DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5J65

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00960

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245266**

2.STATE VENDOR OR MEDICAID NO.
(L2) **196677400**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS**
(L4) **618 EAST 17TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/10/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **95** (L18)

13.Total Certified Beds **95** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 06/19/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/24/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
__ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/24/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/10/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5266

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 04/24/14. On 06/10/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 06/09/14, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 06/10/14, effective 06/07/14. Refer to the CMS-2567B for both health and life safety code.

Effective 06/07/14, the facility is certified for 95 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5266

Electronically Delivered: June 24, 2014

Mr. David Brennan, Administrator
Benedictine Health Center of Minneapolis
618 East 17th Street
Minneapolis, Minnesota 55404

Dear Mr. Brennan:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 7, 2014 the above facility is certified for:

95 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 95 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring, Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 20, 2014

Mr. David Brennan, Administrator
Benedictine Health Center of Minneapolis
618 East 17th Street
Minneapolis, Minnesota 55404

RE: Project Number S5266025

Dear Mr. Brennan:

On May 9, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 14, 2014. (42 CFR 488.422)

On June 20, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Per day civil money penalty of $350.00, for the (44) days begininning April 24, 2014 and continuing through June 6, 2014 for a total of $15,400.00. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on April 24, 2014. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 10, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 7, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 24, 2014, as of June 7, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 7, 2014.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program, Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00960	A. Building B. Wing	6/10/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **06/10/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **06/10/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **06/10/2014**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **06/10/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **06/10/2014**	ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp.** LSC	Correction Completed **06/10/2014**
ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **06/10/2014**	ID Prefix **21630** Reg. # **MN Rule 4658.1350 Subp.** LSC	Correction Completed **06/10/2014**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **06/10/2014**
ID Prefix **21710** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **06/10/2014**	ID Prefix **21800** Reg. # **MN St. Statute144.651 Sub** LSC	Correction Completed **06/10/2014**	ID Prefix **21810** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **06/10/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	06/19/2014	30951	06/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/24/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245266	01 - MAIN BUILDING 01	6/9/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0012	06/07/2014	ID Prefix Reg. # NFPA 101 LSC K0050	06/07/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/AK	06/19/2014	28120	06/09/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/25/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

REVISED

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245266	A. Building B. Wing	6/10/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **06/07/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **06/07/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **06/07/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/25/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/25/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/07/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/07/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/07/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/07/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	08/05/2014	30951	06/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245266	A. Building B. Wing	6/10/2014

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(l** LSC	Correction Completed **06/07/2014**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **06/07/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **06/07/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/07/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/07/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/07/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/07/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/07/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/07/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/07/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	06/19/2014	30951	06/10/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5J65

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00960

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245266**

2.STATE VENDOR OR MEDICAID NO.
(L2) **196677400**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS**
(L4) **618 EAST 17TH STREET**
(L5) **MINNEAPOLIS, MN** (L6) **55404**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/24/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **95** (L18)

13.Total Certified Beds 95 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	95			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 05/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/05/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
02/24/1984
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5266

At the time of the standard survey completed 04/24/14, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow. A Fire Safety Evaluation System (FSES) was conducted at the facility; related documents have been sent to CMS for approval.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

May 9, 2014

Mr. David Brennan, Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, Minnesota 55404

RE: Project Number S5266025

Dear Mr. Brennan:

On April 24, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when they have deficiencies of actual harm or above cited at the current survey, and on the previous standard or intervening survey (i.e. any survey between the current survey and the last standard survey). A level J deficiency (isolated deficiencies that constituted immediate jeopardy whereby corrections were required) whereby significant corrections were required was issued pursuant to a survey completed on 07/12/2013. The current survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G). Your facility meets the criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 14, 2014. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- CMP for the deficiency cited at F309 (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 October 24, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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
Division of Compliance Monitoring
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	245266	A. BUILDING _____ B. WING _____	04/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	**618 EAST 17TH STREET MINNEAPOLIS, MN 55404**

(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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		6/7/14

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

Electronically Signed | 05/22/2014

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 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice on a timely manner prior to termination of Medicare skilled services for 1 of 5 residents (R37) reviewed for liability notice and beneficiary appeal rights. Findings include: R37 was admitted to the facility on 3/24/14, and currently resided at the facility. A Notice of Medicare Provider Non-Coverage indicated R37's skilled services would end effective 3/29/14. The facility provided the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) on 3/28/14, which was less than forty eight hours before Medicare skilled services would be terminated.	F 156	All residents will receive upon admission a notice of Medicare/Medicaid benefits. Medicare notice of denials are to be issued no less than 48 hours prior to services ending. The business office manager or designee will monitor compliance with this regulation with each Medicare denial issued. Random audits will be conducted monthly through our Medicare compliance audit meetings. Date of compliance June 7, 2014	

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F 156	Continued From page 3 Progress Note dated 3/28/14, indicated "Medicare note: resident record reviewed to determine on-going Medicare coverage. Resident will receive last dose of abx [antibiotic] on 3-29-2014. Condition has been stable since hospital return. Medicare denial notice will be issued with last day of coverage [LCD] 3-29-14." On 4/22/14, at 2:54 p.m. the Medicare/admission registered nurse acknowledged R37 had not been given a 48 hours notification per the regulation and further indicated "I will see if we can do a notification for reinstatement to maintain compliance." On 4/23/14, at 10:36 a.m. business office staff stated the facility did not have an actual policy but provided a facility generated handout titled Notice of Medicare/Medicaid Benefit dated 05/2013, which indicated if the facility did not feel the eligibility criteria had been met, the facility would issue a denial notice. The form lack information on the time frame the denial notice would be provided When interviewed on 4/25/14, at 12:44 p.m. the director of nursing acknowledged the resident should have been given 48 hours per regulation for the denial notice.	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246		6/7/14

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F 246	Continued From page 4 endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were in reach for 2 of 40 residents (R24, R12) in the sample. Findings include: R24: On 4/21/14, at 2:49 p.m. R24 was observed setting in w/c on the right side of the bed. The call light was observed around the side rail on the left side of the bed. The resident confirmed she could not reach the call light and stated she would have to wait for someone to come by and check on her. A nursing assistant (NA) was notified of the call light being out of reach for the resident. R24's Minimum Data Set (MDS) dated 4/7/14, indicated R24 needed extensive to total assist with activities of daily living with the exception of eating and wheelchair mobility. R24 was independent with eating and R24 did not ambulate. R24's Brief Interview for Mental Status (BIMS- a test to determine cognition) was 7/15 which depicted moderate cognition impairment. R12: On 4/21/14, at 2:53 p.m. R12's call light was observed on the floor between the wall and his bed. A tour of the facility was conducted on 4/24/14, at 10:05 a.m. with the director of maintenance and	F 246	F 246 It is the practice of Benedictine Health Center of Minneapolis to provide resident services with reasonable accommodation of the resident□s needs and preferences. A. Call lights were placed within reach for R12 and R24 on 4/21/14. B. On 4/23/14 the Administrator and DON performed a full facility audit for call light function and placement. C. Reviewed expectation of call lights being placed at resident□s location of choice, within reach, with nursing and housekeeping staff. D. Weekly random audits of call light placement directed by Director of Nursing or designee. Review of audit results with Quality Council members for input. Compliance date: 6/7/14	

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F 246	Continued From page 5 the director of environmental services. R12 was in his room in his wheelchair watching TV on the other side of his bedroom. The call light was lying across the bed. When the resident was questioned about the ability to reach his call light he turned around in his wheel chair and went towards the bed stating he could reach the call light. R12's MDS dated 1/27/14, indicated R12 needed extensive to total assist with activities of daily living with the exception of eating and wheelchair mobility. R12 was independent with eating and R12 did not ambulate. R12's BIMS score was 15/15 which depicted no cognition impairment. Both of the directors were interviewed during the tour of the facility and both confirmed the residents should have their call lights available at all times.	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to eliminate noxious orders in 5 of 40 resident rooms (R82, R45, R37, R8, R13) which had noxious odors. Findings include: Resident rooms 115, 116, 118, and 301 were	F 253	F253 It is the practice of Benedictine Health Center of Minneapolis to provide housekeeping services necessary to maintain a sanitary, orderly and comfortable interior. A. The specific areas identified in the written comments have been cleaned.	6/7/14

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F 253	Continued From page 6 checked for noxious odors which affected residents R82, R45, R37, R8 and R13. R82's Minimum Data Set (MDS) dated 3/6/14, indicated R82 was continent of bladder and was cognitively intact. R45's MDS dated 3/12/14, indicated R45 was continent of bladder, was intermittently catheterized, and was cognitively intact. R37's MDS dated 3/28/14, indicated R37 was always incontinent of bowel and bladder and was cognitively intact. R8's MDS dated 3/12/14, indicated R8 was continent of bladder and was cognitively intact. R13's MDS dated 3/5/14, indicated R13 was continent of bladder and was cognitively intact. The director of environmental services confirmed the pervasive noxious odors in the rooms. Rooms 115, 116, and 118 were confirmed to have strong urine odors by the director of environmental services stating housekeeping was aware of the urine odor and was working to try to eliminate the odors.	F 253	B. Review of expectations related to housekeeping were covered with housekeeping staff by the Enviromental Services Director. C. Weekly random audits of facility interior for compliance with expectation of sanitary, orderly and comfortable interior will be conducted by the Enviromental Services Director. D. The Enviromental Services Director or designee is responsible for monitoring; results of audits and observations will be communicated to Quality Council for any further action. Compliance Date 06/07/14	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to re-assess pain before and during an observed dressing change for 1 of 2 residents (R98) according to the care plan who was observed to have pain during a dressing	F 282	It is the practice of Benedictine Health Center of Minneapolis to provide services in accord with each resident's written plan of care.	6/7/14

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F 282	Continued From page 7 change. Findings include: R98 was admitted to the facility 2/22/14, with a complicated past medical history that included chronic respiratory failure status post tracheotomy and currently on mechanical ventilation, congestive heart failure, coronary artery disease, taken from his history and physical dated 2/16/14. In addition, R98 had a Stage 4 decubitus ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) on his coccyx. R98 was observed during a dressing change on 4/23/14, at 10:45 a.m. to the Stage 4 pressure ulcer on the coccyx. There were two nursing assistants (NAs) NA-E and NA-F in the resident's room who had just completed morning cares. The dressing change was done by registered nurse (RN)-G. RN-G came into R98's room, took gloves from the bedside stand that had dressing materials. RN-G explained to R98 that she was going to change the dressing on his wound. NA-E assisted RN-G to turn and position the resident onto his left side. NA-E supported the resident on his left side while RN-G removed the old dressing. RN-G then discarded the soiled dressings in the plastic lined waste basket and then removed her gloves. RN-G then washed her hands in the bathroom sink in R98's room. RN-G was asked if that was a clean or sterile dressing change and she stated that she was going to do a clean dressing change. RN-G indicated the resident would let them know when he was	F 282	Refer to the plan of action that was identified in F 309. Date of compliance June 7, 2014.	

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F 282	Continued From page 8	F 282		

having pain. RN-G did not inquire the pain status of the resident before starting the dressing change. RN-G donned gloves, and put saline (salt water) wound wash on a 4 x 4 gauge dressing and dabbed the wound and repeated the procedure one more time. Observation of the wound bed noted bone and fresh red blood oozing at the one o'clock position. RN-G then removed her soiled gloves and discarded them in the plastic lined garbage can. R98 was observed with facial grimacing and was then asked by the surveyor if he was having pain and R98 confirmed that he was having pain. The resident was asked if he had pain with other dressing changes and he replied that he had pain with all dressing changes. RN-G acknowledged she heard the resident state he was having pain. RN-G indicated she would get him something for pain after she finished with the dressing change. RN-G then put on a fresh pair of gloves and packed the wound with SoloSite (a wound dressing gel that creates a moist wound environment) on a 4 x 4 gauge dressing and used a Q-Tip to place the dressing in the wound. The resident continued to facial grimace in pain. RN-G then removed her gloves, washed her hands in the sink in the bathroom. RN-G then came back and placed an ABD dressing (thick absorbent dressing) over the packing and taped the dressing to the resident's skin. The dressing was dated, 4/23/14. RN-G then went out to the med cart and got a Percocet (pain medication) for R98 at 11:00 a.m. RN-G did not do a pain evaluation using a pain scale of 1 to 10 with 10 being the greatest.

