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	03/26/2026

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to obtain and document an informed consent, including with explanation of risk and benefits and alternatives for psychotropic medications for 3 of 5 residents (R10, R22) reviewed for unnecessary medications.Findings include:R22R22's admission Minimum Data Set (MDS) assessment, dated 3/10/26, indicated R22 had intact cognition with no hallucinations, delusion, or rejection of care. MDS indicated R22 was on an antidepressant (psychotropic medication).R22's medical diagnosis report, dated 3/24/26, included the following relevant diagnoses: major depressive disorder, acute respiratory failure with hypoxia (a critical condition where the lungs are unable to adequately oxygenate the blood), acute on chronic congestive heart failure (a life-threatening condition when your heart cannot deliver enough oxygen to your body), and type 2 diabetes (condition which results in elevated blood sugar levels).R22's Order Summary Report, dated 3/24/26, included the following orders: -duloxetine (antidepressant medication) 60 milligram (mg) capsule: give one capsule by mouth one time a day related to major depressive disorder with a start date of 3/5/26-trazodone (antidepressant medication): give 50 mg by mouth at bedtime for insomnia related to major depressive disorder with a start date of 3/4/26. R22's medication and treatment administration record (MAR/TAR) for 3/1/26 to 3/24/26 included the following:-duloxetine 60 mg capsule: give one capsule by mouth one time a day related to major depressive disorder with a start date of 3/5/26. Documentation indicated administered as ordered. -trazodone: give 50 mg by mouth at bedtime for insomnia related to major depressive disorder with a start date of 3/4/26. Documentation indicated administered as ordered. R22's progress notes, dated 3/4/26 to 3/24/26, were reviewed and lacked documentation of education being provided regarding risks, benefits and alternatives for duloxetine or trazodone. R22's hospital Discharge summary, dated [DATE], was reviewed and lacked evidence of a conversation with provider regarding risks, benefits and alternatives for duloxetine or trazodone. Review of R22's entire electronic medication record (EMR) and paper medical record lacked evidence of either a signed consent for antidepressant medications which would include risks, benefits and alternatives or a conversation occurred regarding the risks, benefits or alternatives of antidepressant medications. During an interview on 3/24/26 at 5:18 p.m., licensed practical nurse (LPN)-C stated they do not complete consents for medications with residents or their families. LPN-C stated she might review the side effects, if asked, when administering a medication but does not do any sore of consents regarding medications. LPN-C stated she has never talked to a resident or family about risks, benefits or possible alternatives of psychotropic medication.During an interview on 3/24/26 at 5:46 p.m., registered nurse care coordinator (RN)-C stated a consent form for antipsychotic medications is completed which includes risks, benefits and alternatives. During a follow up interview at 6:12 p.m., RN-C stated if consent for psychotropics (not antipsychotics) was received, it would be verbal consent and believed it would be documented in a note. At 6:42 p.m., RN-C stated consent would be obtained from the provider/prescriber of the medication and should be in the provider's note. Documentation of consent which would include risks, benefits and alternatives was requested. During an interview on 3/24/26 at 7:17 p.m., director of nursing/clinical mentor (DON) stated the expectation would be the facility (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would obtain consent for antipsychotic medications due to the black box warnings. DON stated the facility does not do written consents for psychotropic medications. DON stated the provider would typically discuss any risks, benefits and alternatives with the residents or their representative. DON stated this conversation would be documented in the physician notes. Documentation of consent which included risks, benefits and alternatives was requested.A provider note, dated 3/19/2020, was provided and reviewed. The document indicated R22 has depression, anxiety and insomnia. Furthermore, she is on treatment with duloxetine (Cymbalta), Rexulti, trazodone, melatonin. She is followed by her psychology, psychiatry, provider as well. She is compliant with treatment. Her mood disorder and sleep have improved with treatment. She has no side effect of treatment. The document indicated R22 was prescribed duloxetine 90 mg with a start date of 2/20/2017 along with trazodone 50mg 1-2 tablets as needed at bedtime with no start date. The note lacked evidence of a conversation regarding risks, benefits and alternatives for duloxetine or trazodone. Furthermore, there is no indication if R22 has remained on these medications the entire time since 2017 as the doses have changed. A facility policy titled Psychotropic Medications, reviewed 10/25, indicated if psychotropic medications are initiated or increased during their stay, consent including risk, benefits, alternatives and any associated black box warnings discussed.