Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 17, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: August 25, 2022

Dear Administrator:

On September 15, 2022, we notified you a remedy was imposed. On October 18, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 2, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 15, 2022 be discontinued as of November 2, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 15, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 15, 2022. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 17, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: Reinspection Results
Event ID: 46YZ12

Dear Administrator:

On October 18, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on . At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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Electronically delivered
September 15, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: August 25, 2022

Dear Administrator:

On August 25, 2022, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 15, 2022.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 15, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 15, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 15, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 15, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 25, 2023 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

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

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/22/22-8/25/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/22/22-8/25/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5236091C (MN77443), however NO deficiencies were cited. H5236090C (MN79078), however NO deficiencies were cited due to actions implemented by the facility prior to survey. AND The following complaints were found to be UNSUBSTANTIATED: H5236088C (MN82121) H5236089C (MN80586) H52364073C (MN84802) H52364074C (MN85687)	F 000		

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

Electronically Signed | 09/23/2022

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.

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F 000	Continued From page 1 H5236092C (MN79595) H52364356C (MN85388) H52364072C(MN85920) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess safety with self-administration of medication for 1 of 1 resident (R13) observed to have medications left in their room unsupervised by staff after staff set-up. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/6/22, indicated R13 was cognitively intact and required assistance with activities of daily living (ADL's).	F 554	F554 □ Self Administration of Medications This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	9/25/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 554	Continued From page 2 On 8/23/22, at 9:43 a.m. R13 was observed in his room with no staff present and there were three pills in a medication cup on R13's bedside table. R13 stated about 8:15 a.m. registered nurse (RN)-D brought the pills into the room, set them on the bedside table and exited the room. R13 stated the two larger pills were Tylenol and the smaller pill was Oxycodone. R13 stated he was not due to take the pills for another 30 minutes. On 8/25/22, at 9:44 a.m. R13 was seated in a recliner in his room. There were three pills in a medication cup on the table to the left side of resident's bed. R13 stated RN-D brought the pills into the room at 9:05 a.m. that morning, left the room immediately and had not been back since. R13 stated the medications were two Tylenol and one Oxycodone. R13's medical record lacked a current self-administration of medication assessment. On 8/25/22, at 10:03 a.m. RN-D stated she gave R13 Tylenol and Oxycodone that morning at 9:05 a.m. and thought the resident had taken the medication. RN-D was not aware the resident had not swallowed the pills and the medications were on the table in R13's room. RN-D was unaware whether or not staff had completed a self-administration of medication assessment for R13. Upon return to R13's room, RN-D stated there were two Tylenol and one Oxycodone in the medication cup on the table in R13's room. RN-D stated she handed the medications to R13 earlier in the morning and thought R13 took the medications. RN-D then picked up the medication cup, handed it to R13 and asked R13 to take the pills. R13 dumped the pills into his mouth, set the	F 554	R13 was reviewed to identify if appropriate for self administration of medications (SAM). The right to self-administer medication if the interdisciplinary team has determined that this practice is clinically appropriate. Residents who have been identified as appropriate for self-administration of medication, SAM assessments have been completed. Immediate education provided to nurse involved regarding policy and procedure for resident self-administration of medications. Education provided to licensed nurses/TMAs to review order instructions to verify that resident has instructions for self-administer medications. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Self-Administration of Medications policy has been reviewed and remains appropriate. Don or designee will audit for 4 Resident Medication administrations weekly for (3) weeks, then 2 medication administrations weekly for an additional (3) weeks to ensure SAM assessments are completed with appropriate nursing orders present stating "okay to self-administer medications dispensed by licensed	

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F 554	Continued From page 3 medication cup on the table and reached for his water. At that point, RN-D turned and walked out of the room without observing whether or not R13 swallowed the pills. During interview on 8/25/22, at 10:07 a.m. 12:04 p.m. RN-D stated earlier that morning she watched R13 put the three pills in his mouth and trusted that he swallowed the pills. RN-D was unable to verify R13 swallowed the pills. During interview on 8/25/22, at 10:15 a.m. RN-A and RN-B stated they were unable to find a self-administration of medication assessment for R13. RN-A expected nursing staff to complete an assessment prior to leaving medications for a resident to take on their own and then return within 30 minutes to verify the resident had taken the medication. It was important for the resident to be aware of the purpose for taking the medication and how/when it should be taken. RN-A stated R13 did not have an assessment completed and staff should not have left medications in the residents room unattended. The facilities Self-Administration of Medications policy reviewed 2/2019, identified residents have the right to self-administer medication and the purpose was to enhance the residents independence. The policy directed nursing staff to assess the resident's mental and physical abilities to determine whether self-administering medication was clinically appropriate for the resident and to document the findings in the electronic health record (EHR).	F 554	nurse/TMA. Audit findings will be presented to the facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)	F 578		9/25/22

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F 578	Continued From page 4 §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the	F 578		

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F 578	Continued From page 5 appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure advance directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in the event of an emergency for 1 of 1 resident (R137) reviewed for advance directives. Findings included: R137's quarterly Minimum Data Set (MDS) dated 7/8/22, indicated no cognitive impairment. R137's Provider Orders for Life-Sustaining Treatment (POLST) dated 7/19/21, indicated he wished to have resuscitation/cardiopulmonary resuscitation (CPR) if he had no pulse and was not breathing. A physician order report signed 6/3/22, identified R137 as a full code (wanting CPR). An Interagency Referral (IAR) for hospital discharge dated 7/19/22, identified R137's code status as a do not resuscitate (DNR). A change of code status from CPR to DNR was done in the Electronic Medical Record (EMR) on 7/19/22; R137's code status was changed to a DNR in the header of the EMR. Progress notes from hospital readmission on 7/19/22, did not address the change in R137's code status. An IAR for hospital discharge dated 8/13/22, identified R137's code status as Other-no CPR but may be intubated.	F 578	F578 Planning and Implementing Care This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R137 requested a change in code status which has been confirmed and verified and system has been updated to match the code status. All residents have the ability to be affected. All residents code statuses have been reviewed and verified. All staff have received education and a competency post-test on code status process including hospital re-admissions. Education will be provided by 09/25/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Policy for Code status has been reviewed and remains appropriate. DON or designee will conduct weekly code status audit for 3 weeks, then once a month. Audit findings will be presented to	

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F 578	Continued From page 6 An order for code status of DNR was entered in the EMR on 8/13/22. A progress note dated 8/15/22, indicated the facility spoke with R137 about his code status; R137 did want CPR done and did not want to be a DNR. R137's Face Sheet dated 8/23/22, identified R137 as DNR status. During an interview on 8/23/22, at 1:38 p.m. R137 stated if he stopped breathing and his heart stopped, he would want CPR to be started. During an interview on 8/23/22, at 2:13 p.m. registered nurse (RN)-B and RN-A stated following R137's readmission on 8/13/22, RN-B spoke with R137 and explained what would happen when doing CPR. R137 stated he was worried about his ribs breaking during CPR. RN-B and RN-A then stated they did not want to break his ribs and since it was good chance of the ribs being broke he was kept at a DNR. RN-B stated R137 refused to sign an updated POLST identifying him with a code status of DNR and still wanted chest compressions to be done. An attempt to call R137's medical doctor (MD) was attempted on 8/24/22, at 8:46 a.m. During an interview with R137's nurse practitioner (NP) on 8/24/22, at 8:53 a.m. she stated on 8/17/22, she spoke with R137 about the code status and what he was expecting to happen when CPR was performed. The NP stated R137 still wanted compressions to be done and did not want ribs broken. NP once again educated R137	F 578	the facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	

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	245236	A. BUILDING _____ B. WING _____	C 08/25/2022

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F 578	Continued From page 7 on CPR and R137 stated he still wanted to have chests compression done and did not want to be a DNR. The NP stated R137 should have been a full code as identified in his last POLST from 7/19/21. During an interview on 8/24/22, at 11:52 a.m. with the director of nursing (DON) and RN-C, the DON stated the facility received signed orders on 8/19/22 from R137's primary MD which indicated R137 as a DNR. The DON stated he talked with R137 about the change in code status and had an order for DNR. The DON stated R137 said he wanted chest compression to be done and did not want to be a DNR, R137 was just concerned about his ribs breaking. The DON stated he knew R137's wishes regarding code status and wanting compression started but opted to follow the MD's orders until R137 visited with a provider and discussed it. The facility's policy Advance Care Planning (ACP)-Medical Orders-POLST dated 11/28/17, indicated the POLST as the outline of the plan of care reflecting the resident's wishes concerning care at life's end. The facility would respect the right of the person to not complete medical orders or discuss their end of life wises.	F 578		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		9/25/22

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F 609	Continued From page 8 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported for 1 of 3 residents (R29) reviewed for abuse. Findings include: R29's Face Sheet printed on 8/25/22, indicated R29's diagnoses included anxiety, depression, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following a cerebral infarction (stroke) affecting her right dominant side and acquired absence of left leg below the knee (amputation). R29's admission Minimum Data Set (MDS) dated	F 609	F609 In response to allegations of abuse, neglect, exploitation, or mistreatment This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R29 was interviewed and clinically reviewed, R29 remains at baseline and	