RN-G was interviewed after she gave the pain medication to R98 and confirmed she did not assess the resident for pain before starting the

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F 282	Continued From page 9	F 282		

dressing change and the resident had not received anything for pain before the dressing change. RN-G then discussed with RN-D and both agreed they should check with the resident the status of his pain before doing a dressing change. RN-G confirmed the resident did not have a scheduled pain medication(s) before the dressing change but there was an order for pain medication on an as needed basis (PRN). RN-G stated she would notify R98's physician of pain during a dressing change.

R98's care plan dated 3/5/14, indicated R98 had pain/potential for pain.
" - Pain: alteration in comfort level pain due to immobility and pressure area
-- Resident will verbalize good pain control and /or will have minimal visible indicators of pain
-- Assist with developing coping mechanism
-- Attempt non-pharmacological methods of pain interventions: imagery, distraction techniques, relaxation exercises, massage therapy hot or cold compress. Rest periods to facilitate comfort sleep, and relaxation. Eliminate additional stressors or sources of discomfort, sleep and relaxation. Eliminate additional stressors or sources of discomfort whenever possible
-- Complete pain assessment: annually, quarterly, significant change and PRN (as needed)
-- Medications as per MD orders
-- Monitor for SE of pain medication: sedation, respiratory depression, N/V itching, increased confusion, Educate resident and family
-- Nursing to observe and record effectiveness of scheduled and PRN medications and update MD as indicated
-- Observe for any objective signs of pain: moaning, groaning, and grimacing
-- Resident uses Tylenol PRN for pain

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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
F 282	Continued From page 10 -- Staff to evaluate resident's rate pain on a 1-10 scale if resident states he/she was experiencing pain, or point to faces of pain on a scale." The plan of care was not followed as the staff did not monitor R98 for signs of pain during the dressing change nor did the staff offer pain medication prior to the dressing change. The director of nursing (DON) was interviewed on 4/24/14, at 11:40 a.m. was questioned about pain management, her response was, "I will have to get the policy and read it and get back to you." The DON declined comment on additional questions relating to pain assessments prior to treatments saying she had not read R98's chart and was not familiar with his cares. RN-D was interviewed on 4/24/14, at 11:50 a.m. and confirmed R98 "can tell us when he is having pain and can ask for pain medication, he knows he has pain medication available." We do pain assessments on admission, 14 days, 30 days, and at 60 days. R98 answers were mostly reliable. The resident did not understand the depth and severity of how sick he was. RN-D confirmed the resident should have been asked before the dressing change if he had pain. "We do not routinely do pain assessments before treatments."	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		6/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	04/24/2014

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F 309	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately assess and implement interventions to alleviate pain during wound care for 1 of 2 residents (R98) which resulted in actual harm. Findings include: R98 was admitted to the facility 2/22/14, with a complicated past medical history that included chronic respiratory failure status post tracheotomy and currently on mechanical ventilation, congestive heart failure, coronary artery disease, taken from his history and physical dated 2/16/14. In addition, R98 had a Stage 4 pressure ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) on his coccyx. R98 was observed during a dressing change on 4/23/14, at 10:45 a.m. to the Stage 4 pressure ulcer on the coccyx. There were two nursing assistants (NAs) NA-E and NA-F in the resident's room who had just completed morning cares. The dressing change was done by registered nurse (RN)-G. RN-G came into R98's room, took gloves from the bedside stand that had dressing materials. RN-G explained to R98 that she was going to change the dressing on his wound. NA-E assisted RN-G to turn and position the resident onto his left side. NA-E supported the resident on	F 309	F309 It is the practice of Benedictine Health Center of Minneapolis to provide care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being. A. On 4/23/14 the plan of care for R 98 was revised to include a scheduled dose of pain medication prior to dressing changes. B. The plan of care for other resident□s that require treatments which may cause discomfort were reviewed and revised if indicated. This review focused on whether there was ongoing observation or assessment of treatment associated pain and if so, whether there was a scheduled pain management treatment or modality prior to treatment. C. Review/re-education with licensed staff specific to expectation of ongoing assessment or observation for verbal or nonverbal signs or indications of pain associated with treatments and if present, a plan for pain management. Review of expectations related to documentation related to pain. D. Weekly random audits of medical records as identified in B. The audit results communicated to quality Council for input. Compliance date: 6/7/2014	

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F 309	Continued From page 12 his left side while RN-G removed the old dressing. RN-G indicated the resident would let them know when he was having pain. RN-G did not inquire the pain status of the resident before starting the dressing change. RN-G donned gloves, and put saline (salt water) wound wash on a 4 x 4 gauge dressing and dabbed the wound and repeated the procedure one more time. R98 was observed grimacing and was then asked by the surveyor if he was having pain and R98 confirmed that he was having pain. R98 was asked if he had pain with other dressing changes and he replied that he had pain with all dressing changes. RN-G acknowledged she heard the resident state he was having pain. RN-G indicated she would get him something for pain after she finished with the dressing change. RN-G then put on a fresh pair of gloves and packed the wound with SoloSite (a wound dressing gel that creates a moist wound environment) on a 4 x 4 gauge dressing and used a Q-Tip to place the dressing in the wound. The resident continued to grimace in pain. Following the procedure, RN-G went out to the med cart and got a Percocet (pain medication) for R98 at 11:00 a.m. RN-G was interviewed after she gave the pain medication to R98 and confirmed she did not assess the resident for pain before starting the dressing change and the resident had not received anything for pain before the dressing change. RN-G then discussed with RN-D and both agreed they should check with the resident the status of his pain before doing a dressing change. RN-G confirmed the resident did not have a scheduled pain medication(s) before the dressing change but there was an order for pain medication on an as needed basis (PRN). RN-G stated she would notify R98's physician of pain	F 309		

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F 309	Continued From page 13 during a dressing change. R98 had pain assessments completed on 2/4/14 and 2/7/14. Each assessment indicated he was having pain daily in the buttocks area. Both pain assessments indicated the resident's pain was located in the coccyx area where there was a wound and a check mark was by distressing/miserable (moderate pain). Both of the pain assessments indicated the resident was on Percocet 2 tabs per the G-tube every 4 hours for pain. Another pain assessment was completed on 2/22/14, and indicated R98 had pain in the buttock area and the pain was uncomfortable /annoying (mild pain) and the pain was less than daily and the Tylenol (a mild analgesic) 650 mg was effective and he could have the Tylenol as needed for pain. On 2/25/14, a 4th pain assessment was completed and the pain was once again noted to be in the buttocks area and the pain was distressing/miserable (moderate pain). The resident could have Tylenol through the G-tube every 4 hours for pain and it was noted to be effective. The pain assessments did not have a time when the assessments were completed and it could not be determined if the pain assessments were only completed by interview or in conjunction with cares and wound care treatments. The Care Area Assessment (CAA) done for cognition loss/dementia was done on 2/11/14, and indicated that area triggered because the Brief Interview for Mental Status (BIMS) score showed impaired cognition. The conclusion that was drawn under Analysis of Findings indicated the following: "Resident is alert and oriented. Understand communication and is able to follow instructions. Resident is on ventilator full time. He	F 309		

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F 309	Continued From page 14 is able to mouth words and is understood when cuff is deflated. Resident is able to write some. Hearing is adequate, resident feels he can't hear well." Received a fax dated 4/25/14, and the note on 4/7/14, indicated, "Resident knows pain medication is available and documentation exists in record that he does request it." The CAA for pain was done on 2/17/14, and indicated, "Per resident report during pain interview he has continuous pain that can range from 7 to 10. States it is usually the coccyx area that hurts. Reports that pain medication helps. Was started on QID [four times a day] Percocet with PRN [as needed] Percocet for breakthrough pain." R98's care plan dated 3/5/14, indicated R98 had pain/potential for pain. -- Pain: alteration in comfort level pain due to immobility and pressure area -- Resident will verbalize good pain control and /or will have minimal visible indicators of pain -- Assist with developing coping mechanism -- Attempt non-pharmacological methods of pain interventions: imagery, distraction techniques, relaxation exercises, massage therapy hot or cold compress. Rest periods to facilitate comfort sleep, and relaxation. Eliminate additional stressors or sources of discomfort, sleep and relaxation. Eliminate additional stressors or sources of discomfort whenever possible -- Complete pain assessment: annually, quarterly, significant change and PRN -- Medications as per MD [physician] orders -- Monitor for SE [side effects] of pain medication: sedation, respiratory depression, N/V [nausea and vomiting] itching, increased confusion, Educate resident and family	F 309		

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F 309	Continued From page 15 -- Nursing to observe and record effectiveness of scheduled and PRN medications and update MD as indicated -- Observe for any objective signs of pain: moaning, groaning, grimacing -- Resident uses Tylenol PRN for pain -- Staff to evaluate resident's rate pain on a 1-10 scale if resident states he/she was experiencing pain, or point to faces of pain on a scale. The plan of care was not followed as the staff did not monitor R98 for signs of pain during the dressing change nor did the staff offer pain medication prior to the dressing change. Progress notes were reviewed for R98. - On 3/12/14, at 3:50 p.m. the resident settled in to his room and transferred to facility ventilator. (Resident returned from the hospital). Stated he had some pain to back side. "Dressing change done to Stage IV coccyx ulcer and wound measurements done." - On 3/17/14, at 4:21 p.m. Resident stated he had pain to coccyx. "Resident does have stage IV pressure to coccyx upon re-admission. Resident was on Percocet prn for pain." - On 3/20/14, at 7:01 p.m. Resident stated he had pain in his butt which he rated 6/10." "PRN [as needed] Percocet administered via G-Tube at 0515 [5:15 a.m.] with somewhat effective results. Resident now rates pain at 5/10." - On 3/26/14, at 2:44 p.m. resident requested pain medication for back ache at 2:00 p.m. - On 3/28/14, at 3:02 p.m. resident requested pain medication for back ache at 1320 [1:20 p.m.] and Ativan for anxiety. - On 4/7/14, at 7:05 a.m. requested pain med for pain in low back and cough medicine at 0630 (6:30 a.m.).	F 309		

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F 309	Continued From page 16 - On 4/7/14, at 8:11 a.m. stated that when pain occurs pain medication (Percocet) was good to relieve it. R98 had a physician's order for a dressing change of the coccyx daily, dated 3/13/14. The order was to do the dressing change as follows: "1. Cleanse coccyx daily with normal saline 2. Pack with gauze loosely moistened with SoloSite 3. Skin protectant to wound edges 4. Cover with ABD." R98 had a physician's order dated 3/19/14, for Percocet (oxycodone-acetaminophen) Schedule II tablet: 5-325 milligrams (mg) one tablet per gastric tube four times a day PRN. A pain assessment interview was completed on 4/7/14, at 8:05 a.m. (30 day assessment) and indicated the resident had not received any scheduled pain medication in the last five days. However, R98 had received PRN pain medications in the last five days. The next question was, "at any time in the last 5 days, has the resident received any non-medication intervention for pain?" The answer was "Yes" but the area for description of the pain was left blank. When the resident was asked "Have you had pain or hurting at any time in the last 5 days?" the answer was "Yes." The resident indicated he had pain occasionally and the pain was moderate. The indicators for pain was blank. R98's Minimum Data Set (MDS) dated 4/7/14, indicated R98 was severely cognitively impaired and had an unhealed pressure ulcer at Stage 4. The MDS indicated R98 had occasional pain. R98's physician note dated 4/23/14, indicated a	F 309		

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F 309	Continued From page 17	F 309		

nurse had informed him about identified pain during dressing changes and R98 would be pre-medicated with Percocet in the future. R98 also had a chronic Stage 4 stage pressure ulcer related in part to his debilitated condition poor cardiac output and prolonged bed rest.

