STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245530	A. BUILDING _____ B. WING _____	05/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to ensure a call light was within reach for 1 of 1 residents (R1) reviewed for accidents. Findings include. During an observation and interview on 5/20/2020, at 11:33 a.m. R1 sat in a Broda wheelchair in the upright position on the right side of the her bed near the window. R1's call light was observed outside of R1's reach on the opposite side of the bed draped over the bedside rail. R1 was asked where her call light was, R1 looked down at her lap and on the side of her wheelchair, stated that she did not know where it was, and indicated she could not move her chair around the bed to get to her call light. R1 was asked if she knew what the call light was used for and how to use it, R1 stated to call staff, and then she held her right hand up and made a half closed fist, she moved her thumb up and down as if pushing the button found on top of the call light cord. During subsequent observations on 5/20/2020, at 11:45 a.m., 12:05 p.m., 12:20 p.m. R1's call light continued to remain on the bed rail outside of R1's reach. During an observation and interview on 5/20/2020, at 12:22 p.m. nursing assistant (NA)-A walked to R1's room, observed the call light on the left bed rail, confirmed the call light was not in R1's reach, and stated the call light should be moved so R1 could reach it. NA-A then turned around and walked away from R1's room without first moving the call light so it was within R1's reach. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1's cognition was severely impaired with a Brief Interview for Mental Status score of five and did not have signs or symptom of [MEDICAL CONDITION]. The MDS identified R1 to have adequate hearing, had the ability to make self understood, and had the ability to understand others. The MDS also indicated R1 was dependent on one staff and both of R1's upper extremities had functional limitations in range of motion. R1's Vulnerabilities care plan dated 8/14/19, indicated R1 was vulnerable because of the need for assistance with transfers and mobility. The corresponding interventions included, Before leaving my room, ensure I have easy access to my call light button and preferred personal belongings. During an interview on 5/20/2020, at 12:30 p.m. licensed practical nurse (LPN)-A stated she just came from R1's room, observed the location of the call light, and moved the call light so it was within R1's reach. LPN-A stated call lights should always be within the resident's reach if they have the ability to use them. During an interview on 5/20/2020, at 3:45 p.m. director of nursing (DON) indicated staff should ensure call lights were within the reach of residents. Facility policy Call Lights dated 12/2019, included, It is the policy of Samaritan (NAME)any to provide all residents using the call light system in this facility. Call lights should be placed within reach of the residents.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to comprehensively [MEDICAL CONDITION] spilled hot liquid upon discovery for 1 of 1 residents (R1) reviewed for accidents. Findings included: -Progress note dated 5/18/2020, at 10:21 a.m. indicated R1 had spilled tea into her lap. Bilateral thighs noted to be red in color. Multiple fluid filled blisters noted on bilateral thighs. On right thigh, noted to have an open area from blister that had opened. Provider notified . R1's physician visit note dated 5/18/2020, that was electronically signed at 11:29 a.m. included visit [DIAGNOSES REDACTED]. The note indicated the physician had received a facility communication tool that R1 was drinking hot tea and spilled the tea on her thighs. She incurred second [MEDICAL CONDITION] bilateral medical thighs with opened and closed blisters present. The physical exam included, Right upper thigh there is approximately 5 to 6 cm (centimeters) in diameter [DIAGNOSES REDACTED]tous (red) irregular shaped patch with approximately 3 groupings of closed blister that is about 1 cm each in diameter. At the left upper medial thigh there is an approximately 5 cm in diameter [DIAGNOSES REDACTED]tous patch that is irregular in shape with a now opened and dry blister that is approximately 4 cm in length and 1 to 2 cm in width. During an observation and interview on 5/ 20/20, at 3:08 p.m. with director of nursing (DON) and registered nurse (RN)-A, R1 laid in her bed. Both of R1's upper thighs were wrapped in roll gauze. RN-A washed hands, donned gloves, and carefully removed the roll gauze, then removed the cover dressings from R1's wounds. On R1's left inner thigh was a large fluid filled blister that was approximately 4-5 centimeters (cm) in length by 2-2.5 cm in width; RN-A said the area used to have several groupings of smaller blisters and now it's just one. Superior (above) to the large blister was an open area with pink base that was approximately 1.5-2.0 cm in diameter. A large area of redness encompassed the blister and open wound. RN-A stated the open area and the surrounding redness had not changed since the accident happened. On R1's right inner thigh was 4 intact fluid filled blisters that measured 0.5-1.0 cm in diameter. A large area of redness also encompassed the blisters. RN-A indicated there had not been any changes to that area. R1's [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had severe cognitive impairment and was dependent on staff for transfers and required extensive assistance from staff for bed mobility, toileting, dressing and hygiene. The MDS also indicated R1 did not have any impaired skin integrity other than a Stage 1 pressure ulcer. R1's record was reviewed, the record did not contain a comprehensive skin assessment upon identification. -Progress note dated 5/19/2020, at 1:39 p.m. indicated R1 received shower. Resident continues to have multiple fluid filled blisters noted to bilateral thighs with redness. On right thigh, noted to have an open area from a blister that had opened. Continue to provide normal saline rinses and apply [MEDICATION NAME] ointment and [MEDICATION NAME] (none-adherent dressing) dressing changes BID (twice per day). No signs of infection. -Progress note dated 5/19/2020, at 8:01 p.m., indicated R1's pain related to [MEDICAL CONDITION] better, but R1 reported it hurt when somebody touched it. R1's skin care plan last revised on 2/3/2020, R1 was at risk for skin breakdown and/or pressure ulcer development related to impaired mobility and incontinence. Skin care interventions included, Administer treatments as ordered and monitor for effectiveness. Follow facility policies for the prevention/treatment of [REDACTED]. During an interview on 5/20/20, at 3:23 p.m. licensed practical nurse (LPN)-A stated if a resident had a new skin issue, she would document the finding, and report the new skin injury to the RN unit manager. LPN-A stated the RN would then complete a comprehensive skin assessment, make the necessary notifications, implement any treatments, and revise the care plan. LPN-A indicated the wound is then assessed weekly and as needed, and weekly skin evaluations were completed on bath day. During an interview on 5/20/20, at 3:27 p.m. RN-A indicated she was the unit manager and responsible for completing the initial wound assessment. RN-A reviewed R1's record and confirmed a comprehensive wound assessment was not completed, the assessment should have been completed upon discovery, and the lack of the assessment was an oversight. RN-A indicated the assessment would include baseline measurements for later comparison, number of blisters, drainage, associated pain, effectiveness of interventions, drainage, treatment plan etc. Facility policy Skin/Wound Care dated 4/2019, included: PROCEDURE: Skin integrity is inspected daily during the performance of nursing care. Caregivers will report any problems or concerns to the licensed nurse.

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

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.