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F 609	Continued From page 9 2/15/22, indicated R29 was cognitively intact. R29's quarterly MDS dated 6/22/22, indicated she required an extensive assist of one with activities of daily living. R29's care plan dated 2/9/22, indicated R29 had a self deficit with bathing, grooming, oral cares, ambulation, transferring, mobility, vision, bowel and bladder. Interventions included the assistance of one with bathing and toileting needs. R29's care plan dated 2/8/22, indicated R29 was a vulnerable adult. Interventions directed staff to report and investigate any allegations of suspected abuse, neglect or exploitation. On 8/23/22, at 11:10 a.m. R29 stated on Sunday, 8/21/22, at about 7:00 a.m. nursing assistant (NA)-A treated her roughly during cares while he was putting a compression stocking on her right leg. R29 said she told him he needed to pull the sock away from her toes, but he didn't fix it. R29 stated she was in tears by the time he was done helping her and he told her she needed to calm down. R29 stated she reported this to trained medication aide (TMA)-A. R29 stated around 11:00 a.m. she asked a different staff to look at her sock, this staff person removed her shoe and sock and found her toes to be red and "indented" from the compression sock. On 8/23/22, at 11:34 a.m. the allegation was reported to the administrator who stated it should have been reported when it occurred. The administrator stated he would report the allegation and would take NA-A off the schedule until the allegation was investigated. On 8/23/22, at 12:36 a.m. TMA-A was called, he	F 609	feels safe, staff involved were immediately removed from schedule until investigation completed. Other residents residing on the unit where staff involved were interviewed to ensure no other concerns were reported. Immediate education provided to nursing staff involved regarding policy and procedure for abuse reporting. Education provided to all staff including a competency post-test. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Abuse policy has been reviewed and remains appropriate. DON or designee will complete weekly audits of grievances, concerns and events to ensure reporting occurred as defined by abuse prevention policy. Audit findings will be presented to facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	

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F 609	Continued From page 10 did not return the phone call. On 8/25/22, at 2:02 p.m. NA-A stated he was taking care of 18 other residents in additon to R29 on 8/21/22. NA-A stated "she does not like black people, she does not like men". NA-A further stated R29 liked things done in a specific way; she was "whining and complaining through the care" and told him she was going to report him. NA-A stated R29 was very difficult to work with, but that he spent 40 minutes taking care of her. NA-A volunteered she was crying by the end of the cares. On 8/25/22, at 4:18 p.m. the director of nursing stated he would expect staff to report an allegation of rough treatment immediately. The facility policy titled Abuse Prevention Plan revised 8/14/20, directed staff to notify the facility "Charge of Building" immediately of any reports of possible abuse, neglect, misappropriation of resident property, and/or financial exploitation.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess the need for and failed to develop a comprehensive care plan related to living in a locked memory care unit for 3 of 3 (R3, R20, R38) reviewed for involuntary seclusion. Findings include:	F 641	F641 Accuracy of Assessments This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or	9/25/22

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F 641	Continued From page 11 During an observation on 8/25/22, at 8:55 a.m. at the second-floor nursing station desk, there were three resident photos taped to the plexiglass desk barrier. Each photo had a name, room number, and "wanderer" which identified they were R8, R25 and R41. These residents were not living in the facility's locked memory care unit. Resident #3 R3's quarterly Minimum Data Set (MDS) dated 8/12/22, indicated R3 had a mild cognitive impairment and had diagnoses that included age-related cognitive decline and major depressive disorder. R3 was independent with eating after set up and required staff assistance with all other care areas. However, the MDS indicated R3 exhibited no wandering or exit seeking behaviors. Additionally, the MDS identified R3 utilized no restraints. R3's Elopement Risk Assessment dated 2/25/21, indicated R3 was low risk for elopement. R3's In-house Transfer Notice dated 3/19/21, indicated a room change was initiated for R3 due to "long-term private bed available". R3's care plan edited 8/22/22, indicated R3 had a diagnosis of major depression and age-related cognitive decline which may have impacted her mood/behavior. However, the care plan did not address the need for a secure, locked unit nor did the care plan identify if R3 wandered or had exit seeking behaviors. During an interview on 8/23/22, at 9:21 a.m. R3 stated she had no sense of direction. R3 further	F 641	facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R3, R20, R28 have been reviewed for placement in the secured unit, MD orders obtained for locked memory care unit, careplans reviewed and revised to reside in the secured unit to include placement criteria for the secured unit. All residents who reside in the secured unit have been reviewed for appropriate placement by IDT, care plans have been reviewed/revised if necessary and MD orders have been obtained. Residents will be reviewed quarterly for appropriateness for the need to be in the secured unit. Education provided to interdisciplinary team members involved in resident placement planning to include comprehensive care plan policy and admission criteria to secured unit. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Audits for all transfers into the secure unit will be completed by DON or designee at the initial transfer to the unit to assure clinical appropriateness and appropriate physician orders have been signed. Audit	

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F 641	Continued From page 12 stated she would never try to go outside or leave the unit by herself because she would get confused and scared. She just didn't want to do that, and she felt safe in her room. During an interview on 8/24/22, at 3:32 p.m. trained medication aide (TMA)-B stated R3 was a very nice lady. R3 could tell you what she needed, but staff did offer toileting every two hours because R3 might forget. TMA-A further stated R3 had no behaviors and never tried to leave the unit on her own. R3 liked to stay in her room and really didn't want to come out of her room without staff encouragement. TMA-B then stated R3's family requested R3 be placed in the secure locked unit because R3 tried to "exit by phone"; for example, R3 would sporadically call family and ask them to come get her. During an interview on 8/25/22, at 9:53 a.m. nursing assistant (NA)-F stated R3 would get "confused" every once in a while, but was easy to redirect. NA-F stated it was more like a "skipping record" and R3 would ask the same question repeatedly. R3 never became angry and never tried to leave the unit without staff accompanying her. During an interview on 8/25/22, at 10:06 a.m. TMA-C stated R3 was nice. R3 liked to stay in her room but would occasionally come out for meals. R3 would go to the third floor with activities for church services. However, R3 never attempted to leave on her own. During an interview on 8/25/22, at 1:52 p.m. registered nurse (RN)-C stated R3 did not have a diagnosis of dementia, but R3 did exhibit confusion. R3 could not remember from	F 641	findings will be presented to facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Comprehensive Care Plan Policy has been reviewed and remains appropriate. Baseline compliance to be achieved by September 25, 2022.	

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F 641	Continued From page 13 day-to-day. However, R3 did not exhibit exit seeking behavior. RN-C stated she could not say why R3 was placed in the secure locked unit. Further, RN-C stated it was not a locked unit like it was "in the day". The facility was trying to revamp how they utilized the space. RN-C then stated R3 did not have an order for a secure locked unit, nor was the secure locked unit was identified in R3's care plan. However, RN-C additionally stated the resident photos at the second-floor nurses station identified residents who wandered away from other units. Those residents wore a wander guard (technology made solely for the purpose of keeping elderly people or people with dementia from wandering) to prevent exiting the facility and there were no beds available in the secure locked unit. RN-C confirmed there were residents currently residing in the secure locked unit without exit seeking behavior and social services should review that. During an interview with social services (SS)-A and SS-B on 8/25/22, at 2:04 p.m. SS-A stated each resident case was discussed in the IDT meeting to determine if a resident met criteria for placement in the secure locked unit. Issues discussed were diagnosis, elopement risk, and "fit". SS-B stated nursing would get the order for the secure locked unit from the resident's physician and family education would be conducted. However, because SS-A and SS-B were new to their roles, they would need to review R3's chart. - At 3:06 p.m. SS-B stated there was no documentation in R3's medical record and/or care plan that identified the need for a secure locked unit. Further, R3 was a low elopement risk. Resident #20	F 641		

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F 641	Continued From page 14 R20's quarterly MDS dated 6/14/22, indicated R20 had a severe cognitive impairment and diagnoses that included Parkinson's disease. R20 was non-ambulatory and required staff assistance with all care areas. Further, the MDS identified R20 did not exhibit behaviors during the assessment period nor utilized a restraint. R20's Elopement Risk Assessment dated 6/30/21, indicated R20 was a low elopement risk. R20's care plan dated 7/7/21, did not address the need for a secure locked unit nor did the care plan indicate if R20 wandered or had exit seeking behaviors. R20's In-House Transfer Notice dated 7/8/21, indicated "long term bed available". During an observation on 8/24/22, at 7:25 a.m. R20 was sitting quietly in her wheelchair in the dining room. R20 was waiting for her breakfast meal. R20 greeted staff and residents as they came into the dining room. RN-C was wishing R20 a happy birthday. R20 smiled and asked for a coke. During an interview on 8/24/22, at 3:37 p.m. NA-E stated R20 never had any behaviors nor tried to leave the unit. Just never. "She's a really nice lady." During an interview on 8/25/22, at 10:00 a.m. NA-F stated R20 never had behaviors and never tried to leave the unit. During an interview on 8/25/22, at 10:12 a.m. TMA-C stated R20 went to church on Sundays	F 641		

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F 641	Continued From page 15 with her family. R20 never complained about anything but would get tired and needed an afternoon nap daily. R20 never exhibited behaviors. R20 was very "go with the flow". Whatever staff asked her to do, she would do it without complaint. During an interview with nurse practitioner (NP)-A on 8/25/22, at 12:27 p.m. NP-A stated the facility really made the determination for placement in the secure locked unit. She and the physicians usually agreed with the acilty's determination unless the resident or family objected. R20 did not have a diagnosis of dementia and did not have exit seeking behaviors. However, NP-A stated R20 probably benefitted from a more personalized, quiet environment. During an interview on 8/25/22, at 1:40 p.m. RN-C stated a resident did not have to have a diagnosis of dementia for placement into the secure locked unit. For example, maybe a resident needed a quieter setting due to anxiety. The unit provided a quieter setting, 1:1 activity, and small group activities. The physician would write an order for placement, but the need for a secure locked unit was never identified in the residents' care plans. RN-C then stated R20's family was very happy with R20's placement in the secure locked unit. Her family was able to visit all the time. R20 benefitted from a smaller setting because she was very private. RN-C then stated R20 did not have a diagnosis of dementia and she could not find an order for the secure locked unit. R20 had a severe cognitive impairment and poor decision making. R20 was not always understood, nor did she always understand others. R20 was a low elopement risk. Additionally, RN-C stated the facility had not	F 641		

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F 641	Continued From page 16 attempted any other alternative to a secure locked until because R20 had resided in the facility a little over a year. During an interview on 8/25/22, at 3:06 p.m. SS-B stated there was no documentation in R20's medical record or care plan that identified the need for a secure locked unit. Further, R20 was a low elopement risk. Resident #38 R38's Elopement Risk assessment dated 6/30/21, indicated R38 was low risk for elopement. R38's quarterly MDS dated 7/11/22, indicated R38 had a severe cognitive impairment and diagnoses that included dementia with Lewy bodies, dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD), and major depressive disorder. R38 was on hospice, was non-ambulatory, and R38 required extensive to total assistance with all care areas. Further, the MDS indicated R38 did not exhibit behaviors during the assessment period nor utilized a restraint. R38's care plan edited 8/3/22, did not address the need for a secure locked unit nor did the care plan indicate if R38 wandered or had exit seeking behaviors. An In-House Transfer Notice for R38 was requested, but not provided. During an interview on 8/24/22, at 3:34 p.m. NA-E stated it really depended on the day for R38. R38 could have behaviors like refusing care or	F 641		

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F 641	Continued From page 17	F 641		

refusing to get out of bed. However, NA-E stated R38 couldn't try to leave the unit on her own because she was not physically capable.