A progress note dated 4/24/14, at 3:26 p.m. indicated the following: "Resident received PRN [as needed] Percocet at 0950 [9:50 a.m.] this shift prior to coccyx dressing change. The resident later stated that this medication made the dressing change more comfortable for him."
The Medication Administration Record (MAR) for pain medication usage was reviewed for the last two weeks, 4/11/14 through 4/24/14. R98 received pain medication PRN:
- On 4/11/14, at 3:43 p.m.
- On 4/12/14, at 6:27 p.m.
- On 4/13/14, at 6:40 p.m.
- On 4/15/14, at 6:30 a.m. and again at 12:36 p.m.
- On 4/16/14, at 9:00 a.m.
- On 4/17/14, at 12:45 a.m., 6:57 a.m. and 5:18 p.m.
- On 4/19/14, at 9:32 a.m.
- On 4/21/14, at 8:39 p.m., 12:52 p.m., and 4:45 p.m.

The MAR did not indicate where the pain was, intensity of the pain, or effectiveness of the pain. Also the MAR did not indicate if non-pharmacological means had been used to elevate the pain.

R98's physician was interviewed on 4/23/14, at 2:10 p.m. and it was brought to the attention of the physician that R98 was having pain during dressing changes on his Stage 4 pressure ulcer.

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F 309	Continued From page 18 R98's physician agreed to talk to the resident and addressed the pain during the dressing changes. The physician would evaluate if R98 should have a scheduled pain medication. RN-D was interviewed on 4/24/14, at 8:45 a.m. and confirmed R98's physician saw the resident yesterday, (4/23/14) and assessed R98 for pain during dressing changes. R98's physician wrote a doctor's order on 4/23/14, for Percocet one before each dressing change. R98 was interviewed on 4/24/14, at 8:55 a.m. R98 stated he always experienced pain during the dressing changes and on 4/23/14, the pain was at least a "7, maybe higher" when he had the dressing change (the resident was aware that on a scale of 1 to 10, 10 would be the highest). The director of nursing (DON) was interviewed on 4/24/14, at 11:40 a.m. was questioned about pain management, her response was, "I will have to get the policy and read it and get back to you." The DON declined comment on additional questions relating to pain assessments prior to treatments saying she had not read R98's chart and was not familiar with his cares. RN-D was interviewed on 4/24/14, at 11:50 a.m. and confirmed R98 "can tell us when he is having pain and can ask for pain medication, he knows he has pain medication available." RN-D added they do pain assessments on admission, 14 days, 30 days, and at 60 days, and R98's answers were mostly reliable. RN-D confirmed the resident should have been asked before the dressing change if he had pain. "We do not routinely do pain assessments before treatments."	F 309		

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F 309	Continued From page 19 The pain management policy dated 12/2002, indicated that the standard was, "All residents who are experiencing pain, or may have conditions that may result in pain, will have a comprehensive assessment of pain symptoms and will have a treatment plan established to treat pain symptoms." The policy indicated the following, "1. Each resident will be provided with a consistent, accurate and timely comprehensive assessment of resident's comfort level as related to acute, chronic or suspected pain. 2. Each resident who experiences pain will have a pain prevention/intervention plan established and implemented. 3. A licensed nurse will complete a comprehensive pain assessment that will address a resident's pain origin, location, severity, alleviating and exacerbating factors, current treatment, and resident response to treatment."	F 309		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure safe water temperatures for 4 of 4 residents (R40, R122, R68, R28) who had concerns of hot water. This had the potential to affect all 83 residents.	F 323	It is the practice of Benedictine Center of Minneapolis to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents.	6/7/14

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F 323	Continued From page 20 Findings include: On 4/21/14, at 3:30 p.m. R40 stated he was unable to keep his hands under the hot water because of the high temperature. R40 stated he used the bathroom multiple times per day and the water gets so hot "it burns your skin." At 3:47 p.m. the water at the sink in R40's room was 127.5 degrees. The quarterly Minimum Data Set (MDS) for R40 dated 3/24/14, included a Brief Interview of Mental Status (BIMS) score of 15 (cognitively intact), indicated R40 was independent with toileting and was independent with bathing after set-up. On 4/21/14, at 3:32 p.m. the water at the sink in room 318 was 125.9 degrees. On 4/21/14, at 3:50 p.m. the third floor shower room water at shower head was 120.2 degrees and at the sink in shower room the water was 129.2 degrees. On 4/21/14, at 3:56 p.m. the fourth floor shower room water at shower head was 114.8 degrees and at the sink in shower room the water was 125.9 degrees. On 4/21/14, at 4:00 p.m. the second floor shower room water at the shower head was 121.8 degrees and at the sink the water was 126.5 degrees. On 4/21/14, at 4:06 p.m. the water at the faucet in room 220 was 127.7 degrees. On 4/21/14, at 4:13 p.m. the first floor shower	F 323	When the Maintenance Director was initially informed on 4/21/14 that the water temperatures were too high, he immediately investigated and determined that the mixing valve had failed without any prior warning. The Maintenance Director immediately turned off the hot water supply to the building and notified the staff of the situation. He then called a service plumber who came out right away and replaced the mixing valve with a new mixing valve. This repair was completed on 4/21/14. The Maintenance Director/designee will continue to monitor and log hot water temps on the mixing valve gauge during each week. The safety committee will continue to do quarterly random audits of water temperatures in resident rooms. The Maintenance Director is responsible to monitor this process. Date of compliance June 7, 2014	

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F 323	Continued From page 21 room water at the shower head was 113.5 degrees and at the sink the water was 125.2 degrees. On 4/21/14, at 4:16 p.m. the administrator stated the maintenance man had a call out to get a new mixing valve and it should be here within the hour. On 4/21/14, at 4:30 p.m. the water at the sink in the women's bathroom on fifth floor was 121.2 degrees. The admission MDS dated 4/11/14, for R122 indicated a BIMS score of 14 (cognitively intact). On 4/23/14, at 8:43 a.m. R122 was observed ambulating independently on the unit. When interviewed on 4/22/14, at 1:02 p.m. R122 stated the water in the shower "gets too hot." 4th Floor West Wing On 4/21/14, at 3:26 p.m. during R68's room observation the water temperature in the bathroom sink was very hot approximately eight seconds after turning the faucet on and surveyor was unable to keep hand/fingers under water due to being hot. While still in the room, surveyor asked R68 who was lying in bed at the time if he used the sink he stated, "I do not go in there and neither does my roommate. The staff help us." R68's MDS dated 3/31/14, revealed R68 was totally dependent upon staff for cares and was moderately cognitively impaired. On 4/21/14, at 3:27 p.m. registered nurse (RN)-A was asked to call the maintenance director and	F 323		

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F 323	Continued From page 22 was asked to request him to bring a thermometer with him to the floor. -At 3:29 p.m. maintenance director came up to the floor went to R68's room with surveyor and used a scanning thermometer and the temperature reading was 127 Fahrenheit (°F). Maintenance director stated he was not aware of the hot water temps. East Wing On 4/21/14, at 3:31 p.m. during room observation R28's bathroom sink water temperature was noted to be hot approximately ten seconds after turning the faucet. During observation surveyor was with the maintenance director who checked the water temperature which was recording 123 °F -At 3:32 p.m. maintenance director stated he would go adjust the temperature valve downstairs. He further stated, "I was not aware of the concern at times the valve would be filled and this would cause the temperature to go up." R28's MDS dated 3/31/14, revealed R28 received extensive assist from staff for cares and was severely cognitively impaired. On 4/21/14, at 3:36 p.m. maintenance director returned to the floor stated he had adjusted the valve and had made a call out to have someone to come out to check the concern. He further stated "It's not safe when it creeps up like that. I will check later to make sure the temperatures have gone down as it took time." On 4/21/14, at 3:18 p.m. Hot water temps 127 to 129.2 degrees Fahrenheit were noted on the 4th floor. At 4:40 p.m. the director of maintenance (DM) stated he had lowered the temperature at	F 323		

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the mixing valve and called the mechanical engineer to replace the valve that afternoon. On 4/21/14, at 6:00 p.m. the mechanical engineer arrived, replaced the mixing valve.

Logs were requested of water temperature sampling at the resident rooms to verify water temperatures were maintained within the acceptable range at the patient room. A review of the water temperature log from 12/13/14 to 4/18/14, indicated 77 entries were made in a log that spanned 126 days. On four days a notation of popped safety relief valves was document; on three days a notation of flame failure was documented. It was noted that dometic / hot had water temperatures recorded of 120 to 134 degrees Fahrenheit, and Boiler/supply had water temperatures recorded of 176 to 204 degrees Fahrenheit. On 4/21/14, at 5:00 p.m. a review of the maintenance logs for water temperatures revealed water temperatures were recorded at the mixing valve between 124 and 130 degrees which was necessary to keep the water temperature hot enough at the patient rooms.

A review of the quarterly safety checks in April, July and October of 2013, indicated all room water temperatures were recorded at < 120 degrees Fahrenheit. Last quarterly safety check was completed 3/14/14, indicated 108 to 115 degrees Fahrenheit.

The incident and accidents reports were reviewed going back six months from 4/21/14, and no burns were reported. It could not be determined if the residents had reported the hot water temperatures to the facility.

At 7:11 p.m. a tour of the facility was conducted

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F 323	Continued From page 24 by the administrator, maintenance director and surveyor. Water temperatures were recorded in room 423 at 108 degrees Fahrenheit, room 202 at 105 degrees Fahrenheit, and room 121 at 108 degrees Fahrenheit.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident	F 329	F329 It is the philosophy of Benedictine Health	6/7/14

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F 329	Continued From page 25 specific target behavior and side effects monitoring was implemented with antipsychotic use for 3 of 3 residents (R28, R40, R44) reviewed for unnecessary medications. In addition, the facility failed to ensure a gradual dose reduction (GDR) was attempted or the clinical contraindication was documented for 1 of 5 residents (R40) who received multiple antipsychotic medications. Findings include: R40 was not monitored for resident-specific target behaviors for the use of Lithium, Zyprexa and Saphris (antipsychotic medications) and did not have a GDR attempted or the clinical rationale for continuing the medications documented. On 4/23/14, at 7:22 a.m. R40 was observed awake and sitting in a chair in his room with the radio on. At 7:51 a.m. R40 was observed sitting in the day room are and was interacting pleasantly with the staff. At 7:53 a.m. R40 was observed telling the nurse that he did not want his " water pill " until after church. The Medication Regimen Review from 5/1/13 through 4/15/14, was reviewed and a GDR or clinical indication for continued use of antipsychotics was not recommended during that time. The psychiatrist notes dated 7/16/13, 10/15/13, 1/16/14, and 4/18/14, lacked documentation as to why a GDR was contraindicated and indicated R40 was " at baseline." Review of the medical record lacked evidence of identified target behaviors for antipsychotic use for R40. Review of the weekly summary charting	F 329	Center of Minneapolis that the medication regimen helps promote or maintain the resident□s highest practicable mental, physical, and psychosocial well-being as identified by the resident and or representatives in collaboration with the interdisciplinary team. A. Monitoring and clarification related to use of psychoactive medications for R 40, R 28 and R44 has been implemented. B. Residents using psychotropic medications will have monitoring with the OBRA MDS 3.0 cycle. C. Monthly random audits of medical records of those residents receiving psychotropic medications by members of the interdisciplinary team. D. DON or designee responsible for monitoring, audit results communicated to the Quality council for input. Compliance date: 6/7/2014	

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F 329	Continued From page 26 from 1/1/14 through 4/24/14, lacked evidence of the frequency of any identified behaviors. The Psychosocial Well-Being Care Area Assessment (CAA) and the Behavioral Symptoms CAA dated 1/3/14, indicated a behavior of swearing at staff. The Psychotropic Medication Use CAA dated 1/3/14, indicated current medications in use and lacked documentation regarding a GDR or a clinical contraindication for one. The psychotropic drug use care plan dated 1/6/14, identified R40 was receiving antipsychotic medications, the resident will be prescribed the lowest effective dose of medication and directed to objectively document the resident's behavior. Review of the medical doctor progress note dated 2/19/14, and nurse practitioner note dated 4/23/14, indicated psychiatric issues were followed by the psychiatrist. The quarterly Minimum Data Set (MDS) dated 3/24/14, included a Brief Interview of Mental Status (BIMS) score of 15 (cognitively intact) and revealed delusions, hallucinations and behavioral concerns did not occur. A progress note dated 3/28/14, written by the licensed social worker indicated R40 exhibited negative comments over the past quarter. The Medication Administration History dated 4/1/14 through 4/24/14, included Saphris 10 milligrams (mg) twice daily, Lithium 900 mg at bedtime and Zyprexa 5 mg every evening and 30 mg at bedtime.	F 329		

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The Resident Admission Record dated 4/24/14, for R40 indicated an admission date of 6/19/10, and included diagnoses of paranoid schizophrenia, bipolar disorder, and anxiety.