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe independent medication administration for 1 of 1 residents (R59) reviewed for self-administration. Findings include: R59's quarterly Minimum Data Set, dated [DATE] indicated R59 was cognitively intact with no delirium or behaviors, no upper/lower body impairment, and was independent with activities of daily living and transfers. R59's diagnoses list included back pain, high blood pressure, depression, high cholesterol, osteoporosis, indigestion, and vitamin d deficiency R59's careplan indicated R59 was independent with activities of daily living. R59's medication administration record indicated R59 receives the following scheduled medications: -Morning: atorvastatin 40mg (high cholesterol), vitamin d 50 mcg (supplement), losartan 37.5 mg (high blood pressure), omeprazole 20 mg (indigestion), sertraline 100 mg (depression), senna-s 1 tablet (stool softener), acetaminophen 1000 mg (pain)-Noon: calcium citrate 3 tablets (calcium supplement) , acetaminophen 1000 mg (pain) R59's medication administration record did not indicate it was safe to leave medications at bedside. During observation and interview on 3/23/26 at 7:26 a.m., R59 was sitting in the recliner with a plastic medication cup containing several oral medications located on the table next to her. R59 stated she takes them after she eats breakfast. During observation and interview on 3/23/26 at 12:48 p.m., R59 was sitting in the recliner with lights off stating she was getting ready to take a nap. A clear plastic medication cup containing 3 large white pills was located on the table next to her. R59 stated the medications were her noon meds and she takes them slowly. During observation on 3/25/26 at 8:32 a.m., R59 was sitting in the recliner with a clear plastic medication cup of medications located on the table next to her. During interview on 3/25/26 at 9:01 a.m., licensed practical nurse (LPN)-D stated residents wishing to self-administer medications require a self-administration assessment. If a resident is deemed appropriate, a provider signs the approval, and it is placed on the medication administration record. LPN-D confirmed R59 did not have a self-administration assessment on file. During an interview on 3/25/26 at 9:39 a.m., registered nurse (RN)-D stated self-administration assessments are determined by a resident's diagnoses and cognition. Residents are evaluated for their ability to stated what a medication is, what it is for, identify the medication, and administer it safely. After the assessment, the provider signs order authorizing self-administration of medications and ability to keep at bedside. RN-D confirmed R59 did not have a self administration order on the medication administration record and should have. A policy titled Self-Administration of Medication revised 10/25 indicated, in part, each resident who expresses the wish to self-administer medication is permitted to do so if it has been determined by the licensed nurse and resident's provider that the practice would be safe for the resident. The procedure indicated: the resident will be evaluated for competency and physical ability to self-administer, a Self-Administration of Medication Evaluation will be completed by a licensed nurse to determine if the resident can self-administer medications/treatments safely. The decision and the procedure will be explained to the resident and legal representative if deemed capable of self-administer. A physician's order will be obtained and recorded in the medical record. the licensed nurse or TMA (trained medication aide) administering medications/treatments that a resident takes after set-up, will check with the resident after end of the time the medication/treatment is to be given/completed to assure appropriate medication administration.