During an interview on 8/25/22, at 9:55 a.m. NA-F stated R38 really did not exhibit behaviors anymore because she was hospice, especially in the past month. R38 mostly wanted to be left alone.

During an interview on 8/25/22, at 12:22 p.m. SS-B stated R38 was more appropriate for a secure locked unit before she was on hospice. R38 has always been difficult to get out of bed, but it was more so now. However, R38 was legally blind, and she may have benefitted from a quieter environment.

During an interview on 8/25/22, at 1:50 p.m. RN-C stated R38 was extremely anxious and had major depression. R38 picked at her skin until she had open wounds. Family reported this was a life-long habit. However, R38 was a low elopement risk, and the care plan did not identify the need for a secure locked unit.

During an interview on 8/25/22, at 3:51 p.m. the director of nursing (DON) stated the facility determined as a team whether a resident would benefit from the secure locked unit the most. First, there needed to be an open bed available. Then, if staff felt the resident was an appropriate placement, they would contact the family. The DON stated no family or resident has ever complained about a placement in the secure locked unit. However, the DON stated he has researched the resident rights and he recognized the secure locked unit was the most restrictive placement that he was responsible for. The DON

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BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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F 641	Continued From page 18 then stated R3, R20 and R38 may have adapted to their environments which decreased their need for a secure locked unit. However, each resident was no longer exit seeking and should have been assessed to determine if they required a less restrictive environment. During an interview on 8/25/22, at 4:07 p.m. the administrator stated the staff clinically reviewed each resident to determine who would benefit the most from the secure locked unit. This included safety as well as the available programs. All families had agreed to the placements, never complained, and this was the "best" unit. However, the resident care plans should identify the need for a secure locked unit. The facility policy Comprehensive Assessments and Care Planning revised 7/2/18, identified the facility would provide a comprehensive person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or maintain the highest practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI) specified by the State. The facility policy Safe Harbor Unit revised 11/11, identified each resident received assistance in reaching their highest level of physical, psychological, and spiritual ability. Admission to the SHU was determined through consultation of the nursing staff, physician, family, and Social Services after comprehensive resident assessment was completed. Admission criteria: - Diagnosis of a dementia related illness - Inability to respect the rights of others, for	F 641		

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F 641	Continued From page 19 example wandering into others' rooms, etc. - Ability to benefit from a program designed for memory problems, short attention span, impaired judgement, disorientation, inappropriate behavior, or ritualistic behavior - Exit seeking behavior The policy further identified a physician order was required prior to admission and discharge. The order must include the reason for admission or discharge. The resident plan of care would address the reason for admission to the SHU and stated the benefit of the placement.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide timely toileting for 3 of 4 (R52, R13, R137) residents who had concerns regarding long call light wait times. Finding include R137 R137's quarterly Minimum Data Set (MDS) dated 7/8/22, indicated no cognitive impairment and rejection of care one to three days out of seven. R137 was an extensive assist with toileting, personal hygiene, dressing, and bed mobility and totally dependent on staff for transfers. The MDS indicated R137 was occasionally incontinent of bladder and bowel. Diagnoses included	F 677	F677 ADL Care Provided for Dependent Residents. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Five day toileting diary has been initiated	9/25/22

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F 677	Continued From page 20 hemiplegia/hemiparesis, a right sided below the knee amputation of the leg, and a left sided above the knee amputation of the leg. The MDS also indicated R137 took a diuretic (a medication that may cause frequent urination) 7 of 7 days. During an interview on 8/22/22, at 4:50 p.m. R137 stated he had to wait up to 55 minutes for staff to answer his call light. This past Sunday he turned on the call light at night because he had to urinate and had to wait 55 minutes and ultimately ended up having an accident and urinating in his bed. Also, this past Sunday, 8/14/22, he requested to get up for church at 8 a.m. He stated that morning there was only one nursing aide (NA) on the unit for 17 residents and she was not able to get him up until 9 a.m.. She was not able to start getting him ready for church until 9:40 a.m. R137 stated he missed church that day. R137 stated it worried him because the facility did not have enough staff to care for the residents they have and if he were to fall, he would be afraid of nobody finding him for two hours. During observations on 8/23/22, from 9:45 a.m. through 10:36 a.m. six call lights were on from 10 minutes to 33 minutes. During an interview on 8/23/22, at 2:05 p.m. NA-D stated the facility had a lack of staffing. On Sunday evening, 8/21/22, NA-D was the only aide on the floor for 52 residents. When they were short-staffed residents would not get the care they needed. . Some residents would go weeks without getting a tub bath or a shower. Resident call lights would ring for long times because they were in with other residents, and there was only one aide on the floor. NA-D stated residents who needed to be repositioned, toileted, or changed	F 677	for R52, R13, R137, to identify any toileting patterns, care plan will be updated to reflect new interventions. DON or designee will interview R52, R13, R137 once a week in regards to if their needs have been met. Interviews conducted of all other interviewable residents regards to their satisfaction of the ADL care provided. Any concerns identified will follow community grievance policy. Staff education completed regarding ADL care for dependent residents. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. ADL policy has been reviewed and remains appropriate. Interview 10 residents weekly for 2 weeks re: timeliness of response to their needs, then 5 residents weekly for 4 weeks. Findings will be presented to facility□s Quality Council by DON or designee. Average call light response times will be monitored and reviewed via the Quality Council, ensure an adequate response times have occurred. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	

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F 677	Continued From page 21 every two hours were not checked for up to four hours. NA-D stated residents would be put to bed without having received assistance to wash up, check or have their brief changed. Some residents would sit in a wet brief for four or more hours because they did not have the staffing they needed. R52: R52's quarterly minimun data set (MDS) dated 7/25/22, indicated R52 was cognitively intact and had not displayed verbal or physical behaviors including refusal of cares. R52 required assistance of one staff for activities of daily living (ADL's) including bed mobility, transfers, toileting, and personal hygiene. R52 was always incontinent of bladder and bowel. During interview on 8/22/22, at 3:45 p.m. R52 stated the previous day on 8/21/22, she had loose stools and had turned on her call light and waited two hours for staff to come and change her dirty brief. R52 reported she had spoken to the director of nurses (DON) and the administrator about her concern. Review of the facilty's Device Activity Report indicated the following: - On 8/20/22, R52's call light/bed alarm (call light) turned on at 6:15 p.m. and had not been cleared until 7:22 p.m. R52's call light had been on for a total of 1 hour and 7 minutes. - On 8/21/22, R52's call light turned on at 6:01 p.m. The call light was turned off at 8:16 p.m. and was on for a total of 2 hours and 15 minutes. - On 8/22/22, R52's call light turned on at 6:37 a.m and had not been turned on until 7:44 a.m., a total of 1 hour and 6 minutes.	F 677		

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F 677	Continued From page 22 - During the dates of 8/19/22 through 8/25/22, R13's call light had been on for greater than 30 minutes on 4 occasions. R13: R13's quarterly MDS dated 6/6/22 identified R13 was cognitively intact and exhibited no physical of verbal behaviors including refusal of care. R13 required assistance of one staff with activities of daily living including transfers, toileting, personal hygiene and was occasionally incontinent of bladder and always continent of bowel. During interview on 8/22/22, at 4:20 p.m. R13 stated earlier in the day he needed assistance in the bathroom to clean up after having a loose bowel movement (BM) and had turned the call light on at 1:45 p.m. R13 was unable to clean himself without assitance and staff had not answered the call light. R13 transferred himself into the wheelchair and wheeled into the bedroom area of his room. The bathroom call light was still on. R13 stated the call light was not answered until 3:30 p.m. R13 stated there was BM everywhere and staff had to clean BM from the resident as well as the wheelchair. R13 further stated long call light wait times happened every day. Review of the facilities Device Activity Report identified the following: - On 8/22/22, R13's alarm turned on at 1:54 p.m. and was cleared at 3:17 p.m. R13's call light/alarm was on for 1 hour and 23 minutes. - On 8/22/22, at 6:45 p.m. R13's call light/alarm was turned on and was not cleared until 7:49 p.m. R13's call light/alarm had been on for 1 hour and 3 minutes.	F 677		

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F 677	Continued From page 23 - During the dates of 8/19/22, through 8/25/22, R13's call light/alarm was on for greater than 30 minutes on seven occasions. During interview on 8/25/22, at 4:30 p.m. registered nurse (RN)-D stated she expected call lights to be answered quickly and within 5 minutes. During interview on 8/25/22, at 4:44 p.m. NA-G and NA-H were interviewed together. NA-G and NA-H stated the call lights were busy and staff got to them as quickly as they could	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and	F 690		9/25/22

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F 690	Continued From page 24 (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure staff were educated on how to provide catheter cares for 1 of 1 resident (R5) reviewed for catheter care. Finding include: R5's Face Sheet printed on 8/25/22, indicated diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms (age-associated prostate gland enlargement that can cause urination difficulty), weakness, and noncompliance with other medical treatment and regimen. R5's quarterly Minimum Data Set (MDS) dated 8/17/22, indicated R5 was cognitively intact, required supervision with activities of daily living, and had an indwelling catheter. R5's care plan was requested but not provided. On 8/23/22, at 9:21 a.m. R5 was seated in his wheelchair in his room; he stated he'd had his catheter for over a year. The catheter bag visible	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R5 was provided catheter education immediately in regards to placement of the bag and offer of dignity bag cover. Care plan was updated to reflect resident□s non-compliance. All residents with a catheter identified, reviewed and education completed if needed	

