m., LPN-C indicated working the night shift on 3/4/24 and had gotten report from LPN-B. LPN-C was told in shift report R1 had hit her left side, her face, her shoulder, and her elbow and given acetaminophen for the pain. LPN-C indicated she assessed R1 for pain and changes throughout the night, with no changes or signs of pain noted. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/13/24 at 11:30 a.m., licensed practical nurse (LPN)-A indicated she worked the day shift of 3/5/24. LPN-A stated that morning she informed the aides to not get R1 up until she could do an assessment from the fall. R1 had grimacing with left shoulder range of motion (ROM) so staff got R1 up with an EZ-lift to try and protect that arm, R1 was brought to the dining room where she was fed breakfast. R1 had an eye appointment that morning and FM-A assisted R1 to the appointment. LPN-A stated, she got a phone call from the nurse at the eye clinic mid-morning that R1 was not recognizing FM-A had a change in condition and was brought to the emergency department (ED). During an interview on 3/14/24 at 8:24 a.m., registered nurse (RN)-A stated R1's care plan for transfers was to use a gait belt with CGA at all times and FWW. The wheeled walker would be important to use for R1's balance that was what R1 used prior to coming here when R1 was at home with FM-A. R1 was very unsteady on her feet and would lose her balance very easily. RN-A indicated being involved in the investigation of R1's fall on 3/4/24 and stated, we never checked to see if the FWW was being used during the fall, we were more focused on if the gait belt was used and to make sure the neuro assessments were being completed per policy. During an interview on 3/14/24 at 8:52 a.m., therapy program director (TPD)-A indicated if a resident had an order to use a gait belt with CGA at all times and FWW with transfers this would be used for strength and balance for the resident. TDP-A verified R1 had this order for transfers and was seen by OT and PT for strengthening and balance. TDP-A stated it was very important to follow the care plan exactly for transfers to prevention falls. R4's quarterly MDS dated [DATE], identified R4 to have moderate cognitive impairment and had diagnoses of dementia, anemia, and hypertension. No recent falls. R4's care plan dated 11/30/23, identified a focus of ADL self-care performance deficit related to limited mobility and incontinence, dementia, and diabetes. Intervention to transfer was assist of one staff using CGA to pivot transfer with FWW and gait belt. R4's Fall risk assessment dated [DATE], identified a score of 22 indicating 4 was at moderate risk for falls due to diagnoses of diabetes, cardiovascular disease, and anemia. R1 had chronic bowel and urinary incontinence, unable to ambulate independently, cannot safely transfer independently, and was on hypertensive medications. During an observation and interview on 3/14/24 at 8:41 a.m., R4 was seated on his bed with the gait belt around the waist, the wheelchair was directly across from R4. R4's walker was noted to be on the other side of the room. NA- D was standing to the right of R4 holding the gait belt. R4 had his hands on the arms of the wheelchair in front of him, wheelchair brakes were locked. R4 stood with the help of NA-D pulling up on the gait belt, R4 did not fully standup and tried to sit before reaching the wheelchair. NA-D had to physical lift and guided R4 to the wheelchair with difficulty of ensuring R4 was in a safe position to sit down squarely in the wheelchair. NA-D reviewed R4's care plan on the door and stated, I didn't realize R4 should have used the walker to standup with the transfer, I suppose that would have been easier. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/14/24 at 11:27 a.m. director of nursing (DON) stated an investigation was completed for R1's fall on 3/4/24 at 6:00 p.m. and they were not able to come up with a true root cause to the fall. The investigation focused on the gait belt being used and making sure neuro assessments were being completed per facility policy. The interdisciplinary team (IDT) did not check to see if the walker was used for the transfer with R1's fall. DON was notified of R4's transfer with NA-D not using a walker to transfer R4 to the wheelchair as directed by the care plan. DON stated, the care plan should be followed with all resident transfers. Facility policy, Resident Transfer Policy, revised 6/2023 identified It is Samaritan [NAME]'s policy to transfer residents from one location to another following the residents individualized care plan to prevent resident and staff injuries from occurring. PROCEDURE: 1. Residents will be evaluated for transfers at the time of move-in to the facility and is noted is the residents care plan. 2. The resident care plan will be updated as changes occur. 3. If a resident has fallen a two assist with EZ Lift equipment will be used. 4. When a resident transfer occurs, the staff member assisting must follow the care plan. 5. Resident's arms and pants are not used as a lifting device. 