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and document review, the facility failed to provide a clean room and bathroom for 1 of 1 resident (R11) reviewed for a safe, clean, comfortable, home-like environment.Findings include: R11's quarterly Minimum Data Set (MDS), identified R11 was cognitively intact, was hard of hearing, had clear speech, had the ability to understand, and had no refusals of care. R11's diagnosis included heart failure, high blood pressure, anxiety and malnutrition (requiring feeding through an external tube medically inserted through the abdominal wall) During an observation and interview on 3/23/26 at 8:36 a.m., R11's room identified the intravenous (IV) pole, used when giving tube feeding, had several drops of tube feeding on all four legs extending from the base. The floor around the IV pole had carpet stained with tube feeding residue. The bathroom sink counter had dried brown drops that appeared to be residue from crushed medication. The bathroom sink basin had dried, tan-colored residue in it. The floor between the television and foot of bed had 3 pieces of Kleenex laying there. R11 stated she would prefer the messes to get cleaned up. Since she can't do it on her own, she must rely on facility staff, and it can take them a while to get it cleaned. If she were at home, she would have had it cleaned already. Further observations on 3/24/26 at 11:44 a.m. and 6:19 p.m., and again on 3/25/26 at 8: 33 a.m., R11's room identified the environment observations from the previous day were still present: dirty IV pole, dirty carpet, medication residue on sink in bathroom, dirty bathroom sink basin, Kleenex in front of TV remained. During an interview on 3/25/26 at 9:04 a.m., housekeeper (H)-A, stated resident rooms are cleaned daily. The cleaning included minor dusting, wiping tables, windows and dressers, mopping the bathroom, vacuuming the floor, and wiping down the bathroom vanity and mirror. H-A stated again this cleaning was done every day. H-A stated it is important to keep the residents' rooms clean to prevent infection and keep the rooms looking nice for the residents. During an interview on 3/25/26 at 8:57 a.m., licensed practical nurse (LPN)-B stated resident rooms are cleaned daily by the housekeeping staff. The housekeepers wipe down hard surfaces, vacuum the floors, wipe down sink in bathroom, mop the bathroom floor, and clean windows and mirrors. LPN-B was not sure who cleans the medical equipment like the IV pole, bed, and oxygen machines. LPN-B stated it is important to keep the residents' room clean to prevent infection and so the residents live in a clean room. During an interview on 3/25/26 at 2:20 p.m., registered nurse (RN)-A confirmed the housekeeping team cleans every room every day. When each room is cleaned, the floors were to be cleaned or vacuumed. Mirrors and hard surfaces bathroom sinks, and showers were also to be cleaned. RN-A confirmed any spilled tube feeding liquid should be cleaned by the nurse who spilled it or by the housekeeping team. RN-A confirmed there was tube feeding residue on the floor under the IV pole and on the IV pole. RN-A stated it is important for resident rooms to be cleaned to prevent infection, and so residents had a clean environment to live in. A housekeeping policy was requested but not received.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview and document review the facility failed to ensure appropriate medication side effect monitoring for psychotropic medication use was completed for 1 of 5 residents (R22) reviewed for unnecessary medication use. Findings include: R22's admission Minimum Data Set (MDS) assessment, dated 3/10/26, indicated R22 had intact cognition with no hallucinations, delusion, or rejection of care. MDS indicated R22 was on an antidepressant (psychotropic medication). R22's medical diagnosis report, dated 3/24/26, included the following relevant diagnoses: major depressive disorder, acute respiratory failure with hypoxia (a critical condition where the lungs are unable to adequately oxygenate the blood), acute on chronic congestive heart failure (a life-threatening condition when your heart cannot deliver enough oxygen to your body), and type 2 diabetes (condition which results in elevated blood sugar levels). R22's baseline care plan, dated 3/4/26, indicated R22 used antidepressant medications related to depression with the goal to be free from adverse reactions related to antidepressant therapy through the review date. The only intervention listed was administer medication as ordered. The baseline care plan lacked any interventions to monitor or document any side effects for antidepressant. Furthermore, lacked identification of what side effects to monitor for. R22's care plan, printed 3/24/26, indicated R22 used antidepressant medications related to depression with the goal to be free from adverse reactions related to antidepressant therapy through the review date. The only intervention listed was