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F 690	Continued From page 25 from the hallway was full and lying directly on the floor and was not in a privacy bag. On 8/25/22, at 8:32 a.m. R5 was seated in his wheel chair eating his breakfast in his room, his catheter bag was lying on the floor not in a privacy bag. On 8/25/22, at 9:40 a.m. R5 stated the facility had not provided any education to him on catheter care. He stated he did not know he was supposed to keep the catheter bag off the floor and below the level of his bladder. During an interview on 8/25/22, at 9:50 a.m. registered nurse (RN)-B stated R5 had been educated on keeping his catheter off the floor but "he does what he wants to do". During a follow-up interview on 8/25/22, at 3:27 p.m. RN-B stated he was unable to find any evidence of education done with R5 on how to care for his catheter. During an interview on 8/25/22, at 4:22 p.m. the director of nursing (DON) stated he would expect staff to give education to residents on how to care for their catheter. He would not expect to see a resident's catheter lying on the floor. The facility policy titled Changing of Urinary Drainage Bag revised 8/2008 did not address education of catheter care for residents. A facility policy on catheter care was requested but not provided.	F 690	Staff education provided regarding the resident catheter education requirements and catheter care in addition how to document resident non-compliance, additionally, education provided on infection risks associated with catheter bag care and placement. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Procedures and competencies for Catheter care have been reviewed and remain appropriate. DON or designee will complete 10 audits of residents with catheters weekly for 2 weeks, then 5 audits for 2 weeks to ensure resident catheter bag placement and privacy bag are appropriately in place. Audit findings will be presented to facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		9/25/22

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F 758	Continued From page 26 §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their	F 758		

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F 758	Continued From page 27 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a gradual dose reduction (GDR) of antidepressant medications (Wellbutrin and sertaline) were attempted or a contraindication to dose reduction was documented for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings include: R5's Face Sheet printed on 8/25/22, indicated R5's diagnoses included depression, limitation of activities due to disability, and noncompliance with other medical treatment and regimen. R5's quarterly Minimum Data Set (MDS) dated 8/17/22, indicated R5 was cognitively intact. The MDS indicated R5 required supervision with activities of daily living (ADLs), required limited assistance with toilet use and took an antidepressant. R5's Physician Order Report printed 8/25/22, indicated an order for Wellbutrin XL (antidepressant) 300 milligrams (mg) for unkempt appearance, impaired thinking process/low concentration, and poor self esteem to be taken daily in the morning and an order for sertaline 150 mg for lethargy, lack of interest in ADLs, and	F 758	F758 Free from Unnecessary Psychotropic Medication/PRN Use. This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R5 was reviewed with provider and pharmacist, GDR was initiated, continue monitoring to determine if GDR is successful. GDR was requested by the pharmacist consultant and sent to the provider on 6/1/22, re-sent to provider on 6/10/22, provider return and requested family consent. On 6/27/22 R5 family decline GDR until after family reunion in August 2022. On 9/13/22 R5 had sertraline decreased from 150 mg to 125 mg. All residents on psychotropic medications who have resided in the facility within the	

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F 758	Continued From page 28 anxiety to be taken every morning. R5's care plan was requested but not provided. Review of Consultant Pharmacist Recommendation to Physician from 5/22/22, and 7/25/22, revealed the following: "Practice guidelines for major depression in primary care recommend continuing the same dose for 4-9 months following the acute phase. Whether a patient is to continue therapy in his maintenance phase depends on the established history of previous depressive episodes and the physician assessment. A trial dose reduction may be reasonable at this time." "This resident has been using Wellbutrin XL 300 mg and Sertraline 150 mg daily without a recent GDR." "If this therapy is required to prevent future depressive episodes, please document to that effect in your progress notes." The provider did not address either request. The physician progress note from 7/25/22, was reviewed. The note indicated R5 remained on sertaline and Wellbutrin XL, nothing indicated a GDR was considered or gave rationale to continue. During an interview on 8/25/22, at 1:51 p.m. the consultant pharmacist (CP)-F stated he had asked for a GDR twice because R5 was on two antidepressants. The first request was in May and the second was in July. He stated he would expect the provider to either try a GDR or give rationale as to why the GDR should not be attempted. CP-F stated his next step would be to	F 758	past year have been identified have been reviewed. If resident have been identified as needing a GDR the primary MD and family if applicable have been updated. RN Clinical managers and DON received education on GDR completion process. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Policy for Psychotropic Medication Use has been reviewed and remains appropriate. DON or designee will audit monthly pharmacist recommendations each month to ensure pharmacist recommendations have been addressed, for four months. Audit findings will be presented to facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	

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F 758	Continued From page 29 bring the request to the medical director. During an interview on 8/25/22, at 4:22 p.m. the director of nursing (DON) stated he would expect a provider to address the request for a GDR or provide rationale on why it should not be attempted. The DON stated after the request has been made twice with no response they would need to take further action. The facility policy titled Psychotropic Medication Use dated 8/24/17, indicated GDR was to be attempted in two separate quarters (with at least one month between the attempts), unless clinically contraindicated and documented by the medical provider.	F 758		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		9/28/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	C 08/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 31 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 3 (R72) observed during personal cares. In addition, the facility failed to provide the required personal protective equipment (PPE) for direct care staff who had the potential to provide direct care to COVID-19 positive residents for 1 of 1 residents (R9) reviewed for infection control. Findings include: R72's Face Sheet printed on 8/25/22, indicated diagnoses which included urethal erosion (tearing of the urethra primarily at the urinary meatus), weakness, abnormal posture, lymphedema (swelling in arm or leg), and emphysema (a condition in which the air sacs of the lungs are damaged and enlarged causing breathlessness. R72's significant change Minimum Data Set (MDS) dated 8/5/22, indicated R72 was severely cognitively impaired, required extensive assistance with activities of daily living, and had a supra pubic catheter (a catheter that is left in place, inserted through the abdomen into the bladder) and was always incontinent of bowel. R72's care plan dated 8/12/20, indicated R72 had a self deficit with bathing, grooming, and bowel and bladder. Interventions included extensive	F 880	F880 □ Infection Prevention and Control This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R9 has been reviewed and monitored for signs and symptoms of infection for 1 week with no adverse effects. R9 no longer requires transmission-based precautions. R 72 no longer resides in the facility. The infection control log from August 2022 to current has been reviewed for the spread of infection. There are currently no residents on droplet and/or contact precautions in LTC. There are two residents on TCU on droplet precautions due to vaccination status at the time of admission. RCA completed with IDT on 9/19/22	

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F 880	Continued From page 32 assistance of two staff with wiping and cleansing after a bowel movement. R72's care plan indicated he was incontinent of bowel. On 8/24/22, at 7:30 a.m. R72 gave permission to observe cares. Nursing assistant (NA)-B put on gloves and began removing pillows, NA-C started running water in the bathroom sink. NA-C wearing gloves gently washed R72's face and dried it. NA-C washed and dried the front of R72's groin. NA-C let R72 know they were going to turn him on his side, he had soft brown stool which NA-C removed using several disposable wipes once each and throwing the wipes into the garbage. NA-C then used a wash cloth and warm water to finish cleaning R72's rectal area and buttocks. NA-C then removed her gloves, and without performing hand hygiene, put on a new pair of gloves, and applied barrier cream to R72's buttocks. NA-C then picked out a shirt and both NAs put on R72's shirt and a new brief rolling him side to side. At 7:44 a.m. NA-B and NA-C boosted R72 up in bed and adjusted his pillows. NA-C removed her gloves, still wearing the same pair of gloves, picked up R72's water cup and offered him a drink of water which he drank. On 8/24/22, at 7:48 a.m. NA-C went into the bathroom and washed her hands with soap and water. NA-B left the room with bagged garbage and linen. During an interview on 8/24/22, at 7:55 a.m. NA-C stated she could not perform hand hygiene between her glove changes as R72 was in pain and there wasn't time. NA-C acknowledged the reason for hand hygiene between glove changes was because there could be a tear in the gloves that can not be seen and that was why it was	F 880	Hand Hygiene education and competency completed for all staff on or before 9/28/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Competency to be reviewed by ICP for further education needed. The policy for hand hygiene has been reviewed and remains appropriate. DON or designee will audit hand hygiene for 10 staff per day with various staff for 1 week, and based upon compliance will complete 5 staff hand hygiene audits per day for 2 weeks. Audit findings will be presented to the facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Education for all associated staff per modules as recommended per DPOC. All residents on transmission-based precautions reviewed, PPE supplies reviewed and location of supplies reviewed. PPE and transmission-based precaution education and competency completed for all staff on or before 9/28/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Competency to be reviewed by ICP for further education needed.	