When interviewed on 4/24/14, at 1:24 p.m. registered nurse (RN)-M stated there are no flow sheets to monitor target behaviors and any behavior documentation would be done in the progress notes or in the weekly charting. RN-M verified the weekly charting are not specific to each resident and are general to all residents.

Nursing assistant (NA)-G was interviewed on 4/24/14, at 1:32 p.m. and after reviewing the point of care terminal, stated there was no required behavior documentation for R40.

The nurse manager, RN-I was interviewed on 4/24/14, at 1:55 p.m. and stated behavior is documented in the progress notes and weekly summary and specific target behaviors are not identified. RN-I stated staff training and education provide "clues" as to what target behaviors to look for. RN-I stated the consultant pharmacist recommendations are used to identify when a GDR was needed and she was unable to locate a GDR request or documentation of a clinical contraindication for R40.

When interviewed on 4/24/14, at 2:49 p.m. the director of nursing (DON) stated the facility did not monitor target behaviors daily with antipsychotic use and the weekly charting was used to monitor residents.

R28's specific behaviors and potential side effects were not being monitored.

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F 329	Continued From page 28 On 4/23/14, at 7:55 a.m. R28 observed propelling his wheelchair (w/c) down the hallway. R28 observed to be calm and pleasant as he went past other residents and staff before getting to the dining room (DR). On 4/23/14, at 8:38 a.m. to 9:11 a.m. R28 was observed sitting at the dining room (DR) table eating his breakfast observed to be calm and conversing to staff during the meal. -At 9:18 a.m. R28 was observed propelling himself down the hallway to his room -At 9:19 a.m. observed a staff wheeling R28 to the common area. -At 9:20 a.m. observed R28 wheeling himself back to his room stated he was going to the bathroom. -At 9:22 a.m. observed the call light in room on R28 was observed sitting on his w/c outside the door looking down the hallway. -At 9:23 a.m. observed a staff nursing assistant going to room and shut the door. -At 9:26 a.m. observed NA-C coming out of room door and R28 was observed watching television (TV) in his room sitting on his w/c calmly facing the door. On 4/23/14, at 9:38 to 9:47 a.m. observed R28 sitting at the DR table area calmly listening as the therapeutic recreation staff was reading the newspaper as R28 asked questions. -At 9:48 observed R28 leaving the table after the activity propelled self towards the elevator. -At 9:53 a.m. surveyor and R28 got on the elevator when asked what floor he was going to R28 stated "I like to go downstairs to smoke and hang around." The care plan dated 3/13/12, identified R28 was	F 329		

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diagnosed with depression due to multiple problems. R28's antipsychotic medication care plan dated 4/6/12, indicated R28 received medication related to agitation as evidenced by striking out at staff, swearing, verbally abusive and lack of impulse control. The care plan directed to monitor R28's behaviors and quantitatively and objectively document R28's behavior. The care plan directed to document behavior/mood as indicated.

R28's psychotropic medication CAA dated 7/11/13, identified R28 had diagnoses of depression and Psychosis as well as agitation and anxiety. The CAA indicated R28 often presented with symptoms of tearfulness and would be physically and verbally abusive to staff at times. In addition, the CAA indicated R28 required use of medication to keep his symptoms under control directed nursing staff to continue to observe for adverse side effects of medications.

Review of the facility CP Medication Regimen Review dated 8/7/13 through 4/15/14, revealed side effects and specific behavior monitoring had not been identified as lacking.

Review of the Medication Administration Record (MARs) and Treatment Administration Record (TARs) dated 4/1/14, through 4/24/14, revealed no monitoring of behavior and side effects were being monitored daily for both anti-depressant and anti-psychotropic medications R28 was taking daily.

R28's diagnoses included dementia, unspecified psychosis/agitation, anxiety, depression and encephalopathy damage obtained from the quarterly MDS dated 4/8/14. In addition, the MDS

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indicated R28 received anti-psychotic and anti-depressant medications. R28 exhibited behavioral symptoms which included physical and verbal symptoms directed towards other such as hitting and kicking among others.

R28's Physician Order Report dated 4/8/14, indicated R28 received Lexapro 10 mg orally once a day for depression and Risperdal (an antipsychotic medication) 3 mg oral three times a day with "Special Instructions: Please call MD if any agitation occurs."

During further document review it was revealed behavior charting was being completed in the Progress Notes dated 9/5/13, through 4/24/14, as it happened and in also one to two times weekly using the facility generated "Behavior/Mood" sheets dated 1/4/14, through 4/18/14, which staff we checking off the behaviors, interventions listed but the sheets lacked R28's individualized specific behaviors and interventions that were used.

When interviewed on 4/23/14, at 1:17 p.m. RN-N stated R28 did not have specific behaviors to be monitored daily but the nurses would complete behavior in the progress notes.

R44's specific behaviors and side effects were not being monitored
On 4/23/14, at 8:12 a.m. to 9:11 a.m. during continuously morning cares observation R44 was observed to be calm, pleasant, cooperative, thanking NA-A and asking NA-A same question where was and when "Mom" was coming.

On 4/23/14, at 10:30 a.m. observed R44 sitting on his broad chair (a specialized wheelchair) at

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the television lounge area. R44 was observed to be dosing on and off looking around and was calm no behavior observed.

R44's care plan dated 9/17/12, indicated he had potential for alteration in cognition due to use of psychotropic medication. The goal for R44 was R44 "Will not have adverse effects from psychotropic medications." Care plan directed staff to administer medications as ordered, monitor medications administration and any associated behaviors of side effects.

The CAA dated 7/29/13, indicated R44 was on psychotropic medications which did put him at increased risk for falls and directed staff to monitor for side effects of medications.

Review of the CP Medication Regimen Review dated 9/12/13, through 4/2/14, revealed side effects and specific behavior monitoring had not been identified as lacking in R44's medical record.

R44's diagnoses included dementia, psychotic disorder, diabetes mellitus, cerebrovascular accident (CVA), hemiplegia and seizure disorder obtained from the quarterly MDS dated 1/21/14. In addition, the MDS indicated R44 was receiving anti-psychotic and anti-depressant medications.

R44's Physician Order Report dated 3/26/14, indicated R44 received Seroquel (an antipsychotic medication) 25 mg by mouth (PO) twice daily, Trazodone 25 mg PO every bedtime for depression and insomnia and Zoloft 50 mg PO once daily for depression.

Review of the Treatment Administration Record

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(TAR) dated 4/1/14, through 4/24/14, revealed the only behaviors indicated in the TAR were refusing medications and meals and staff were directed to record R44's food intake percentage. The TAR lacked information on the side effects for both anti-depressants and anti-psychotropic medications R44 was taking daily.

During further document review was revealed behavior charting was being completed one to two times weekly using the facility generated "Behavior/Mood" sheets dated 11/05/13, through 4/19/14, with staff checking off the behaviors, interventions listed and wrote additional comments/descriptions. The sheet lacked R44's specific behaviors and interventions that worked for R44.

When interviewed on 4/23/14, at 1:23 p.m. the director of social services stated residents who received any anti-psychotropic medication the staff would document the behaviors as they see them. Surveyor asked the director you mean by exception the director of social service stated "Yes." She further stated there was also weekly behavior charting that was completed for residents using the facility generic behavior charting.

When interviewed on 4/23/14, at 2:00 p.m. RN-B stated "Normally we don't have the specific side effects to monitor if during the shift we notice side effects we would write a progress note and let the nurse practitioner know and then they would give us orders."

When interviewed on 4/25/14, at 11:27 a.m. RN-A was also the nurse manager, stated the facility protocol is to use weekly behavior nursing

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assessment for monitoring resident's behaviors. RN-A further stated because the facility is small the staff would be aware of any change in a resident and would chart on it as indicated or as it happened. RN-A indicated for the side effects the Abnormal Involuntary Movement Scale (AIMS) for anti-psychotropic medications were completed every six months or as indicated if otherwise but no daily monitoring of side effects and behavior was being documented only as it happened.

When interviewed on 4/25/14, at 12:38 a.m. the DON stated currently "Symptom" charting was being done weekly. DON indicated the facility worked closely with clinical Psychologist for some of the residents on antipsychotic medications regularly that monitored residents closely. DON further stated she had listened to a phone conference sometime last year 2013, not sure when exactly offered by Minnesota Department of Health and had the impression "Symptom" monitoring was to be done on a periodic basis as long as the staff were aware of the resident exact concerns and done consistently it was sufficient enough.

When interviewed on 4/25/14, at 3:01 p.m. the consultant pharmacist stated the nurses are supposed to monitor and document side effects as they see them in the progress note. CP indicated the facility does other side effects monitoring such as the AIMS which was completed every six months. CP indicated because of the resident population diagnoses at the facility psychotic behavior monitoring in only done when there was a concern or rather behavior episode.

The facility Antipsychotic Medication Use policy

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F 329	Continued From page 34 (undated), indicated the "consultant pharmacist is responsible for communicating GDR recommendations consistent with regulatory time frames. When antipsychotic therapy is initiated, the resident is monitored to determine the effectiveness of the medication and to observe for possible adverse reactions. Gradual dose reduction is recommended for all residents who receive antipsychotic medications, unless clinically contraindicated. Contraindication to dose reductions must be described in the resident's medical record by the MD/NP or Psychiatrist."	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident specific target behavior and side effects monitoring was implemented with antipsychotic use for 3 of 3 residents (R28, R40, R44) reviewed for unnecessary medications. In addition, the facility failed to ensure a gradual dose reduction (GDR) was attempted or the clinical contraindication was documented for 1 of 5	F 428	F428 It is the practice of Benedictine Health Center of Minneapolis to have the consultant pharmacist report irregularities as part of the review of the drug regimen. These reports are provided to the attending physician and the director of nursing.	6/7/14

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F 428	Continued From page 35 residents (R40) who received multiple antipsychotic medications. Findings include: R40 was not monitored for resident-specific target behaviors for the use of Lithium, Zyprexa and Saphris (antipsychotic medications) and did not have a GDR attempted or the clinical rationale for continuing the medications documented. On 4/23/14, at 7:22 a.m. R40 was observed awake and sitting in a chair in his room with the radio on. At 7:51 a.m. R40 was observed sitting in the day room are and was interacting pleasantly with the staff. At 7:53 a.m. R40 was observed telling the nurse that he did not want his " water pill " until after church. The Medication Regimen Review from 5/1/13 through 4/15/14, was reviewed and a GDR or clinical indication for continued use of antipsychotics was not recommended during that time. The psychiatrist notes dated 7/16/13, 10/15/13, 1/16/14, and 4/18/14, lacked documentation as to why a GDR was contraindicated and indicated R40 was " at baseline." Review of the medical record lacked evidence of identified target behaviors for antipsychotic use for R40. Review of the weekly summary charting from 1/1/14 through 4/24/14, lacked evidence of the frequency of any identified behaviors. The Psychosocial Well-Being Care Area Assessment (CAA) and the Behavioral Symptoms CAA dated 1/3/14, indicated a behavior of swearing at staff. The Psychotropic	F 428	Refer to the plan of action that was identified in F329 Complaince date is 06/07/2014	

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Medication Use CAA dated 1/3/14, indicated current medications in use and lacked documentation regarding a GDR or a clinical contraindication for one.