administer medication as ordered. The care plan lacked any interventions to monitor or document any side effects for antidepressant. Furthermore, lacked identification of what side effects to monitor for. R22's Order Summary Report, dated 3/24/26, included the following orders: -duloxetine (antidepressant medication) 60 milligram (mg) capsule: give one capsule by mouth one time a day related to major depressive disorder with a start date of 3/5/26-trazodone (antidepressant medication): give 50 mg by mouth at bedtime for insomnia related to major depressive disorder with a start date of 3/4/26.R22's order summary report lacked documentation or any direction to monitor for side effects. R22's medication and treatment administration record (MAR/TAR) for 3/1/26 to 3/24/26 included the following:-duloxetine 60 mg capsule: give one capsule by mouth one time a day related to major depressive disorder with a start date of 3/5/26. Documentation indicated administered as ordered. -trazodone: give 50 mg by mouth at bedtime for insomnia related to major depressive disorder with a start date of 3/4/26. Documentation indicated administered as ordered. R22's MAR/TAR lacked evidence of any side effect monitoring in place. Furthermore, MAR/TAR lacked evidence of what side effects to monitor for. R22's progress notes, dated 3/4/26 to 3/24/26, were reviewed and lacked documentation of side effects being monitored for duloxetine or trazodone.Review of R22's entire electronic medication record (EMR) and paper medical record lacked evidence of side effect monitoring or identification of what side effects to be monitored with use of two antidepressants. During an interview on 3/24/26 at 5:18 p.m., licensed practical nurse (LPN)-C stated they have worked in the facility for over 2 years. LPN-C stated they were unsure if they do side effect monitoring for psychotropic medications. LPN-C stated if it was done, it would probably be documented on the MAR or in a progress note. LPN-C stated they were not sure if side effects to monitor would be listed on the care plans. During an interview on 3/24/26 at 5:49 p.m., registered nurse care coordinator (RN)-C stated, we are always monitoring for side effects. RN-C stated if any new symptoms or side effects develop, the provider would be notified. Documentation for any side effect monitoring or what side effects to monitor for was requested. At 6:45 p.m., RN-C stated it would be expected the LPN's are monitoring for side effects for psychotropic medications. RN-C stated LPN's have access to the care plan and the side effects for psychotropics are initiated on the baseline care plan so would be on the care plan. During a follow up interview on 3/25/26 at 3/20/26, RN-C stated it is a standard of practice to monitor side effects for psychotropics and when residents (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admit to the facility a baseline care plan is created while populate tasks for staff to monitor. RN-C reviewed the baseline care plan for R22, dated 3/4/26, and stated it should contain the required monitoring for medications. After review, RN-C verified the baseline care or comprehensive care plan did not contain the side effect monitoring for antidepressant medications and was not being completed. A facility policy titled Psychotropic Medications, reviewed 10/25, indicated if side effects or adverse reactions occur, notification will occur to the resident's provider.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and document review, the facility failed to ensure oxygen tubing was changed according to standards of care to prevent respiratory infections for 1 of 1 residents (R22) who was admitted for acute respiratory failure with hypoxia (a critical condition where the lungs are unable to adequately oxygenate the blood) who required oxygen.Findings include:R22's admission Minimum Data Set (MDS) assessment, dated 3/10/26, indicated R22 had intact cognition with no hallucinations, delusion, or rejection of care with admission date of 3/4/26. Section O indicated R22 required continuous oxygen therapy.R22's medical diagnosis report indicated on 3/4/26, R22's primary diagnosis for admission to the facility was acute respiratory failure with hypoxia. Additional relevant diagnoses included: acute on chronic congestive heart failure (a life-threatening condition when your heart cannot deliver enough oxygen to your body), acute eosinophilic pneumonia (lung disease that develops suddenly that progresses rapidly to sever respiratory failure), and atrial fibrillation (heart beats abnormally).During an interview on 3/23/26 at 2:05 p.m., R22 was observed wearing oxygen. The oxygen tubing was not dated. R22 was not sure if