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F 880	Continued From page 33 important to perform hand hygiene when changing gloves. NA-C verified she did not remove her gloves prior to offering R72 water. During an interview on 8/25/22, at 3:35 p.m. registered nurse (RN)-B stated he would expect staff to perform hand hygiene between glove changes. During and interview on 8/25/22, at 4:20 p.m. the director of nursing (DON) stated he would expect hand hygiene to be performed before entering a resident's room and after exiting a resident room and between glove changes. The facility policy on hand hygiene was requested but not provided. A policy titled Procedure for Wearing Gloves revised 2/2007, did not address when to perform hand hygiene with glove use. R9's quarterly Minimum Data Set (MDS) dated 5/25/22, indicated R9 was cognitively intact and required assistance of one staff for activities of daily living (ADL's) including bed mobility, toileting, transfers, and ambulation in the room. R9's diagnoses included cerebral palsy, mild intellectual disability, and legal blindness. The facility's SARS-CoV-2 RT-PCR Assay (a laboratory test used to detect if a person is positive or negative for COVID-19) dated 8/19/22, indicated R9 was positive for COVID-19. The facility's N95 Fit Testing log indicated nursing assistant (NA)-D passed the fit testing on 6/9/21, with the 3M 8210 mask size. The facility's nursing department schedule identified NA-D worked on the LTC (124) unit	F 880	RCA completed with IDT on 9/19/22. The policy for PPE and transmission-based precautions has been reviewed and remains appropriate. A new procedure was identified for the storage of N95. Education of placement of N95 storage completed to nursing staff. N95 storage in unit linen room. DON or designee will audit each unit per day for all PPE donning and doffing for transmission-based precautions for 1 week, based upon results will audit each unit 3x/week for 2 weeks for all PPE donning and doffing for transmission-based precautions for 2 weeks. Audit findings will be presented to the facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee will audit source control surgical grade masks for all shifts 4x/week for 1 week, then 2x/week for 1 week once compliance is met for source control masking for all staff, visitors and residents. Audit findings will be presented to the facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee will audit all aerosolized	

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F 880	Continued From page 34 during the 6:00 p.m.-10:00 p.m. (evening) shift of 8/23/22, and the 6:00 a.m.-2:00 p.m. (day) shift of 8/24/22. R9 resided on the LTC (124) unit. During interview on 8/25/22, at 10:29 a.m. NA-D stated she was fit tested for the 3M 8210 N95 masks which were not supplied in the transmission based precaution (TBP) cart on the Woodland Way (LTC (124)) unit where NA-D had been working that day. The 3M Aura 9205+NIOSH N95 masks that were on the TBP cart outside of R9's room did not snuggly seal around her face and had allowed air in/out of the sides of the mask. NA-D stated she had entered the COVID-19 isolation rooms and had worn two surgical masks instead of the N-95 mask. On 8/25/22, 2:53 p.m. review of Woodland Way 331-349 TBP cart included surgical masks, gloves, yellow gowns and 3M Aura 9205+NIOSH N95 masks. The TBP cart did not contain 3M 8210 N95 masks. During interview on 8/25/22, at 3:13 p.m. the director of nursing (DON) stated it was his expectation that the facility would supply the different types of N95 masks. The facility's 2019 Novel Coronavirus policy revised 3/26/22, directed staff to place COVID-19 positive residents in droplet/contact precautions and health care personal caring for those residents were to use full personal protective equipment (PPE), including a NIOSH-approved N95 or equivalent or higher-level respirator. The facility's Guidance on Personal Protective Equipment (PPE) policy dated 1/2022, indicated an N95 respirator was a respiratory protective	F 880	generating procedures for 1 week. Audit findings will be presented to the facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 28, 2022.	

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F 880	Continued From page 35 device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The 'N95' designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small (approximately 0.3 micron) test particles. The policy directed staff to wear an N95 masks during resident care when COVID-19 was suspected or confirmed.	F 880		

Electronically delivered
September 15, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: 46YZ11

Dear Administrator:

The above facility was surveyed on August 22, 2022 through August 25, 2022 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 only a suggestion 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. 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.

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:

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00861	A. BUILDING: _____ B. WING _____	C 08/25/2022

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BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/22/22-8/25/22, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. In addition, on 8/22/22-8/25/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaint were found to be SUBSTANTIATED: H5236090C (MN79078) with no related licensing orders. H5236091C (MN77443) with no related licensing orders. The following complaints were found to be UNSUBSTANTIATED: H5236088C (MN82121), with no related licensing orders. H5236089C (MN80586), with no related licensing orders. H52364072C (MN85920), with no related licensing orders. H52364073C (MN84802), with no related licensing orders. H52364074C (MN85687), with no related licensing orders. H5236092C (MN79595), with no related licensing orders. H52364356C (MN85388), with no related licensing orders.	2 000		

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2 000	Continued From page 3 H52364072C(MN85920), with no related licensing orders. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 4 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess the need for and failed to develop a comprehensive care plan related to living in a locked memory care unit for 3 of 3 (R3, R20, R38) reviewed for involuntary seclusion. Findings include: During an observation on 8/25/22, at 8:55 a.m. at the second-floor nursing station desk, there were three resident photos taped to the plexiglass desk barrier. Each photo had a name, room number, and "wanderer" which identified they were R8, R25 and R41. These residents were not living in the facility's locked memory care unit. Resident #3 R3's quarterly Minimum Data Set (MDS) dated 8/12/22, indicated R3 had a mild cognitive impairment and had diagnoses that included age-related cognitive decline and major depressive disorder. R3 was independent with	2 550	F641 Accuracy of Assessments This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R3, R20, R28 have been reviewed for placement in the secured unit, MD orders obtained for locked memory care unit, careplans reviewed and revised to reside in the secured unit to include placement criteria for the secured unit. All residents who reside in the secured	9/25/22

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	00861	A. BUILDING: _____ B. WING _____	C 08/25/2022

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2 550	Continued From page 5 eating after set up and required staff assistance with all other care areas. However, the MDS indicated R3 exhibited no wandering or exit seeking behaviors. Additionally, the MDS identified R3 utilized no restraints. R3's Elopement Risk Assessment dated 2/25/21, indicated R3 was low risk for elopement. R3's In-house Transfer Notice dated 3/19/21, indicated a room change was initiated for R3 due to "long-term private bed available". R3's care plan edited 8/22/22, indicated R3 had a diagnosis of major depression and age-related cognitive decline which may have impacted her mood/behavior. However, the care plan did not address the need for a secure, locked unit nor did the care plan identify if R3 wandered or had exit seeking behaviors. During an interview on 8/23/22, at 9:21 a.m. R3 stated she had no sense of direction. R3 further stated she would never try to go outside or leave the unit by herself because she would get confused and scared. She just didn't want to do that, and she felt safe in her room. During an interview on 8/24/22, at 3:32 p.m. trained medication aide (TMA)-B stated R3 was a very nice lady. R3 could tell you what she needed, but staff did offer toileting every two hours because R3 might forget. TMA-A further stated R3 had no behaviors and never tried to leave the unit on her own. R3 liked to stay in her room and really didn't want to come out of her room without staff encouragement. TMA-B then stated R3's family requested R3 be placed in the secure locked unit because R3 tried to "exit by phone"; for example, R3 would sporadically call	2 550	unit have been reviewed for appropriate placement by IDT, care plans have been reviewed/revised if necessary and MD orders have been obtained. Residents will be reviewed quarterly for appropriateness for the need to be in the secured unit. Education provided to interdisciplinary team members involved in resident placement planning to include comprehensive care plan policy and admission criteria to secured unit. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Audits for all transfers into the secure unit will be completed by DON or designee at the initial transfer to the unit to assure clinical appropriateness and appropriate physician orders have been signed. Audit findings will be presented to facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Comprehensive Care Plan Policy has been reviewed and remains appropriate. Baseline compliance to be achieved by September 25, 2022.	

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2 550	Continued From page 6 family and ask them to come get her. During an interview on 8/25/22, at 9:53 a.m. nursing assistant (NA)-F stated R3 would get "confused" every once in a while, but was easy to redirect. NA-F stated it was more like a "skipping record" and R3 would ask the same question repeatedly. R3 never became angry and never tried to leave the unit without staff accompanying her. During an interview on 8/25/22, at 10:06 a.m. TMA-C stated R3 was nice. R3 liked to stay in her room but would occasionally come out for meals. R3 would go to the third floor with activities for church services. However, R3 never attempted to leave on her own. During an interview on 8/25/22, at 1:52 p.m. registered nurse (RN)-C stated R3 did not have a diagnosis of dementia, but R3 did exhibit confusion. R3 could not remember from day-to-day. However, R3 did not exhibit exit seeking behavior. RN-C stated she could not say why R3 was placed in the secure locked unit. Further, RN-C stated it was not a locked unit like it was "in the day". The facility was trying to revamp how they utilized the space. RN-C then stated R3 did not have an order for a secure locked unit, nor was the secure locked unit was identified in R3's care plan. However, RN-C additionally stated the resident photos at the second-floor nurses station identified residents who wandered away from other units. Those residents wore a wander guard (technology made solely for the purpose of keeping elderly people or people with dementia from wandering) to prevent exiting the facility and there were no beds available in the secure locked unit. RN-C confirmed there were residents currently residing	2 550		

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2 550	Continued From page 7 in the secure locked unit without exit seeking behavior and social services should review that. During an interview with social services (SS)-A and SS-B on 8/25/22, at 2:04 p.m. SS-A stated each resident case was discussed in the IDT meeting to determine if a resident met criteria for placement in the secure locked unit. Issues discussed were diagnosis, elopement risk, and "fit". SS-B stated nursing would get the order for the secure locked unit from the resident's physician and family education would be conducted. However, because SS-A and SS-B were new to their roles, they would need to review R3's chart. - At 3:06 p.m. SS-B stated there was no documentation in R3's medical record and/or care plan that identified the need for a secure locked unit. Further, R3 was a low elopement risk. Resident #20 R20's quarterly MDS dated 6/14/22, indicated R20 had a severe cognitive impairment and diagnoses that included Parkinson's disease. R20 was non-ambulatory and required staff assistance with all care areas. Further, the MDS identified R20 did not exhibit behaviors during the assessment period nor utilized a restraint. R20's Elopement Risk Assessment dated 6/30/21, indicated R20 was a low elopement risk. R20's care plan dated 7/7/21, did not address the need for a secure locked unit nor did the care plan indicate if R20 wandered or had exit seeking behaviors. R20's In-House Transfer Notice dated 7/8/21, indicated "long term bed available".	2 550		