The psychotropic drug use care plan dated 1/6/14, identified R40 was receiving antipsychotic medications, the resident will be prescribed the lowest effective dose of medication and directed to objectively document the resident's behavior.

Review of the medical doctor progress note dated 2/19/14, and nurse practitioner note dated 4/23/14, indicated psychiatric issues were followed by the psychiatrist.

The quarterly Minimum Data Set (MDS) dated 3/24/14, included a Brief Interview of Mental Status (BIMS) score of 15 (cognitively intact) and revealed delusions, hallucinations and behavioral concerns did not occur.

A progress note dated 3/28/14, written by the licensed social worker indicated R40 exhibited negative comments over the past quarter.

The Medication Administration History dated 4/1/14 through 4/24/14, included Saphris 10 milligrams (mg) twice daily, Lithium 900 mg at bedtime and Zyprexa 5 mg every evening and 30 mg at bedtime.

The Resident Admission Record dated 4/24/14, for R40 indicated an admission date of 6/19/10, and included diagnoses of paranoid schizophrenia, bipolar disorder, and anxiety.

When interviewed on 4/24/14, at 1:24 p.m. registered nurse (RN)-M stated there are no flow

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sheets to monitor target behaviors and any behavior documentation would be done in the progress notes or in the weekly charting. RN-M verified the weekly charting are not specific to each resident and are general to all residents.

Nursing assistant (NA)-G was interviewed on 4/24/14, at 1:32 p.m. and after reviewing the point of care terminal, stated there was no required behavior documentation for R40.

The nurse manager, RN-I was interviewed on 4/24/14, at 1:55 p.m. and stated behavior is documented in the progress notes and weekly summary and specific target behaviors are not identified. RN-I stated staff training and education provide "clues" as to what target behaviors to look for. RN-I stated the consultant pharmacist recommendations are used to identify when a GDR was needed and she was unable to locate a GDR request or documentation of a clinical contraindication for R40.

When interviewed on 4/24/14, at 2:49 p.m. the director of nursing (DON) stated the facility did not monitor target behaviors daily with antipsychotic use and the weekly charting was used to monitor residents.

The consultant pharmacist was interviewed on 4/24/14, at 2:58 p.m. and stated she expected the psychiatrist to monitor antipsychotic medications as they are the expert. The consultant pharmacist stated she only expected antipsychotic monitoring if there were behaviors.

R28's specific behaviors and potential side effects were not being monitored.

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F 428	Continued From page 38 On 4/23/14, at 7:55 a.m. R28 observed propelling his wheelchair (w/c) down the hallway. R28 observed to be calm and pleasant as he went past other residents and staff before getting to the dining room (DR). On 4/23/14, at 8:38 a.m. to 9:11 a.m. R28 was observed sitting at the dining room (DR) table eating his breakfast observed to be calm and conversing to staff during the meal. -At 9:18 a.m. R28 was observed propelling himself down the hallway to his room -At 9:19 a.m. observed a staff wheeling R28 to the common area. -At 9:20 a.m. observed R28 wheeling himself back to his room stated he was going to the bathroom. -At 9:22 a.m. observed the call light in room on R28 was observed sitting on his w/c outside the door looking down the hallway. -At 9:23 a.m. observed a staff nursing assistant going to room and shut the door. -At 9:26 a.m. observed NA-C coming out of room door and R28 was observed watching television (TV) in his room sitting on his w/c calmly facing the door. On 4/23/14, at 9:38 to 9:47 a.m. observed R28 sitting at the DR table area calmly listening as the therapeutic recreation staff was reading the newspaper as R28 asked questions. -At 9:48 observed R28 leaving the table after the activity propelled self towards the elevator. -At 9:53 a.m. surveyor and R28 got on the elevator when asked what floor he was going to R28 stated "I like to go downstairs to smoke and hang around." The care plan dated 3/13/12, identified R28 was	F 428		

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diagnosed with depression due to multiple problems. R28's antipsychotic medication care plan dated 4/6/12, indicated R28 received medication related to agitation as evidenced by striking out at staff, swearing, verbally abusive and lack of impulse control. The care plan directed to monitor R28's behaviors and quantitatively and objectively document R28's behavior. The care plan directed to document behavior/mood as indicated.

R28's psychotropic medication CAA dated 7/11/13, identified R28 had diagnoses of depression and Psychosis as well as agitation and anxiety. The CAA indicated R28 often presented with symptoms of tearfulness and would be physically and verbally abusive to staff at times. In addition, the CAA indicated R28 required use of medication to keep his symptoms under control directed nursing staff to continue to observe for adverse side effects of medications.

Review of the facility CP Medication Regimen Review dated 8/7/13 through 4/15/14, revealed side effects and specific behavior monitoring had not been identified as lacking.

Review of the Medication Administration Record (MARs) and Treatment Administration Record (TARs) dated 4/1/14, through 4/24/14, revealed no monitoring of behavior and side effects were being monitored daily for both anti-depressant and anti-psychotropic medications R28 was taking daily.

R28's diagnoses included dementia, unspecified psychosis/agitation, anxiety, depression and encephalopathy damage obtained from the quarterly MDS dated 4/8/14. In addition, the MDS

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indicated R28 received anti-psychotic and anti-depressant medications. R28 exhibited behavioral symptoms which included physical and verbal symptoms directed towards other such as hitting and kicking among others.

R28's Physician Order Report dated 4/8/14, indicated R28 received Lexapro 10 mg orally once a day for depression and Risperdal (an antipsychotic medication) 3 mg oral three times a day with "Special Instructions: Please call MD if any agitation occurs."

During further document review it was revealed behavior charting was being completed in the Progress Notes dated 9/5/13, through 4/24/14, as it happened and in also one to two times weekly using the facility generated "Behavior/Mood" sheets dated 1/4/14, through 4/18/14, which staff we checking off the behaviors, interventions listed but the sheets lacked R28's individualized specific behaviors and interventions that were used.

When interviewed on 4/23/14, at 1:17 p.m. RN-N stated R28 did not have specific behaviors to be monitored daily but the nurses would complete behavior in the progress notes.

R44's specific behaviors and side effects were not being monitored
On 4/23/14, at 8:12 a.m. to 9:11 a.m. during continuously morning cares observation R44 was observed to be calm, pleasant, cooperative, thanking NA-A and asking NA-A same question where was and when "Mom" was coming.

On 4/23/14, at 10:30 a.m. observed R44 sitting on his broad chair (a specialized wheelchair) at

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the television lounge area. R44 was observed to be dosing on and off looking around and was calm no behavior observed.

R44's care plan dated 9/17/12, indicated he had potential for alteration in cognition due to use of psychotropic medication. The goal for R44 was R44 "Will not have adverse effects from psychotropic medications." Care plan directed staff to administer medications as ordered, monitor medications administration and any associated behaviors of side effects.

The CAA dated 7/29/13, indicated R44 was on psychotropic medications which did put him at increased risk for falls and directed staff to monitor for side effects of medications.

Review of the CP Medication Regimen Review dated 9/12/13, through 4/2/14, revealed side effects and specific behavior monitoring had not been identified as lacking in R44's medical record.

R44's diagnoses included dementia, psychotic disorder, diabetes mellitus, cerebrovascular accident (CVA), hemiplegia and seizure disorder obtained from the quarterly MDS dated 1/21/14. In addition, the MDS indicated R44 was receiving anti-psychotic and anti-depressant medications.

R44's Physician Order Report dated 3/26/14, indicated R44 received Seroquel (an antipsychotic medication) 25 mg by mouth (PO) twice daily, Trazodone 25 mg PO every bedtime for depression and insomnia and Zoloft 50 mg PO once daily for depression.

Review of the Treatment Administration Record

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(TAR) dated 4/1/14, through 4/24/14, revealed the only behaviors indicated in the TAR were refusing medications and meals and staff were directed to record R44's food intake percentage. The TAR lacked information on the side effects for both anti-depressants and anti-psychotropic medications R44 was taking daily.

During further document review was revealed behavior charting was being completed one to two times weekly using the facility generated "Behavior/Mood" sheets dated 11/05/13, through 4/19/14, with staff checking off the behaviors, interventions listed and wrote additional comments/descriptions. The sheet lacked R44's specific behaviors and interventions that worked for R44.

When interviewed on 4/23/14, at 1:23 p.m. the director of social services stated residents who received any anti-psychotropic medication the staff would document the behaviors as they see them. Surveyor asked the director you mean by exception the director of social service stated "Yes." She further stated there was also weekly behavior charting that was completed for residents using the facility generic behavior charting.

When interviewed on 4/23/14, at 2:00 p.m. RN-B stated "Normally we don't have the specific side effects to monitor if during the shift we notice side effects we would write a progress note and let the nurse practitioner know and then they would give us orders."

When interviewed on 4/25/14, at 11:27 a.m. RN-A was also the nurse manager, stated the facility protocol is to use weekly behavior nursing

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F 428	Continued From page 43 assessment for monitoring resident's behaviors. RN-A further stated because the facility is small the staff would be aware of any change in a resident and would chart on it as indicated or as it happened. RN-A indicated for the side effects the Abnormal Involuntary Movement Scale (AIMS) for anti-psychotropic medications were completed every six months or as indicated if otherwise but no daily monitoring of side effects and behavior was being documented only as it happened. When interviewed on 4/25/14, at 12:38 a.m. the DON stated currently "Symptom" charting was being done weekly. DON indicated the facility worked closely with clinical Psychologist for some of the residents on antipsychotic medications regularly that monitored residents closely. DON further stated she had listened to a phone conference sometime last year 2013, not sure when exactly offered by Minnesota Department of Health and had the impression "Symptom" monitoring was to be done on a periodic basis as long as the staff were aware of the resident exact concerns and done consistently it was sufficient enough. When interviewed on 4/25/14, at 3:01 p.m. the consultant pharmacist stated the nurses are supposed to monitor and document side effects as they see them in the progress note. CP indicated the facility does other side effects monitoring such as the AIMS which was completed every six months. CP indicated because of the resident population diagnoses at the facility psychotic behavior monitoring in only done when there was a concern or rather behavior episode.	F 428		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		6/7/14

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F 431 SS=E	Continued From page 44 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 431	F 431	