staff changed the oxygen tubing.R22's care plan, printed 3/24/26, indicated R22 reviewed oxygen therapy related to acute respiratory failure with hypoxia. The care plan had one intervention: provide oxygen as ordered 1-2 liters (L) nasal canula (NC) l to maintain oxygen levels (SP02) at 90% or above.The care plan lacked any indication on how often the oxygen tubing should be changed or who was responsible for changing the oxygen tubing.R22's Order Summary Report, dated 3/24/26, included the following order:- 1-2L NC to maintain SPO2 above >/= 92%. Wean oxygen as able. every shift related to acute respiratory failure with hypoxia with a start date of 3/13/26.The Order Summary Report lacked evidence of an order to change oxygen tubing. R22's medication and treatment administration record (MAR/TAR) for 3/1/26 to 3/24/26 included the following orders:- 1-2L NC to maintain SPO2 above >/= 92%. Wean oxygen as able. every shift related to acute respiratory failure with hypoxia with a start date of 3/13/26. The document included oxygen saturations which ranged from 91-98 which were monitored every shift. The document did not include how much oxygen was being delivered via nasal canula.- 1-2L NC to maintain SPO2 above >/= 90%. Wean oxygen as able. every shift related to acute respiratory failure with hypoxia with a start date of 3/5/26 and discontinue date of 3/13/26. The document included oxygen saturations which ranged from 93-98 which were monitored every shift. The document did not include how much oxygen was being delivered via nasal canula. R22's task log was reviewed and did not include any changing of oxygen tubing. R22's progress notes dated 3/4/26 to 3/24/26 were reviewed and included the following:-3/24/26: Discussed with resident that we assessed her oxygen need at rest, sleep and with activity and she continues to require oxygen.-3/23/26: On 1L oxygen. Sat 91% this afternoon.-3/23/26: Oxygen saturations assessed to see if resident is able to be weaned from 02. Oxygen levels decreased with o2 off. o2 with activity dropped to 88-89% RA, 02 dropped 89-91% RA at rest, and 02 dropped at bedtime with o2 off 86-88% RA. Resident continues to require oxygen at this time.-3/18/26: On 1L oxygen. Sat 96% this afternoon.-3/18/26: On 1L oxygen with a 96% sat.-3/15/26: On 1L oxygen with a 95% sat.-3/14/26: On 1L oxygen with a 96% sat.-3/13/26: She is to have her supplemental 02 weaned to as able for goal of Spo2 of >/=92%-3/12/26: On 1L oxygen with a 98% sat.-3/11/26: On 1L oxygen with a 97% sat.-3/10/26: On 1L oxygen. Sat 97% this afternoon. -3/9/26: On 1L oxygen with a 96% sat.-3/6/26: Goal to maintain o2 sats >90% (greater) and wean supplemental oxygen as able. Continues on prednisone taper r/t pneumonia. -3/5/26: on 1L oxygen with 95% sat.-3/4/26: On 1L oxygen. Sat 97% this afternoon. The progress notes lacked any indication of oxygen tubing being changed during R22's admission at the facility. During an interview on 3/24/26 at 2:07 p.m., trained medication aid (TMA)-A stated they work as a TMA and nursing assistant at the facility. TMA-A stated they have worked at the facility for over 2 years. TMA-A stated the oxygen tubing should be changed weekly. TMA-A stated they are unsure of who changes the oxygen tubing as it previous was night shift, but it might (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have moved to day shift. TMA-A stated the tubing previously was dated but doesn't believe that was the practice any longer. TMA-A stated they have not changed any oxygen tubing for a long time. TMA-A stated the oxygen tubing was kept in the medication room which only TMA's and nurses have the key for so only nurses and TMA's would be responsible for changing the oxygen tubing. During an interview on 3/24/26 at 2:21 p.m., R22 stated she was unsure when the oxygen tubing was last changed. The oxygen tubing appeared clean. During an interview on 3/24/26 at 4:54 p.m., nursing assistant (NA)-C stated they have worked in the facility for over 2 years. NA-C stated they believe oxygen tubing should be changed weekly. NA-C stated oxygen tubing used to be changed every Saturday but that was no longer the practice. NA-C stated they give a resident new oxygen tubing when they notice the tubing was dirty. NA-C stated they do not document when the oxygen tubing was changed or date the tubing. NA-C stated they are unsure of when R22's oxygen tubing was changed.During an interview on 3/24/26 at 5:16 p.m., licensed practical nurse (LPN)-C stated they have worked in the facility for over 2 years. LPN-C stated oxygen tubing should be changed weekly and as needed. LPN-C stated they date oxygen tubing when they provide a resident with new tubing. LPN-C stated they do