6. Samaritan [NAME] Types of Transfers include: a. Independent: Resident can transfer independently from sitting to standing positioning or from a standing to sitting position and does not require assistance from staff. b. One-staff Assist: Resident can bear weight on one or both legs and requires a gait belt with all transfers, which helps to provide support and balance for the resident. i. A walker, cane, or other support equipment may be used. Facility policy, Fall Protocol, revised 3/2024, identified when a fall occurs, it will be Samaritan [NAME]'s practice to investigate the contributing factors/circumstances surrounding the fall, looking for patterns, etc. to prevent further falls and/or minimize the risk of injury. PROCEDURE: 1. When a resident sustains a fall he or she will not be moved until a licensed nurse has evaluated their condition. 2. Pulse, respirations, and blood pressure, o2 saturation, and temperature obtained and recorded. 3. If an injury has occurred, it will be evaluated by the licensed nurse. Skin tears, bruises, abrasions, etc. will be treated using the facility standing orders. 4. If the fall was not witnessed and/or the resident hit their head, neuro checks will be initiated. 5. The nurse practitioner / MD will be notified immediately when there is need for further evaluation, emergency room visit or hospitalization . 6. A huddle is conducted, with staff present at the time of the fall, to determine contributing factors and what immediate intervention is to be put in place, to prevent further falls. These contributing factors and interventions will be documented in the electronic medical record. 7. A comprehensive assessment will be completed after each fall by the Care Coordinator looking for patterns, contributing factors, resident observation, fall history, physical limitations, medications, environment, and diagnoses. 8. IDT (Inter Disciplinary Team) meetings are held for 2 falls in 24 hours, 3 falls in a month, or after a fall with significant injury. Documentation of the IDT meeting will be entered in the progress notes in the resident's electronic medical record, including interventions put in place to prevent further falls. 9. Care Plan and Kardex are reviewed and updated when changes occur. 10. Resident falls are reported at stand-up meetings. A meeting is conducted with the Care Coordinators after stand-up after each fall to review fall and new intervention. 11. Fall Investigation Reports will be kept for one year. This report is a quality assurance investigation and is not part of the residents' record. 12. Falls are reviewed, and trends reported at Quality Assurance meetings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38685 Based on interview and record review the facility failed to accurately transcribe physician's orders into the electronic heath record (EHR) for 1 of 3 residents (R1) who recieved 14 wrong doses of aspirin. Findings include: R1's physician visit dated 2/23/24, identified R1 to have quite a bit of drainage from her nose, constant in nature and many times is bloody/serosanguinous (yellowish with samll amounts of blood) from history of recurring nose bleeds was receiving aspirin (medication to thin the blood) 325 milligrams (mg) daily. New orders to discontinue aspirin 325 mg daily and change to aspirin 81 mg daily due to frequent nose bleeds. R1's order summary dated 2/23/24, identified an order of aspirin 325 mg daily for permanent atrial fibrillation. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 to have severe cognitive impairment and diagnoses of atrial fibrillation (An irregular, often rapid heart rate that commonly causes poor blood flow), thrombocytopenia (low platelets) and hypertension (high blood pressure). R1's February and March 2024 medication administration records (MAR) identified R1 received aspirin 325 mg daily from 2/23/24 through 3/5/24. R1 received the wrong dose of aspirin for 14 days. During a phone interview on 3/13/24, at 4:15 p.m., family member (FM)-A reported a concern that on 2/23/24 R1 was seen by the physician and had ordered a change in R1's aspirin dosage from 325 mg to 81 mg due to frequent nose bleeds. FM-A stated, this was never changed and R1 received 325 mg daily when she should have been getting 81 mg daily. During an interview on 3/14/24 at 2:20 p.m., director of nursing (DON) indicated when a medication error occurs, the nurse would document the error of a medication error report form, assess, and monitor the resident and notify the doctor. DON indicated an unawareness of the transcription medication error with R1's aspirin. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy Medication error, dated 11/23, identified It is Samaritan Bethany's policy to evaluate medication and treatment errors that occur at the facility and provide education/corrective action to the person making the error. A medication error is the observed or identified preparation or administration of medications or biologicals which is not in accordance with: The prescriber order, Manufacturers specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. The Licensed nurse that identifies the error initiates the Medication Error Report. The error must be determined as significant or non-significant. A significant error is one that causes the resident discomfort or jeopardizes the residents health or safety and follows these three general guidelines: Resident condition, Drug category, and Frequency of the error. Any significant medication error or resident reaction must be reported to the following: MD/NP, Resident or the residents representative, an explanation must be made in the residents record for a significant error. If the medication error is significant, it will be reported under Vulnerable Adult guidelines. The medication error is reviewed with the individual making the error looking at any potential contributing factors