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F 431	Continued From page 45 review, the facility failed to ensure expired medications were removed for 5 of 5 residents (R62, R53, R57, R89, R98). In addition, the facility failed to ensure medications were stored at the proper temperature in 1 of 4 (1st floor) medication refrigerators which affected R13 and R57 medications. Findings include: During observation of the fourth floor East wing medication cart on 4/23/14, at 1:58 p.m. six tablets of Prochlorperazine (used for nausea) 10 milligrams (mg) for R62 with an expiration date of 11/19/13, were found. Registered nurse (RN)-B verified the findings and stated "they are definitely expired." R62's Minimum Data Set (MDS) dated 3/6/14, indicated R82 had severely impaired decision making skills and had a diagnosis of epilepsy. The third floor medication room was observed on 4/24/14, at 10:44 a.m. and the following were noted; a multi-use vial of Aspart insulin (for diabetes) for R53 with an expiration date of 3/4/14, and a multi-use vial of Aplisol (used to test for tuberculosis) dated as opened 3/4/14 (expired 30 days after opening). RN-I verified the findings. R53's MDS dated 3/12/14, indicated R53 was cognitively intact and had a diagnosis of diabetes. On 4/24/14, at 11:11 a.m. the first floor medication cart was observed. A Xopenex inhaler (used to treat Asthma) for R57 with an expiration date of November 2013 was found. Licensed practical nurse (LPN)-B verified the findings.	F 431	It is the practice of Benedictine Health Center of Minneapolis to store drugs and biologicals under proper temperature controls and to remove or dispose of expired meds on a timely basis. A. The refrigerator on 1st floor was replaced and the identified medications were removed. B. Medications rooms are checked for presence of expired medications. Daily temperature log for medications refrigerators in place. C. Review with licensed nursing staff the expectations related to removal and disposal of expired meds D. Weekly random audits of med rooms for presence of expired or discontinued meds and for refrigerator temperature log documentation. Results communicated to Quality council for input. Compliance date: 6/7/2014	

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F 431	Continued From page 46 R57's MDS dated 2/5/14, indicated R57 was cognitively intact and had a diagnosis of asthma. During observation of the second floor medication room and East medication cart on 4/24/14, at 11:26 a.m. the following was observed; a bottle of liquid Metoprolol (used to treat high blood pressure for R89 with an expiration date of 4/17/14, and Glucagen (used for low blood sugar) for R98 dated as expired 3/2014, with the expiration date circled in black. LPN-C and RN-J verified the findings. R89's MDS dated 2/27/14, indicated R89 was moderate cognitively impaired and had a diagnosis of cardiac dysthymia. R98's MDS dated 4/7/14, indicated R98 was severely cognitively impaired and had a diagnosis of diabetes. On 4/24/14, at 11:20 a.m. the first floor medication refrigerator was observed to have a temperature of 50 degrees. The refrigerator included two unopened vials of Novolog insulin (used to treat diabetes) for R13 and R57 had Compro suppositories (used for nausea). LPN-B verified the findings and stated she was not sure what the safe storage temperature for insulin was. R13's Minimum Data Set (MDS) dated 3/5/14, indicated R13 had a diagnosis of diabetes and was cognitively intact. Review of the Insulin Storage Recommendations dated 9/30/13; revealed unopened Novolog was good until the expiration date when stored between 36 and 46 degrees and was only good for 28 days when stored at room temperature	F 431		

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F 431	Continued From page 47 between 59 and 86 degrees. When interviewed on 4/24/14, at 2:49 p.m. the director of nursing (DON) stated she expected medications to be removed and discarded when expired and stated there were no temperature logs for the first floor medication refrigerator. The DON stated a new refrigerator had been purchased to replace the one on first floor. The consultant pharmacist was interviewed on 4/24/14, at 3:12 p.m. and stated 50 degrees would be above refrigerator temperature and Novolog insulin would only be good for thirty days at that temperature. The facility Storage of Medications policy dated April, 2007, directed " the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." The package insert for Aspart insulin from Physicians Total Care, Inc. last revised 1/12/12, read "Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Opened vials may be refrigerated." The package insert information for the Aplisol from JHP Pharmaceuticals, LLC dated November 2013, informed users that "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The package insert information for the Compro suppositories from PD-Rx Pharmaceuticals, Inc.	F 431		

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F 431	Continued From page 48 last revised 12/22/10, read, " Store at 20° to 25°C (68° to 77°F)."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		6/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	04/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

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F 441	Continued From page 49 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain infection control practices to prevent possible cross contamination during catheter care for 1 of 2 residents (R98) who was observed for catheter care; failed to maintain equipment in a sanitary manner for 1 of 1 resident (P7) who received nutrition from a tube feeding; the facility failed to ensure proper hand washing was provided for 2 of 2 residents (R44, R66) during cares which had the potential to affect 26 of 26 residents residing on the floor; and the facility failed to ensure reusable blood sugar monitors were cleaned to prevent cross contamination which had the potential to affect 4 of 8 residents (R40, R97, R53, R54) whose blood sugar was monitored. In addition, the facility failed to prevent ice packs used on resident body parts from being stored in the nourishment refrigerator which had the potential to affect 21 residents on the third floor. Findings include: During observation of catheter care the nursing assistant did not follow the facility's policy on catheter care which had the potential to introduce organisms into the urinary tract system. During observation of morning cares on 4/23/14 at 10:15 a.m. through 10:30 a.m. two nursing assistants (NAs), NA-E and NA-F were observed doing pericare and urinary catheter care for R98. NA-F explained to R98 that he was going to wash	F 441	F441 It is the practice of Benedictine Health Center of Minneapolis to practice infection control measures with care delivery. A. The finger stick blood glucose meter with a defective battery cover was replaced on 4/23. Just in time review of catheter care and handwashing at the unit level during this time frame. B. Remaining blood glucose meters were checked for any defects. Review of policies related to handwashing, catheter care, blood glucose meter disinfection were reviewed and revised. C. Expectations related to infection control practices were reviewed during staff meetings. D. Weekly random audits of infection control practices via direct observation by DON or designee; audit results communicated to Quality Council for input. Compliance date: 6/7/2014	

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F 441	Continued From page 50 the resident's pericare area. NA-F put on gloves, took a clean wet wash cloth and added soap to the wash cloth from a squeeze bottle. NA-F then washed the pericare area to include the head of the penis. NA-F then discarded the wash cloth in the plastic lined garbage container used for linens.NA-F removed his gloves, discarded the gloves in a plastic lined garbage container used for garbage. NA-F put on a new pair of gloves, took a new wet wash cloth and added soap form the squirt bottle and washed the pericare area a second time. The NA then discarded the wash cloth in the appropriate receptacle. NA-F removed his gloves, put on new gloves and took a new wash cloth and wiped the area dry. NA-F repeated the drying process. NA-F then discarded the gloves and used a sanitizer on his hands and gloved with a new pair of gloves. NA-F then held on to the penis and washed the urinary catheter tubing approximately 8 inches above the head of the penis and worked down toward the head of the penis. NA-F repeated this process of washing the tubing and then going toward the head of the penis. After NA-F and NA-E completed the pericare and catheter cares, they were questioned about their technique of washing the urinary catheter tubing down to the head of the penis. As soon as they were queried NA-E acknowledged that they should have washed from the head of the penis toward the urinary catheter tubing to prevent possible contamination. NA-E confirmed they had washed the urinary catheter in the wrong direction. NA-F confirmed he had washed the catheter first instead of washing the tubing after he had washed the head of the penis. RN-G was interviewed on 4/23/14, at 10:40 a.m.	F 441		

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F 441	Continued From page 51 and confirmed the NAs should have washed from the head of the penis to the tubing to prevent introducing bacteria into the urinary tract system. RN-D was interviewed on 4/24/14, at 11:45 a.m. and confirmed that she had talked to NA-F and he told her that he had been washing something off the tubing. RN-D confirmed that she had already reviewed the policy/procedure with NA-F. The facility's policy/procedure, on Catheter Care - Urinary undated, listed the procedure for catheter care as: "9. Put on gloves, 10. Wash genital area from front to back, rinsing frequently, 11. Dry thoroughly, 12. Hold catheter at meatus to prevent pulling, 13. Wipe downward away from meatus, cleaning, approximately 4 inches of catheter tubing, 14. Secure drainage tubing (cath-secure, thigh strap) to thigh or to abdomen if a supra-pubic catheter. Remove gloves and wash hands after care is given." Housekeeping personnel failed to maintain a sanitary intravenous (IV) pole. During a tour of the facility on 4/24/14, at 10:05 a.m. a IV pole in P7's room was noted to have multiple areas of dried on white substance. The IV pole had a bag of Isosource (nutritional supplement) with tubing connected to the bag. The tube feeding solution was not being infused into P7 at the time of the tour. The tubing had been capped off. The environmental service director (ESD) was interviewed during the environmental tour of the facility and confirmed that housekeeping was	F 441		

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F 441	Continued From page 52	F 441		

responsible for wiping down the IV pole. The ESD confirmed that there was dried on white substance on multiple areas of the pole and should have been wiped off by housekeeping.

R22 and R44 did not receive proper hand washing during cares.

On 4/23/14, the following was observed during continuous observation:
-At 8:10 a.m. observed the nursing assistant (NA)-A going to R44 ' s room.
-At 8:12 a.m. observed the NA-A had set up water in a wash basin. NA removed resident gown and covered resident with a white sheet then took a wash towel cued R44 before she started to wipe his face with a wet wash towel and then dried off the face.
-At 8:15 a.m. observed NA-A cued R44 before starting to wash R44's torso, dried armpits and torso then applied deodorant. NA-A removed her gloves did not wash hands grabbed R44's shirt and re-applied gloves.
-At 8:18 a.m. NA-A was observed tearing R44's pad off; squeezed extra water off the wash towel; provided front peri-care and then with the same gloves adjusted R44's pillow, linen, shirt and touched R44's head then turned R44 to his right side pulled the wet incontinent pad off complete peri-anal cares, applied cream, removed left glove and re-applied another glove on that hand and continued to apply a clean pad but never washed hands.
-A8:28 to 8:30 a.m. NA-A was observed assisting R44 to apply his pants and adjusted them.
-At 8:33 a.m. NA-A observed leaving the room stated she was going to get someone to help her to transfer R44 in his chair. On the way out NA-A removed gloves never washed hands went down

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F 441	Continued From page 53	F 441		

to the North Hallway. NA-A was observed standing outside another room then came walking down the hallway with NA-B
-At 8:35 a.m. NA-A was observed going to the East Hallway grabbed the E-Z stand lift (machine used for transferring) then was observed going to R66's room with NA-C and shut the door. Surveyor knocked the door immediately and entered room.
-At 8:36 a.m. NA-A was observed applying a pair of gloves never seen washing or cleansing hands.
-At 8:38 a.m. observed standing by the E-Z stand as NA-B was observed standing by R66 at bedside.
-At 8:40 a.m. NA-A removed gloves never washed hands tossed the used gloves in the trash then opened R66's door pushed the E-Z stand out of room came outside the room to the alcove re-arranged lifts then grabbed a Hoyer lift and was observed going down the hallway to R44's room.
-At 8:42 a.m. NA-A and NA-B were both observed going to R44's room. NA-A was observed with bare hands lifting the floor mat off the floor, folded it and kept it standing by the chair. NA-A then applied gloves never washed hands.
-At 8:45 to 8:49 a.m. observed both NA-A and NA-B rolling R44 side to side applied the lift sheet and transferred R44 to the broad wheelchair (Specialized wheelchair). NA-C removed gloves tossed them in the trash and cleansed hands with hand sanitizer on his way out using hand sanitizer located in the room to the right of the door.
-At 8:53 a.m. NA-A was observed applying R44's shoes.
-At 8:54 a.m. NA-A finally removed gloves and cleansed her hands with hand sanitizer and left the room went outside the room to the alcove

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F 441	Continued From page 54 grabbed a towel briefly. -At 8:55 to 8:59 a.m. NA-A observed assisting R44 to brush his teeth, went back to the bathroom rinsed the basin and tooth brush then removed gloves never washed hands then came back from bathroom with comb and cued R44 she was going to comb his hair. -At 9:00 a.m. observed NA-A attempting to apply resident thigh pads but was not able then stated she was going to have someone come assist her and left the room without washing hands. -At 9:02 to 9:06 a.m. both NA-A and NA-C were observed applying gloves, repositioned R44 in the w/c. Then both removed gloves and NA-C asked NA-A to ask the registered nurse (RN)-A for prescribed cream for R44's scalp for itching. NA-A left the room went outside spoke briefly to RN-A then came back to room never washed hands. -At 9:07 a.m. NA-A came back to room and was observed donning another pair of gloves and RN-A came to R44's room and was observed applying cream to R44's scalp as NA-A stood by. -At 9:08 a.m. DON came to room observed checking call lights when leaving cued both RN-A and NA-A to wash hands before leaving the room. -At 9:11 a.m. both NA-A and RN-A were observed removing gloves and cleansed hands with hand sanitizer in the room. When interviewed at 9:15 a.m. NA stated she was supposed to wash her hands before starting cares, leaving room and after removing gloves. NA further stated "I forgot." When interviewed at 9:17 a.m. RN-B stated the NA's are supposed to follow the hand hygiene policy and indicated he was going to find what the	F 441		