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2 550	Continued From page 8 During an observation on 8/24/22, at 7:25 a.m. R20 was sitting quietly in her wheelchair in the dining room. R20 was waiting for her breakfast meal. R20 greeted staff and residents as they came into the dining room. RN-C was wishing R20 a happy birthday. R20 smiled and asked for a coke. During an interview on 8/24/22, at 3:37 p.m. NA-E stated R20 never had any behaviors nor tried to leave the unit. Just never. "She's a really nice lady." During an interview on 8/25/22, at 10:00 a.m. NA-F stated R20 never had behaviors and never tried to leave the unit. During an interview on 8/25/22, at 10:12 a.m. TMA-C stated R20 went to church on Sundays with her family. R20 never complained about anything but would get tired and needed an afternoon nap daily. R20 never exhibited behaviors. R20 was very "go with the flow". Whatever staff asked her to do, she would do it without complaint. During an interview with nurse practitioner (NP)-A on 8/25/22, at 12:27 p.m. NP-A stated the facility really made the determination for placement in the secure locked unit. She and the physicians usually agreed with the acilty's determination unless the resident or family objected. R20 did not have a diagnosis of dementia and did not have exit seeking behaviors. However, NP-A stated R20 probably benefitted from a more personalized, quiet environment. During an interview on 8/25/22, at 1:40 p.m. RN-C stated a resident did not have to have a	2 550		

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2 550	Continued From page 9 diagnosis of dementia for placement into the secure locked unit. For example, maybe a resident needed a quieter setting due to anxiety. The unit provided a quieter setting, 1:1 activity, and small group activities. The physician would write an order for placement, but the need for a secure locked unit was never identified in the residents' care plans. RN-C then stated R20's family was very happy with R20's placement in the secure locked unit. Her family was able to visit all the time. R20 benefitted from a smaller setting because she was very private. RN-C then stated R20 did not have a diagnosis of dementia and she could not find an order for the secure locked unit. R20 had a severe cognitive impairment and poor decision making. R20 was not always understood, nor did she always understand others. R20 was a low elopement risk. Additionally, RN-C stated the facility had not attempted any other alternative to a secure locked until because R20 had resided in the facility a little over a year. During an interview on 8/25/22, at 3:06 p.m. SS-B stated there was no documentation in R20's medical record or care plan that identified the need for a secure locked unit. Further, R20 was a low elopement risk. Resident #38 R38's Elopement Risk assessment dated 6/30/21, indicated R38 was low risk for elopement. R38's quarterly MDS dated 7/11/22, indicated R38 had a severe cognitive impairment and diagnoses that included dementia with Lewy bodies, dementia with behavioral disturbance, chronic obstructive pulmonary disease (COPD),	2 550		

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2 550	Continued From page 10 and major depressive disorder. R38 was on hospice, was non-ambulatory, and R38 required extensive to total assistance with all care areas. Further, the MDS indicated R38 did not exhibit behaviors during the assessment period nor utilized a restraint. R38's care plan edited 8/3/22, did not address the need for a secure locked unit nor did the care plan indicate if R38 wandered or had exit seeking behaviors. An In-House Transfer Notice for R38 was requested, but not provided. During an interview on 8/24/22, at 3:34 p.m. NA-E stated it really depended on the day for R38. R38 could have behaviors like refusing care or refusing to get out of bed. However, NA-E stated R38 couldn't try to leave the unit on her own because she was not physically capable. During an interview on 8/25/22, at 9:55 a.m. NA-F stated R38 really did not exhibit behaviors anymore because she was hospice, especially in the past month. R38 mostly wanted to be left alone. During an interview on 8/25/22, at 12:22 p.m. SS-B stated R38 was more appropriate for a secure locked unit before she was on hospice. R38 has always been difficult to get out of bed, but it was more so now. However, R38 was legally blind, and she may have benefitted from a quieter environment. During an interview on 8/25/22, at 1:50 p.m. RN-C stated R38 was extremely anxious and had major depression. R38 picked at her skin until she had open wounds. Family reported this was a	2 550		

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2 550	Continued From page 11 life-long habit. However, R38 was a low elopement risk, and the care plan did not identify the need for a secure locked unit. During an interview on 8/25/22, at 3:51 p.m. the director of nursing (DON) stated the facility determined as a team whether a resident would benefit from the secure locked unit the most. First, there needed to be an open bed available. Then, if staff felt the resident was an appropriate placement, they would contact the family. The DON stated no family or resident has ever complained about a placement in the secure locked unit. However, the DON stated he has researched the resident rights and he recognized the secure locked unit was the most restrictive placement that he was responsible for. The DON then stated R3, R20 and R38 may have adapted to their environments which decreased their need for a secure locked unit. However, each resident was no longer exit seeking and should have been assessed to determine if they required a less restrictive environment. During an interview on 8/25/22, at 4:07 p.m. the administrator stated the staff clinically reviewed each resident to determine who would benefit the most from the secure locked unit. This included safety as well as the available programs. All families had agreed to the placements, never complained, and this was the "best" unit. However, the resident care plans should identify the need for a secure locked unit. The facility policy Comprehensive Assessments and Care Planning revised 7/2/18, identified the facility would provide a comprehensive person-centered interdisciplinary care assessment of the resident's condition, in order to develop consistent quality care that will attain or	2 550		

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2 550	Continued From page 12 maintain the highest practicable physical, mental and psychological functioning possible, a facility must make a comprehensive assessment of a resident's needs, using the Resident Assessment Instrument (RAI) specified by the State. The facility policy Safe Harbor Unit revised 11/11, identified each resident received assistance in reaching their highest level of physical, psychological, and spiritual ability. Admission to the SHU was determined through consultation of the nursing staff, physician, family, and Social Services after comprehensive resident assessment was completed. Admission criteria: - Diagnosis of a dementia related illness - Inability to respect the rights of others, for example wandering into others' rooms, etc. - Ability to benefit from a program designed for memory problems, short attention span, impaired judgement, disorientation, inappropriate behavior, or ritualistic behavior - Exit seeking behavior The policy further identified a physician order was required prior to admission and discharge. The order must include the reason for admission or discharge. The resident plan of care would address the reason for admission to the SHU and stated the benefit of the placement. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents were assessed for restraints to reduce the risk of involuntary seclucion. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing	2 550		

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2 550	Continued From page 13 compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 3 (R72) observed during personal cares. In addition, the facility failed to provide the required personal protective equipment (PPE) for direct care staff who had the potential to provide direct care to COVID-19 positive residents for 1 of 1 residents (R9) reviewed for infection control. Findings include: R72's Face Sheet printed on 8/25/22, indicated diagnoses which included urethal erosion (tearing of the urethra primarily at the urinary meatus), weakness, abnormal posture, lymphedema (swelling in arm or leg), and emphysema (a condition in which the air sacs of the lungs are damaged and enlarged causing breathlessness. R72's significant change Minimum Data Set	21385	F880 □ Infection Prevention and Control This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R9 has been reviewed and monitored for signs and symptoms of infection for 1 week with no adverse effects. R9 no longer requires transmission-based precautions. R 72 no longer resides in the facility. The infection control log from August 2022	9/28/22

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21385	Continued From page 14 (MDS) dated 8/5/22, indicated R72 was severely cognitively impaired, required extensive assistance with activities of daily living, and had a supra pubic catheter (a catheter that is left in place, inserted through the abdomen into the bladder) and was always incontinent of bowel. R72's care plan dated 8/12/20, indicated R72 had a self deficit with bathing, grooming, and bowel and bladder. Interventions included extensive assistance of two staff with wiping and cleansing after a bowel movement. R72's care plan indicated he was incontinent of bowel. On 8/24/22, at 7:30 a.m. R72 gave permission to observe cares. Nursing assistant (NA)-B put on gloves and began removing pillows, NA-C started running water in the bathroom sink. NA-C wearing gloves gently washed R72's face and dried it. NA-C washed and dried the front of R72's groin. NA-C let R72 know they were going to turn him on his side, he had soft brown stool which NA-C removed using several disposable wipes once each and throwing the wipes into the garbage. NA-C then used a wash cloth and warm water to finish cleaning R72's rectal area and buttocks. NA-C then removed her gloves, and without performing hand hygiene, put on a new pair of gloves, and applied barrier cream to R72's buttocks. NA-C then picked out a shirt and both NAs put on R72's shirt and a new brief rolling him side to side. At 7:44 a.m. NA-B and NA-C boosted R72 up in bed and adjusted his pillows. NA-C removed her gloves, still wearing the same pair of gloves, picked up R72's water cup and offered him a drink of water which he drank. On 8/24/22, at 7:48 a.m. NA-C went into the bathroom and washed her hands with soap and water. NA-B left the room with bagged garbage	21385	to current has been reviewed for the spread of infection. There are currently no residents on droplet and/or contact precautions in LTC. There are two residents on TCU on droplet precautions due to vaccination status at the time of admission. RCA completed with IDT on 9/19/22 Hand Hygiene education and competency completed for all staff on or before 9/28/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Competency to be reviewed by ICP for further education needed. The policy for hand hygiene has been reviewed and remains appropriate. DON or designee will audit hand hygiene for 10 staff per day with various staff for 1 week, and based upon compliance will complete 5 staff hand hygiene audits per day for 2 weeks. Audit findings will be presented to the facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Education for all associated staff per modules as recommended per DPOC. All residents on transmission-based precautions reviewed, PPE supplies reviewed and location of supplies reviewed.	