this so then everyone would know when the resident got new tubing. LPN-C stated nurses or TMA's are responsible for changing oxygen tubing. LPN-C stated they do not document when a resident's oxygen tubing was changed. LPN-C verified R22's oxygen tubing on portable oxygen tank and on oxygen tubing on oxygen concentrator was not labeled. LPN-C stated they are unsure of when or if R22's oxygen tubing had been changed and should be changed. During an interview on 3/24/26 at 5:44 p.m., registered nurse care coordinator (RN)-C stated the expectation would be oxygen tubing to be changed weekly and as needed so that it would not be contaminated. RN-C stated the expectation would be to follow that standard practice. During a follow up interview at 6:41 p.m., RN-C stated the expectation would be oxygen tubing would be changed with the shower schedules. RN-C stated when a resident received their weekly shower or bath, their oxygen tubing should be changed as we integrated that into the bath schedules like our nail care. RN-C stated they do not document the changing of the oxygen tubing. During an interview on 3/24/26 at 7:03 p.m., NA-D stated they worked at the facility for 1 1/2 years. NA-D stated they have never changed any oxygen tubing. NA-D verified they are responsible for providing resident showers and baths. NA-D stated nursing assistants do not change oxygen tubing here. A facility policy, dated 2/26/26, indicated oxygen tubing is replaced weekly on the resident's bath/skin day.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 1 direct-care nursing staff (Licensed Practical Nurse (LPN)-A) was appropriately trained and competent in the assessment and care of tube feeding and lidocaine patch application for 1 of 1 (R11) resident.Findings include: R11 was admitted to the facility on [DATE], R11 had a gastric tube surgically implanted 8/14/25 to provide enteral feedings due to malnutrition R11's quarterly Minimum Data Set (MDS), identified R11 was cognitively intact, was hard of hearing, had clear speech, had the ability to understand, and had no refusals of care. R11's diagnosis included heart failure, high blood pressure, anxiety, and malnutrition requiring a feeding tube medically inserted through R11'S abdominal wall. R11's current, undated physician's orders included:Enteral tube Feed of Nutren 1.5 at 100 (milliliters/hour (ml/hr) for a total of 250 ml, twice per day.60 ml water flush before and after enteral feedings.Medications given via G-tube:flush 30ml of water prior to medication administration,finely crush and mix together Tylenol, amlodipine, buspirone, cetirizine, hydrochlorothiazide, melatonin, oxycodone, senna, and sertraline with at least 30ml of water.Flush with 30ml of water following medication administration every shift.Aspiration precautions:Sit the resident (R11) upright with all oral intake and when completing oral cares. Ensure R11 ate small bites, took small sips, and would eat slowly. Avoid laying down for 30 minutes after meals. Provide good oral care 3-5 times each day. Watch R11 closely for signs of aspiration. Ensure R11's mouth was Empty before adding more food/liquid.Alternate solid food with small amounts of liquid. Do not allow use of straws. Require supervision/assistance every shift for aspiration precautions.Resident to sit up during tube feeding or keep the head of the bed elevated to 45 degrees, and remain upright 1 hours after feedings, three times per day. R11's undated, current care plan indicated R11 had a self-care performance deficit related to her gastric tube and required assistance from facility staff to manage her gastric tube. Additionally, R11 had a nutritional problem, requiring tube feedings. Staff were to ensure no pureed food was given, provide set up assistance, and ensure a regular diet with soft, bite-sized textures was provided. R11 was also to have thin liquids, small portions, and staff were to allow R11 to have regular snacks if she requested. R11 was able to eat slowly and self-monitor eating. Staff were to ensure she sat as upright as possible, provide tube feedings, and provide supplements and snacks as ordered. During an observation and interview on 3/23/26 at 8:36 a.m., licensed practical nurse (LPN)-A was administering medication to R11. LPN-A administered 30cc of water, crushed THE medications, then administered them through her gastric tube, and flushed the tube with 30cc of water. LPN-A then applied a lidocaine patch to R11's left shoulder, placing the lidocaine patch so it slightly covered an existing lidocaine patch on R11 without removing the old patch. LPN-A stated she had not had any recent education about administering tube feeding via a gastric tube. LPN-A stated it