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F 441	Continued From page 55 facility policy exactly directed. When interviewed on 4/24/14, at 11:18 a.m. RN-A stated her expectation was NA should have washed hands upon removing gloves, before entering, leaving the room and after doing pericare. When interviewed on 4/24/14, at 12:41 p.m. the director of nursing stated all the staff are supposed to follow hand washing procedure per CDC guidelines and are supposed to wash hands during cares, after removing gloves, before and after cares. The facility Handwashing policy dated 6/2002, directed "Procedures must be followed to prevent cross-contamination, including handwashing or changing gloves after providing personal care, or when performing tasks among individuals which provide the opportunity for cross contamination to occur. The facility follows the CDC's Guideline for Handwashing..." Reusable blood sugar monitors were not cleaned as required to prevent cross-contamination between residents. During observations on 4/21/14, at 5:14 p.m. registered nurse (RN)-K checked R 40's blood sugar. RN-K wiped the blood sugar monitor with an alcohol wipe and placed the monitor in a basket. Without any additional cleaning of the blood sugar monitor, RN-K entered another room and checked R97's blood sugar. RN-K again wiped the blood glucose monitor with an alcohol wipe. When RN-K returned to the treatment cart, she stated now that she was done with the wing, she would disinfect the blood glucose monitor.	F 441		

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F 441	Continued From page 56 RN-K was observed using a Sani-wipe to wipe off the blood glucose monitor. RN-K verified she checks all blood sugars on the west wing and only uses alcohol wipes until she is done with the wing. During observations on 4/23/14, at 7:39 a.m. RN-L was observed checking R97 's blood sugar and then placed the blood sugar monitor in her pocket. RN-L took the blood sugar monitor out of her pocket and without sanitizing the monitor she entered R 53's room and checked R53's blood sugar. RN-L placed the blood sugar monitor back in her pocket. RN-L returned to the treatment cart and used a Sani-wipe to clean the monitor. RN-L stated she used Sani-wipes when she was done with a round of blood sugar checks or at the end of the night when working night shift. When interviewed on 4/24/14, at 2:25 p.m. RN-I stated she expected blood sugar monitors to be cleaned between each patient with bleach wipes (Sani-wipes). The facility Blood Glucose Meters Use and Disinfection policy (undated), directed the blood glucose meter will be cleaned and disinfected after each use. The policy directed to use the alcohol prep pads to cleanse the outside of the blood glucose meter and place on a new paper towel and then to use a disinfectant wipe when outside of the room. On 4/23/14, at 1:10 p.m. a blood glucose meter (meter) was used for R54 to obtain a blood glucose level. After using the meter, RN-E wiped the meter down with alcohol swab, placed it on a clean paper towel, and then used a PDA-Sani wipe to disinfect the meter. As RN-E was	F 441		

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F 441	Continued From page 57 disinfecting the meter it was noted to have a soiled piece of tape securing the battery cover to the machine. RN-E carried the meter back to the med cart. RN-F stated the tape was to hold the cover on and did not affect the machine working. RN-D removed the meter from service since it was no longer able to be disinfected /cleaned between resident use. A new meter was obtained to replace the broken meter. The policy/procedure The Return demonstration of use and cleaning/disinfecting of a blood glucose meter (BGM) indicated (after use) dated 5/10. "1. With gloved hands, use alcohol pad to cleanse the outside of meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. Place clean meter on a new paper towel. 2. Remove all supplies into appropriate receptacles by gloving disposable non-sharp items that may contain small traces of blood into the garbage 3. Wash hands Disinfect blood glucose meter (done at cart) 1. Take meter to the outside cart for disinfection. 2. Place the meter on paper towel barrier. 3. Don new gloves. Disinfect is toxic when absorbed through the skin, always wear gloves. 4. Get the disinfectant cloth from locked medication cart. 5. Wipe down the outside of the meter with this cloth until the entire surface is wet with disinfectant. 6. Wrap the cloth around the meter to maintain surface wetness for 2 minutes. 7. After 2 minutes (swell time) removed the disinfectant wipe and discard to the trash. Allow to air dry.	F 441		

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F 441	Continued From page 58 8. Blood glucose meter is now disinfected and ready to store or to use on another resident. " The Blood Glucose Meters Use and Disinfection policy dated May 4/10. "- With gloved hands, use alcohol pad to cleanse the outside of meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. Place clean meter on a new paper towel. - Remove all supplies into appropriate receptacles by gloving disposable non-sharp items that may contain small traces of blood into the garbage - Wash hands Disinfect blood glucose meter (done at cart) - Take meter to the outside cart for disinfection. - Place the meter on paper towel barrier. - Don new gloves. Disinfect is toxic when absorbed through the skin, always wear gloves. - Get the disinfectant cloth from locked medication cart. - Wipe down the outside of the meter with this cloth until the entire surface is wet with disinfectant. - Wrap the cloth around the meter to maintain surface wetness for 2 minutes. - After 2 minutes (swell time) removed the disinfectant wipe and discard to the trash. Allow to air dry. - Blood glucose meter is now disinfected and ready to store or to use on another resident. " Re-usable ice packs were stored in the third floor medication room refrigerator with ice cream and yogurt. On 4/24/14, at 10:56 a.m. during a tour of the	F 441		

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F 441	Continued From page 59 third floor medication room three blue ice packs were observed in the freezer with ice cream and yogurt. RN-I stated the blue ice packs were used on resident's body parts and verified the findings.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Heatlh Center of Mpls was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/21/2014

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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BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	**618 EAST 17TH STREET MINNEAPOLIS, MN 55404**

(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 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 5-story building was determined to be of Type II(000) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirement for construction	K 012	Correction not needed. Benedictine Health Center of Minneapolis has	6/7/14

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	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2014**

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K 012	Continued From page 2 type and height. This deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:45 AM on 04/25/2014, observation revealed that this 5-story, non-combustible facility of Type II(000) construction does not meet the minimum construction requirements for a building of this height. The roof of the facility does not have a fire rating. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012	achieved a passing FSES score.	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide	K 050	Benedictine Health Center of Minneapolis will conduct unannounced fire drills at	6/7/14

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K 050	Continued From page 3 quarterly drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all residents. Findings include: On facility tour between 9:30 AM and 11:45 AM on 04/25/2014, record review revealed that the there was no AM shift fire drill for the 2nd quarter of 2013 and no PM shift fire drill for the 3rd quarter of 2013. This deficient practice was verified by the administrator at the time of the inspection.	K 050	least quarterly on each shift. The Maintenance Director has created a schedule matrix to plan and track fire drills on a quarterly basis on each shift. The Maintenace Director will be responsible for auditing this schedule and meeting the requirements of NFPA 101 LSC (00) Section 19.7.1.2. Compliance date: June 7, 2014	

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Monday, April 28, 2014 3:15 PM
To: 'rochi_lsc@cms.hhs.gov'
Cc: robert.rexeisen@state.mn.us; 'dave.brennan@bhshealth.org'; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Kleppe, Anne (MDH); Leach, Colleen (MDH); Meath, Mark (MDH); Zwart, Benjamin (MDH)
Subject: Benedictine Health Center of Minneapolis (245266) 2014 FSES - Previously Approved - No Changes

This is to inform you that I am accepting the FSES report that was conducted on 4-25-14 at the Benedictine HC of Minneapolis. The exit date was 4-25-14.

I am recommending that CMS approve this report.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

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	00960	A. BUILDING: _____ B. WING _____	04/24/2014

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

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

Electronically Signed | 05/22/14

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2 000	Continued From page 1 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. On 4/21/14, through 4/24/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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. 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to re-assess pain before	2 565	-	6/7/14

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2 565	Continued From page 2 and during observed dressing changes for 1 of 2 residents (R98) according to the care plan who was observed to have pain during a dressing change. Findings include: R98 was admitted to the facility 2/22/14, with a complicated past medical history that included chronic respiratory failure status post tracheotomy and currently on mechanical ventilation, congestive heart failure, coronary artery disease, taken from his history and physical dated 2/16/14. In addition, R98 had a Stage 4 decubitus ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) on his coccyx. R98 was observed during a dressing change on 4/23/14, at 10:45 a.m. to the Stage 4 pressure ulcer on the coccyx. There were two nursing assistants (NAs) NA-E and NA-F in the resident's room who had just completed morning cares. The dressing change was done by registered nurse (RN)-G. RN-G came into R98's room, took gloves from the bedside stand that had dressing materials. RN-G explained to R98 that she was going to change the dressing on his wound. NA-E assisted RN-G to turn and position the resident onto his left side. NA-E supported the resident on his left side while RN-G removed the old dressing. RN-G then discarded the soiled dressings in the plastic lined waste basket and then removed her gloves. RN-G then washed her hands in the bathroom sink in R98's room. RN-G was asked if that was a clean or sterile dressing change and she stated that she was going to do a	2 565		

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2 565	Continued From page 3	2 565		

clean dressing change. RN-G indicated the resident would let them know when he was having pain. RN-G did not inquire the pain status of the resident before starting the dressing change. RN-G donned gloves, and put saline (salt water) wound wash on a 4 x 4 gauge dressing and dabbed the wound and repeated the procedure one more time. Observation of the wound bed noted bone and fresh red blood oozing at the one o'clock position. RN-G then removed her soiled gloves and discarded them in the plastic lined garbage can. R98 was observed with facial grimacing and was then asked by the surveyor if he was having pain and R98 confirmed that he was having pain. The resident was asked if he had pain with other dressing changes and he replied that he had pain with all dressing changes. RN-G acknowledged she heard the resident state he was having pain. RN-G indicated she would get him something for pain after she finished with the dressing change. RN-G then put on a fresh pair of gloves and packed the wound with SoloSite (a wound dressing gel that creates a moist wound environment) on a 4 x 4 gauge dressing and used a Q-Tip to place the dressing in the wound. The resident continued to facial grimace in pain. RN-G then removed her gloves, washed her hands in the sink in the bathroom. RN-G then came back and placed an ABD dressing (thick absorbent dressing) over the packing and taped the dressing to the resident's skin. The dressing was dated, 4/23/14. RN-G then went out to the med cart and got a Percocet (pain medication) for R98 at 11:00 a.m. RN-G did not do a pain evaluation using a pain scale of 1 to 10 with 10 being the greatest.