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21385	Continued From page 15 and linen. During an interview on 8/24/22, at 7:55 a.m. NA-C stated she could not perform hand hygiene between her glove changes as R72 was in pain and there wasn't time. NA-C acknowledged the reason for hand hygiene between glove changes was because there could be a tear in the gloves that can not be seen and that was why it was important to perform hand hygiene when changing gloves. NA-C verified she did not remove her gloves prior to offering R72 water. During an interview on 8/25/22, at 3:35 p.m. registered nurse (RN)-B stated he would expect staff to perform hand hygiene between glove changes. During and interview on 8/25/22, at 4:20 p.m. the director of nursing (DON) stated he would expect hand hygiene to be performed before entering a resident's room and after exiting a resident room and between glove changes. The facility policy on hand hygiene was requested but not provided. A policy titled Procedure for Wearing Gloves revised 2/2007, did not address when to perform hand hygiene with glove use. R9's quarterly Minimum Data Set (MDS) dated 5/25/22, indicated R9 was cognitively intact and required assistance of one staff for activities of daily living (ADL's) including bed mobility, toileting, transfers, and ambulation in the room. R9's diagnoses included cerebral palsy, mild intellectual disability, and legal blindness. The facility's SARS-CoV-2 RT-PCR Assay (a laboratory test used to detect if a person is positive or negative for COVID-19) dated 8/19/22,	21385	PPE and transmission-based precaution education and competency completed for all staff on or before 9/28/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Competency to be reviewed by ICP for further education needed. RCA completed with IDT on 9/19/22. The policy for PPE and transmission-based precautions has been reviewed and remains appropriate. A new procedure was identified for the storage of N95. Education of placement of N95 storage completed to nursing staff. DON or designee will audit each unit per day for all PPE donning and doffing for transmission-based precautions for 1 week, based upon results will audit each unit 3x/week for 2 weeks for all PPE donning and doffing for transmission-based precautions for 2 weeks. Audit findings will be presented to the facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee will audit source control surgical grade masks for all shifts 4x/week for 1 week, then 2x/week for 1 week once compliance is met for source control masking for all staff, visitors and residents. Audit findings will be presented to the facility□s Quality Council by DON or	

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	00861	A. BUILDING: _____ B. WING _____	C 08/25/2022

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21385	Continued From page 16 indicated R9 was positive for COVID-19. The facility's N95 Fit Testing log indicated nursing assistant (NA)-D passed the fit testing on 6/9/21, with the 3M 8210 mask size. The facility's nursing department schedule identified NA-D worked on the LTC (124) unit during the 6:00 p.m.-10:00 p.m. (evening) shift of 8/23/22, and the 6:00 a.m.-2:00 p.m. (day) shift of 8/24/22. R9 resided on the LTC (124) unit. During interview on 8/25/22, at 10:29 a.m. NA-D stated she was fit tested for the 3M 8210 N95 masks which were not supplied in the transmission based precaution (TBP) cart on the Woodland Way (LTC (124)) unit where NA-D had been working that day. The 3M Aura 9205+NIOSH N95 masks that were on the TBP cart outside of R9's room did not snuggly seal around her face and had allowed air in/out of the sides of the mask. NA-D stated she had entered the COVID-19 isolation rooms and had worn two surgical masks instead of the N-95 mask. On 8/25/22, 2:53 p.m. review of Woodland Way 331-349 TBP cart included surgical masks, gloves, yellow gowns and 3M Aura 9205+NIOSH N95 masks. The TBP cart did not contain 3M 8210 N95 masks. During interview on 8/25/22, at 3:13 p.m. the director of nursing (DON) stated it was his expectation that the facility would supply the different types of N95 masks. The facility's 2019 Novel Coronavirus policy revised 3/26/22, directed staff to place COVID-19 positive residents in droplet/contact precautions and health care personal caring for those	21385	designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. DON or designee will audit all aerosolized generating procedures for 1 week. Audit findings will be presented to the facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 28, 2022. Corrected.	

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21385	Continued From page 17 residents were to use full personal protective equipment (PPE), including a NIOSH-approved N95 or equivalent or higher-level respirator. The facility's Guidance on Personal Protective Equipment (PPE) policy dated 1/2022, indicated an N95 respirator was a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The 'N95' designation means that when subjected to careful testing, the respirator blocks at least 95 percent of very small (approximately 0.3 micron) test particles. The policy directed staff to wear an N95 masks during resident care when COVID-19 was suspected or confirmed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure staff who cared for residents with COVID-19 had access to required personal protective equipment. In addition, the facility needed to ensure all staff were fit tested fro N95 respirator use. The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure all staff followed proper hand hygiene and glove use practices. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		

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21565	Continued From page 18	21565		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively assess safety with self-administration of medication for 1 of 1 resident (R13) observed to have medications left in their room unsupervised by staff after staff set-up. Findings include: R13's quarterly Minimum Data Set (MDS) dated 6/6/22, indicated R13 was cognitively intact and required assistance with activities of daily living (ADL's). On 8/23/22, at 9:43 a.m. R13 was observed in his room with no staff present and there were three pills in a medication cup on R13's bedside table. R13 stated about 8:15 a.m. registered nurse (RN)-D brought the pills into the room, set them on the bedside table and exited the room. R13 stated the two larger pills were Tylenol and the smaller pill was Oxycodone. R13 stated he was not due to take the pills for another 30 minutes. On 8/25/22, at 9:44 a.m. R13 was seated in a recliner in his room. There were three pills in a medication cup on the table to the left side of resident's bed. R13 stated RN-D brought the pills	21565	F554 □ Self Administration of Medications This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R13 was reviewed to identify if appropriate for self administration of medications (SAM). The right to self-administer medication if the interdisciplinary team has determined that this practice is clinically appropriate. Residents who have been identified as appropriate for self-administration of medication, SAM assessments have been completed. Immediate education provided to nurse involved regarding policy and procedure for resident self-administration of	9/25/22

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21565	Continued From page 19 into the room at 9:05 a.m. that morning, left the room immediately and had not been back since. R13 stated the medications were two Tylenol and one Oxycodone. R13's medical record lacked a current self-administration of medication assessment. On 8/25/22, at 10:03 a.m. RN-D stated she gave R13 Tylenol and Oxycodone that morning at 9:05 a.m. and thought the resident had taken the medication. RN-D was not aware the resident had not swallowed the pills and the medications were on the table in R13's room. RN-D was unaware whether or not staff had completed a self-administration of medication assessment for R13. Upon return to R13's room, RN-D stated there were two Tylenol and one Oxycodone in the medication cup on the table in R13's room. RN-D stated she handed the medications to R13 earlier in the morning and thought R13 took the medications. RN-D then picked up the medication cup, handed it to R13 and asked R13 to take the pills. R13 dumped the pills into his mouth, set the medication cup on the table and reached for his water. At that point, RN-D turned and walked out of the room without observing whether or not R13 swallowed the pills. During interview on 8/25/22, at 10:07 a.m. 12:04 p.m. RN-D stated earlier that morning she watched R13 put the three pills in his mouth and trusted that he swallowed the pills. RN-D was unable to verify R13 swallowed the pills. During interview on 8/25/22, at 10:15 a.m. RN-A and RN-B stated they were unable to find a self-administration of medication assessment for R13. RN-A expected nursing staff to complete an assessment prior to leaving medications for a	21565	medications. Education provided to licensed nurses/TMAs to review order instructions to verify that resident has instructions for self-administer medications. Education to be provided by 09/25/2022, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Self-Administration of Medications policy has been reviewed and remains appropriate. Don or designee will audit for 4 Resident Medication administrations weekly for (3) weeks, then 2 medication administrations weekly for an additional (3) weeks to ensure SAM assessments are completed with appropriate nursing orders present stating "okay to self-administer medications dispensed by licensed nurse/TMA. Audit findings will be presented to the facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	

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21565	Continued From page 20 resident to take on their own and then return within 30 minutes to verify the resident had taken the medication. It was important for the resident to be aware of the purpose for taking the medication and how/when it should be taken. RN-A stated R13 did not have an assessment completed and staff should not have left medications in the residents room unattended. The facilities Self-Administration of Medications policy reviewed 2/2019, identified residents have the right to self-administer medication and the purpose was to enhance the residents independence. The policy directed nursing staff to assess the resident's mental and physical abilities to determine whether self-administering medication was clinically appropriate for the resident and to document the findings in the electronic health record (EHR). SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents were comprehensively assessed for safety with self-administration of medication. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights	21830		9/25/22

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21830	Continued From page 21 Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the	21830		

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21830	Continued From page 22 resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this	21830		

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21830	Continued From page 23 subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure advance directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in the event of an emergency for 1 of 1 resident (R137) reviewed for advance directives. Findings included: R137's quarterly Minimum Data Set (MDS) dated 7/8/22, indicated no cognitive impairment. R137's Provider Orders for Life-Sustaining Treatment (POLST) dated 7/19/21, indicated he wished to have resuscitation/cardiopulmonary resuscitation (CPR) if he had no pulse and was not breathing. A physician order report signed 6/3/22, identified R137 as a full code (wanting CPR). An Interagency Referral (IAR) for hospital discharge dated 7/19/22, identified R137's code status as a do not resuscitate (DNR). A change of code status from CPR to DNR was done in the Electronic Medical Record (EMR) on 7/19/22; R137's code status was changed to a DNR in the header of the EMR. Progress notes	21830	F578 Planning and Implementing Care This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R137 requested a change in code status which has been confirmed and verified and system has been updated to match the code status. All residents have the ability to be affected. All residents code statuses have been reviewed and verified. All staff have received education and a competency post-test on code status process including hospital re-admissions. Education will be provided by 09/25/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift.	

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21830	Continued From page 24 from hospital readmission on 7/19/22, did not address the change in R137's code status. An IAR for hospital discharge dated 8/13/22, identified R137's code status as Other-no CPR but may be intubated. An order for code status of DNR was entered in the EMR on 8/13/22. A progress note dated 8/15/22, indicated the facility spoke with R137 about his code status; R137 did want CPR done and did not want to be a DNR. R137's Face Sheet dated 8/23/22, identified R137 as DNR status. During an interview on 8/23/22, at 1:38 p.m. R137 stated if he stopped breathing and his heart stopped, he would want CPR to be started. During an interview on 8/23/22, at 2:13 p.m. registered nurse (RN)-B and RN-A stated following R137's readmission on 8/13/22, RN-B spoke with R137 and explained what would happen when doing CPR. R137 stated he was worried about his ribs breaking during CPR. RN-B and RN-A then stated they did not want to break his ribs and since it was good chance of the ribs being broke he was kept at a DNR. RN-B stated R137 refused to sign an updated POLST identifying him with a code status of DNR and still wanted chest compressions to be done. An attempt to call R137's medical doctor (MD) was attempted on 8/24/22, at 8:46 a.m. During an interview with R137's nurse practitioner (NP) on 8/24/22, at 8:53 a.m. she stated on	21830	Policy for Code status has been reviewed and remains appropriate. DON or designee will conduct weekly code status audit for 3 weeks, then once a month. Audit findings will be presented to the facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by September 25, 2022.	