had been a long time since she had cared for a resident requiring a tube feeding via a gastric tube. LPN-A stated she didn't think it would be an issue to place the lidocaine patches so they overlap; she just needed to place them where the resident had pain. During an observation and interview on 3/23/26 at 12:10 p.m., registered nurse (RN)-A entered R11's room to complete the tube feeding. RN-A stopped the tube feeding portion and tried programming the pump to administer the 60 ml water flush. RN-A stated she was not familiar with this pump and could not get the pump programmed correctly. RN-A turned the pump off, elevated the head of the bed higher to approximately 45 degrees, and gave the 60 ml water flush via a syringe. RN-A stated staff had received education about tube feedings and gastric tubes before the resident arrived. During an interview on 3/25/26 at 2:29 p.m., LPN-B stated any nurse working with R11 should have received tube feeding and gastric tube education prior to caring for her. LPN-B stated she completed this education the week prior to the resident returning to the facility. During an interview and document review on 3/25/26 at 2:40 p.m., RN-A stated staff who worked with (continued on next page)

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	03/26/2026

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.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11 were provided education prior to her arrival. RN-A stated staff were provided with information about how to specifically care for R11 and the care she required for her tube feedings and gastric tube. Any staff who worked with R11 should have had pertinent tube feeding and gastric tube education. RN-A confirmed LPN-A had not had the required tube feeding and gastric tube education. RN-A stated it is important for staff to have education about tube feedings and gastric tube before the resident arrived so that staff feel comfortable using the gastric tube, ensure resident safety, and prevent complications RN-A confirmed LPN-A should have had the education prior to working with R11 and confirmed the resident's head of bed should have been placed at 45 degrees for the duration of the tube feeding and up to an hour after to prevent aspiration. Additionally, RN-A confirmed LPN-A had administered the lidocaine patch incorrectly when the 2nd patch was placed over top the first patch. Staff are educated about medication administration upon hire and annually. That was important as medications are administered safely and accurately. A facility medication administration titled Enteral Medicine Administration dated 02/26 was received, the policy lacked information to assure the head of the bed was elevated for medication administration and tube feeding administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper use of personal protective equipment (PPE) for 1 of 1 resident (R11) reviewed for enhanced barrier precautions (EBP).Findings include: R11's quarterly Minimum Data Set (MDS) dated [DATE], identified R11 was cognitively intact, was hard of hearing, had clear speech, had the ability to understand, and had no refusals of care. R11's diagnosis included heart failure, high blood pressure, anxiety and malnutrition (requiring feeding through an external tube medically inserted through the abdominal wall). R11 had a percutaneous endoscopic gastronomy (PEG tube) placed on 8/14/25 due to complete intestinal blockage. A PEG tube is considered an indwelling medical device, according to the Center for Disease Control (CDC). Due to this, R11 required additional personal protective equipment (PPE) requiring Enhanced Barrier Precaution (EBP) isolation. EBP are designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes; they require gown and glove use during high-contact resident care activities. R11's undated, current care plan lacked information regarding infection prevention and need for EBP due to PEG tube. R11's undated, current physician's orders lacked an order to use EBP. During an observation on 3/23/26 at 8:36 a.m., licensed practical nurse (LPN)-A entered R11's room to perform medication administration and initiate tube feeding via PEG tube. LPN-A failed to don an isolation gown and put on the proper PPE before providing personal cares to R11. LPN-A completed medication administration and initiated tube feeding and exited R11's room without performing hand hygiene. During an observation on 3/23/26 at 12:10 p.m., registered nurse (RN)-A entered R11's room to administer medication and complete the tube feed and flush the PEG tube. RN-A failed to don an isolation gown and put on the proper PPE before providing personal cares to R11. RN-A was unable to disconnect