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21830	Continued From page 25 8/17/22, she spoke with R137 about the code status and what he was expecting to happen when CPR was performed. The NP stated R137 still wanted compressions to be done and did not want ribs broken. NP once again educated R137 on CPR and R137 stated he still wanted to have chests compression done and did not want to be a DNR. The NP stated R137 should have been a full code as identified in his last POLST from 7/19/21. During an interview on 8/24/22, at 11:52 a.m. with the director of nursing (DON) and RN-C, the DON stated the facility received signed orders on 8/19/22 from R137's primary MD which indicated R137 as a DNR. The DON stated he talked with R137 about the change in code status and had an order for DNR. The DON stated R137 said he wanted chest compression to be done and did not want to be a DNR, R137 was just concerned about his ribs breaking. The DON stated he knew R137's wishes regarding code status and wanting compression started but opted to follow the MD's orders until R137 visited with a provider and discussed it. The facility's policy Advance Care Planning (ACP)-Medical Orders-POLST dated 11/28/17, indicated the POLST as the outline of the plan of care reflecting the resident's wishes concerning care at life's end. The facility would respect the right of the person to not complete medical orders or discuss their end of life wises. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's advance directives were accurately reflected in all areas of the resident's medical chart.	21830		

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21830	Continued From page 26 The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		

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BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE** **DULUTH, MN 55811**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/23/2022. At the time of this survey, Benedictine Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/23/2022

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2022**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Benedictine Health Center is a three story building with no basement. The original building was constructed in 1980 with an addition in 1990. Both buildings are of type II (111) construction. Because the original building and the addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with	K 000		

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K 000	Continued From page 2 smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a licensed capacity of 96 beds and had a census of 93 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not properly maintain enclose stairways used for exits and smoke proof enclosures in accordance with NFPA 101 (2012), Life Safety Code, section 7.1.3.2.1. This deficient finding could a patterned impact on the residents within the facility. Findings include: On 08/23/2022, between 9:00am and 12:00pm, it was revealed by observation that storage materials had been placed in the emergency exit vestibule in the emergency exit in the physical therapy area.	K 225	K225 □ Physical Therapy emergency exit egress obstructions. 1.) Stored items in that area have been removed. 2.) Therapy staff have been notified that they can no longer use that area for storage. 3.) EVS Director will audit once a week for 4 weeks, then switching to monthly to ensure the area is not using for storage. 4.) EVS Director is responsible to ensure ongoing compliance. 5.) Compliance achieved 09/25/2022	9/25/22

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K 225	Continued From page 3 An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 225		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	K 321	K321 □ Room 268 mechanical room door	9/25/22

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K 321	Continued From page 4 facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.1.3 and 19.3.2.1.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/23/2022 between 9:00am and 12:00pm, it was revealed by observation that the door leading to the main utility room did not have self-closing device. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 321	is missing a self-closing device. 1.) Self-closing device has been installed 2.) EVS Director or designee will audit similar doors to ensure they have automatic closures. 3.) Monthly of required doors will be completed. 4.) EVS Director is responsible to ensure ongoing compliance. 5.) Compliance achieved 09/25/2022	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation, staff interview, the facility failed to maintain the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 9.6.1.3, 9.6.7.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.3.1 and 14.6.2.4. These deficient findings could have a widespread impact on the residents within the facility.	K 345	K345 □ Smoke alarm semi-annual inspection report (see attached files) 1.) Test were completed on 3/08/2022 2.) Reminders have been created on electronic work order system to remind maintenance staff that the tests need to be scheduled and completed every 6 months.	9/25/22

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K 345	Continued From page 5 Findings include: 1. On 08/23/2022 between 9:00am and 12:00pm, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Environmental Services Director that the facility could not provide current documentation verifying that a semiannual inspection of initiating devices had been completed. 2. On 08/23/2022 between 9:00am and 12:00pm, it was revealed by a review of available fire alarm test and inspection documentation and an interview with the Environmental Services Director that the facility could not provide an annual fire alarm testing documentation that provided a complete listing of each individual device tested, to include device type, address, location and the test results for each individual device. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 345	3.) EVS Director will follow up if the electronic task is not completed by its due date to ensure inspection occurs timely. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance achieved 09/25/22	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for	K 351		9/25/22

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K 351	Continued From page 6 sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain spacing between storage and the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, Section 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, Section 5.2.1.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, Sections 8.6.5.3.2 and 8.15.9. This deficient finding could a patterned impact on the residents within the facility. Findings include: On 08/23/2022, between 9:00am and 12:00pm, it was revealed by observation that storage materials had been placed on a storage rack, bringing the storage materials within the required 18 inch clearance area under the sprinkler heads. These obstructions were found in storage room 243A and in the Kitchen Dry Storage. An interview with the Enviromental Services Director verified this deficient finding at the time of discovery.	K 351	K351 □ Storage room 234A and Kitchen dry storage rack 1.) Items removed that caused the clearance to be less than 18 inches. New shelving or devices ordered to prevent items being able to be stored in a manner that would breach the 18 inches. 2.) EVS Director or designee will audit additional storage closets weekly for 3 weeks then switching to monthly to ensure on going compliance. 3.) EVS Director has electronic task in electronic work order system to remind that the task needs to be completed. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance achieved by 09/25/22	
K 355 SS=F	Portable Fire Extinguishers	K 355		9/25/22

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K 355	Continued From page 7 CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain portable fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, section 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/23/2022 between 9:00am and 12:00pm, it was revealed by documentation review that the fire extinguishers annual inspection documentation could not be provided. An interview with Environmental Services Director verified this deficient finding at the time of discovery.	K 355	K355 □ Fire extinguishers annual report 1.) Inspection occurred on 03/03/2022 (see attached files) 2.) Electronic tasks have been created in electronic work order system for maintenance staff so to know when the inspections are due. 3.) Inspection due dates will be on EVS directors and Administrators calendar to serve as a back up to insure inspections occur timely. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance achieved by 09/25/2022	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.	K 372		9/25/22

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K 372	Continued From page 8 Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. This deficient finding could have a widespreed impact on the residents within the facility. Findings include: On 08/23/2022 between 9:00am and 12:00pm, it was revealed by observation that there were penetrations running from one smoke compartment to another above doors 103A, 103B and 262. An interview with Environmental Services Director verified this deficient finding at the time of discovery	K 372	K372 □ Smoke barrier penetrations. 1.) Identified penetrations have been appropriately filled. 2.) Policy/agreement created for contractors doing work in the future to agree to prior to start of a project that leads to wall penetrations that they agree to fill any newly created penetrations appropriately. Contractor will sign once completed and EVS Director will verify that the work has been completed appropriately. 3.) EVS Director will sign off that penetrations have been completed with future projects. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance achieved by 09/25/22	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors	K 374		9/25/22

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K 374	Continued From page 9 are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install self-closing device per NFPA 101 (2012 edition), Life Safety Code, section 8.5.4.1 and 8.5.4.4. This deficient finding could have a widespreed impact on the residents within the facility. Findings include: On 08/23/2022 between 9:00am and 12:00pm, it was revealed by observation that smoke barrior doors 262, 103A and 103B did not completely close when tested. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 374	K374 □ All smoke barrier doors in the facility including; 262,103A and 103B 1.) Identified doors have been adjusted and close appropriately. 2.) All other smoke barrier doors have been audited to confirm they close appropriately. 3.) EVS director will audit all smoke barrier doors once a month to ensure doors are closing appropriately and don□t need adjustments. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance achieved on 09/25/2022.	
K 511 SS=E	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2	K 511		9/25/22

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K 511	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to secure electrical panels per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 08/23/2022, between 9:00am and 12:00pm, it was revealed by observation that the electrical panel located outside of rooms 256 and 215 were not locked. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 511	K511 □ Electrical panel doors not locked. 1.) Identified panel doors have been appropriately secured. 2.) EVS Director or designee have audited all other electrical panels to ensure they are appropriately secured. 3.) EVS Director will audit panels monthly to ensure panels remain appropriately locked and secured. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance achieved on 09/25/2022.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced	K 901		9/25/22

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K 901	Continued From page 11 by: Based on a review of available documentation and staff interview, the facility has failed to provide a complete facility Risk Assessment per NFPA 99 (2012 edition), Health Care Facilities Code, section 4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/23/2022 between 9:00am and 12:00pm, it was revealed during documentation review and an interview with the Environmental Services that the utility risk assessment document could not be provided at the time of the survey An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K 901	K901 □ Utility risk assessment (see attached files) 1.) Utility Risk assessment was completed on 7/01/2022 2.) Electronic reminder put into place for EVS Director to review the risk assessment at least annually. 3.) EVS Director will report on the utility risk assessment at least annual to facilities quality council to ensure assessment has been reviewed at least annually. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance achieved on 09/25/2022	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test	K 918		9/27/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 12 under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the generator per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.4, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.1 and 8.4.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1) On 08/23/2022 between 9:00am and 12:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing weekly generator inspections were not performed from 01/01/2022 to 08/23/2022.	K 918	K918 □ Generator load testing 1.) Generator will be tested on 9/27/2022 2.) Electronic work orders have been added to electronic work order system 3.) EVS Director will audit electronic work order system to assure inspections and testing are completed prior to due date. 4.) EVS Director is responsible for ongoing compliance. 5.) Compliance will be achieved on 09.27.22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/23/2022**

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K 918	Continued From page 13 2) On 08/23/2022 between 9:00am and 12:00pm, it was revealed by a review of available documentation of the emergency generator maintenance and testing monthly generator inspections were not performed between 01/01/2022 to 08/23/2022. An interview with Environmental Services Director verified these deficient findings at the time of discovery.	K 918		