the PEG tube from the tube feed line, so RN-B entered the room to aid with disconnecting the line. RN-B failed to don an isolation gown and put on the proper PPE before providing personal cares to R11. During an observation on 3/23/26 at 1:24 p.m., nursing assistant (NA)-A and nursing assistant (NA)-B entered R11's room and failed to don an isolation gown prior to entering R11's room to assist R11 with changing her soiled undergarments. NA-A and NA-B failed to put on the proper PPE before providing personal cares to R11. During an interview on 3/25/26 at 2:29 p.m., licensed practical nurse (LPN)-B stated R11 required EBP due to her PEG tube. LPN-B stated anyone administering medication, starting or stopping tube feeding, or providing personal cares such as changing undergarments should have worn EBP. LPN-B stated appropriate use of EBP is important because it prevents the spread of infection from one resident to another. During an observation and interview on 3/25/26 at 2:40 p.m., registered nurse (RN)-A stated staff know who required EBP by looking at the list in the main office, and by opening the cabinet door outside of each resident room. If a resident was in EBP, there would be an isolation sign inside the cabinet door. RN-A confirmed R11 had an EBP sign on the inside of her cabinet door and R11 required EBP precautions due to her PEG tube. Additionally, RN-A confirmed she should have been wearing EBP when she stopped the tube feeding in R11's room. RN-A confirmed it is important to wear EBP to keep the residents safe and to stop the spread of infection from residents to residents. A facility policy titled Enhanced Barrier Precautions dated 1/2026, residents with any of the following require enhanced barrier precautions during high-contact cares: indwelling medication devices; urinary catheter, feeding tube, wound drains, etc. High contact care consists of providing any care for indwelling medical devices and changing incontinent products. When high-contact care is required, staff must: complete hand hygiene prior to entering room and put on gown and gloves prior to entering room. Precautions are implemented and kept in place for the duration of the resident's stay or until their wound is healed or the indwelling medical device is discontinued (no longer in use).

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and document review, the facility failed to ensure the nursing daily staffing report was posted in a readily available, visible location within the care center. This had the potential to affect all 95 residents, visitors, and staff who wished to view the information. Findings include: During an observation on 3/24/26 at 4:42 p.m., the nursing daily staffing report was posted on the wall behind the receptionist desk. Office specialist (OS)-A stated the nursing daily staffing report was posted in the morning. OS-A stated if the nursing daily staffing report needed to be changed throughout the day they would cross off the one entered and write in the new totals on the nursing daily staffing report. OS-A stated from where she was sitting, at the reception desk by the computer, the nursing daily staffing report was hard to visualize the information. During an interview on 3/25/26 at 10:17 a.m., the nursing daily staffing report was posted on the wall behind the receptionist desk. OS-B stated the nursing daily staffing report was posted every morning. OS-B stated she would take the nursing daily staffing report down and change the numbers with any changes that needed to be made throughout the day. OS-B stated the nursing daily staffing report had been posted on the wall behind the reception desk since she had started working four years earlier. OS-B stated she could not read the nursing daily staffing report from the desk. OS-B stated people in wheelchairs could not see the nursing daily staffing report and other people would have to lean over the counter to see the nursing daily staffing report. and might not be able to read it. During an interview on 3/25/26 at 10:25 a.m., Administrator stated she had been at the facility for 14 years and the nursing daily staffing report had always been posted behind the reception desk. The administrator stated no one had ever said anything about it. The administrator stated the nursing daily staffing report does not mean a thing to the residents because it is in hours and it is only regulatory thing. The administrator stated she could not read the nursing daily staffing report and had to lean into the reception desk to see the nursing daily staffing report behind the desk. The administrator stated the font could be bigger for people to read. A facility policy was requested and none was provided.