RN-G was interviewed after she gave the pain medication to R98 and confirmed she did not

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2 565	Continued From page 4 assess the resident for pain before starting the dressing change and the resident had not received anything for pain before the dressing change. RN-G then discussed with RN-D and both agreed they should check with the resident the status of his pain before doing a dressing change. RN-G confirmed the resident did not have a scheduled pain medication(s) before the dressing change but there was an order for pain medication on an as needed basis (PRN). RN-G stated she would notify R98's physician of pain during a dressing change. R98's care plan dated 3/5/14, indicated R98 had pain/potential for pain. " - Pain: alteration in comfort level pain due to immobility and pressure area -- Resident will verbalize good pain control and /or will have minimal visible indicators of pain -- Assist with developing coping mechanism -- Attempt non-pharmacological methods of pain interventions: imagery, distraction techniques, relaxation exercises, massage therapy hot or cold compress. Rest periods to facilitate comfort sleep, and relaxation. Eliminate additional stressors or sources of discomfort, sleep and relaxation. Eliminate additional stressors or sources of discomfort whenever possible -- Complete pain assessment: annually, quarterly, significant change and PRN (as needed) -- Medications as per MD orders -- Monitor for SE of pain medication: sedation, respiratory depression, N/V itching, increased confusion, Educate resident and family -- Nursing to observe and record effectiveness of scheduled and PRN medications and update MD as indicated -- Observe for any objective signs of pain: moaning, groaning, and grimacing -- Resident uses Tylenol PRN for pain	2 565		

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2 565	Continued From page 5 -- Staff to evaluate resident's rate pain on a 1-10 scale if resident states he/she was experiencing pain, or point to faces of pain on a scale." The plan of care was not followed as the staff did not monitor R98 for signs of pain during the dressing change nor did the staff offer pain medication prior to the dressing change. The director of nursing (DON) was interviewed on 4/24/14, at 11:40 a.m. was questioned about pain management, her response was, "I will have to get the policy and read it and get back to you." The DON declined comment on additional questions relating to pain assessments prior to treatments saying she had not read R98's chart and was not familiar with his cares. RN-D was interviewed on 4/24/14, at 11:50 a.m. and confirmed R98 "can tell us when he is having pain and can ask for pain medication, he knows he has pain medication available." We do pain assessments on admission, 14 days, 30 days, and at 60 days. R98 answers were mostly reliable. The resident did not understand the depth and severity of how sick he was. RN-D confirmed the resident should have been asked before the dressing change if he had pain. "We do not routinely do pain assessments before treatments." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		

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2 830	Continued From page 6	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to re-assess pain before and during an observed dressing change for 1 of 2 residents (R98). Findings include: R98 was admitted to the facility 2/22/14, with a complicated past medical history that included chronic respiratory failure status post tracheotomy and currently on mechanical ventilation, congestive heart failure, coronary artery disease, taken from his history and physical dated 2/16/14. In addition, R98 had a Stage 4 decubitus ulcer (Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures e.g., tendon, joint capsule. Undermining and sinus tracts also may be associated with Stage 4 pressure ulcers) on his coccyx.	2 830	-	6/7/14

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2 830	Continued From page 7 R98 was observed during a dressing change on 4/23/14, at 10:45 a.m. to the Stage 4 pressure ulcer on the coccyx. There were two nursing assistants (NAs) NA-E and NA-F in the resident's room who had just completed morning cares. The dressing change was done by registered nurse (RN)-G. RN-G came into R98's room, took gloves from the bedside stand that had dressing materials. RN-G explained to R98 that she was going to change the dressing on his wound. NA-E assisted RN-G to turn and position the resident onto his left side. NA-E supported the resident on his left side while RN-G removed the old dressing. RN-G then discarded the soiled dressings in the plastic lined waste basket and then removed her gloves. RN-G then washed her hands in the bathroom sink in R98's room. RN-G was asked if that was a clean or sterile dressing change and she stated that she was going to do a clean dressing change. RN-G indicated the resident would let them know when he was having pain. RN-G did not inquire the pain status of the resident before starting the dressing change. RN-G donned gloves, and put saline (salt water) wound wash on a 4 x 4 gauge dressing and dabbed the wound and repeated the procedure one more time. Observation of the wound bed noted bone and fresh red blood oozing at the one o'clock position. RN-G then removed her soiled gloves and discarded them in the plastic lined garbage can. R98 was observed grimacing and was then asked by the surveyor if he was having pain and R98 confirmed that he was having pain. The resident was asked if he had pain with other dressing changes and he replied that he had pain with all dressing changes. RN-G acknowledged she heard the resident state he was having pain. RN-G indicated she would get him something for pain	2 830		

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2 830	Continued From page 8 after she finished with the dressing change. RN-G then put on a fresh pair of gloves and packed the wound with SoloSite (a wound dressing gel that creates a moist wound environment) on a 4 x 4 gauge dressing and used a Q-Tip to place the dressing in the wound. The resident continued to grimace in pain. RN-G then removed her gloves, washed her hands in the sink in the bathroom. RN-G then came back and placed an ABD dressing (thick absorbent dressing) over the packing and taped the dressing to the resident's skin. The dressing was dated, 4/23/14. RN-G then went out to the med cart and got a Percocet (pain medication) for R98 at 11:00 a.m. RN-G did not do a pain evaluation using a pain scale of 1 to 10 with 10 being the greatest. RN-G was interviewed after she gave the pain medication to R98 and confirmed she did not assess the resident for pain before starting the dressing change and the resident had not received anything for pain before the dressing change. RN-G then discussed with RN-D and both agreed they should check with the resident the status of his pain before doing a dressing change. RN-G confirmed the resident did not have a scheduled pain medication(s) before the dressing change but there was an order for pain medication on an as needed basis (PRN). RN-G stated she would notify R98's physician of pain during a dressing change. R98 had pain assessments completed on 2/4/14 and 2/7/14. Each assessment indicated he was having pain daily in the buttocks area and 2/7/14. Both pain assessments stated the resident's pain was located in the coccyx area where there was a wound and a check mark was by distressing/miserable (moderate pain). Both of the pain assessments indicated the resident was	2 830		

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2 830	Continued From page 9 on Percocet 2 tabs per the G-tube every 4 hours for pain. Another pain assessment was completed on 2/22/14, and indicated R98 had pain in the buttock area and the pain was uncomfortable /annoying (mild pain) and the pain was less than daily and the Tylenol (a mild analgesic) 650 mg was effective and he could have the Tylenol as needed for pain. On 2/25/14, a 4th pain assessment was completed and the pain was once again noted to be in the buttocks area and the pain was distressing/miserable (moderate pain). The resident could have Tylenol through the G-tube every 4 hours for pain and it was noted to be effective. The pain assessments did not have a time when the assessments were completed and it could not be determined if the pain assessments was only completed by interview or in conjunction with cares and treatments. The Care Area Assessment (CAA) done for cognition loss/dementia was done on 2/11/14, and indicated that area triggered because the Brief Interview for Mental Status (BIMS) score showed impaired cognition (9/15). The conclusion that was drawn under Analysis of Findings indicated the following: "Resident is alert and oriented. Understand communication and is able to follow instructions. Resident is on ventilator full time. He is able to mouth words and is understood when cuff is deflated. Resident is able to write some. Hearing is adequate, resident feels he can't hear well." Received a fax dated 4/25/14, and the note on 4/7/14, indicated, "Resident knows pain medication is available and documentation exists in record that he does request it." The care area assessment (CAA) for pain was done on 2/17/14. "Per resident report during pain	2 830		

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2 830	Continued From page 10 interview he has continuous pain that can range from 7 to 10. States it is usually the coccyx area that hurts. Reports that pain medication helps. Was started on QID [four times a day] Percocet with PRN Percocet for breakthrough pain." R98's care plan dated 3/5/14, indicated R98 had pain/potential for pain. "- Pain: alteration in comfort level pain due to immobility and pressure area -- Resident will verbalize good pain control and /or will have minimal visible indicators of pain -- Assist with developing coping mechanism -- Attempt non-pharmacological methods of pain interventions: imagery, distraction techniques, relaxation exercises, massage therapy hot or cold compress. Rest periods to facilitate comfort sleep, and relaxation. Eliminate additional stressors or sources of discomfort, sleep and relaxation. Eliminate additional stressors or sources of discomfort whenever possible -- Complete pain assessment: annually, quarterly, significant change and PRN -- Medications as per MD [physician] orders -- Monitor for SE [side effects] of pain medication: sedation, respiratory depression, N/V [nausea and vomiting] itching, increased confusion, Educate resident and family -- Nursing to observe and record effectiveness of scheduled and PRN medications and update MD as indicated -- Observe for any objective signs of pain: moaning, groaning, grimacing -- Resident uses Tylenol PRN for pain -- Staff to evaluate resident's rate pain on a 1-10 scale if resident states he/she was experiencing pain, or point to faces of pain on a scale." The plan of care was not followed as the staff did not monitor R98 for signs of pain during the dressing change nor did the staff offer pain medication	2 830		

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2 830	Continued From page 11 prior to the dressing change. Progress notes were reviewed for R98. - On 3/12/14, at 3:50 p.m. the resident settled in to his room and transferred to facility ventilator. (Resident returned from the hospital). Stated he had some pain to back side. "Dressing change done to Stage IV coccyx ulcer and wound measurements done. Wound was macerated at edges and had undermining from 9 to 3 o'clock. Bone was palpable. R98 was on specialty mattress MA95Z with 20 degrees rotation to left and right at this time." - On 3/17/14, at 4:21 p.m. Resident stated he had pain to coccyx. "Resident does have stage IV pressure to coccyx upon re-admission. Resident was on Percocet prn for pain. Resident was hospitalized 3/9/14 to 3/12/14 with diagnosis of pneumonia." - On 3/20/14, at 7:01 p.m. Resident stated he had pain in his "butt" which he rated 6/10". "PRN Percocet administered via G-Tube at 0515 with somewhat effective results. Resident now rates pain at '5/10'." - On 3/26/14, at 2:44 p.m. resident requested pain medication for back ache at 2:00 p.m. - On 3/28/14, at 3:02 p.m. resident requested pain medication for back ache at 1320 [1:20 p.m.] and Ativan for anxiety. - On 3/30/14, at 10:14 a.m. Wound Care Clinician note. "Coccyx stage IV pressure ulcer 6.8 x 4.4 x 1.4 deep. Undermining 1.5 [centimeters] at 12 o'clock, 2.6 at 6 to 9 o'clock. Base 80% granulation." - On 4/7/14, at 7:05 a.m. requested pain med for pain in low back and cough medicine at 0630 (6:30 a.m.). - On 4/7/14, at 8:11 a.m. stated that when pain occurs pain medication (Percocet) was good to relieve it.	2 830		

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2 830	Continued From page 12 R98 had a physician's order for a dressing change of the coccyx daily, dated 3/13/14. The order was to do the dressing change as follows: "1. Cleanse coccyx daily with normal saline 2. Pack with gauze loosely moistened with SoloSite 3. Skin protectant to wound edges 4. Cover with ABD." Review of the documents indicated that R98 had a Physician's Order dated 3/19/14, for Percocet (oxycodone-acetaminophen) Schedule II tablet: 5-325 milligrams (mg) one tablet per gastric tube four times a day PRN. A pain assessment interview was completed on 4/7/14, at 8:05 a.m. (30 day assessment) and indicated the resident had not received any scheduled pain medication in the last five days. However, R98 had received PRN pain medications in the last five days. The next question was, "at any time in the last 5 days, has the resident received any non-medication intervention for pain?" The answer was "Yes" but the area for description of the pain was left blank. When the resident was asked "Have you had pain or hurting at any time in the last 5 days?" the answer was "Yes." The resident indicated he had pain occasionally and the pain was moderate. The indicators for pain was blank. R98's Minimum Data Set (MDS) dated 4/7/14, indicated R98 was severely cognitively impaired and had an unhealed pressure ulcer at Stage 4. The MDS indicated R98 had occasional pain. R98's Physician Note dated 4/23/14, and electrically signed at 3:30 p.m. indicated a nurse had informed him about identified pain during dressing changes and R98 would be	2 830		

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2 830	Continued From page 13	2 830		

pre-medicated with Percocet in the future. R98 also had a chronic Stage 4 stage decubitus ulcer related in part to his debilitated condition poor cardiac output and prolonged bed rest. "Position good improvement with auto-debridement." R98's physician confirmed he was not aware the resident was having pain until it was brought to his attention by the surveyor.

A progress note dated 4/24/14, at 3:26 p.m. indicated the following: "Resident received PRN Percocet at 0950 this shift prior to coccyx dressing change. The resident later stated that this medication made the dressing change more comfortable for him."
The Medication Administration Record (MAR) for pain medication usage was reviewed for the last two weeks, 4/11/14 through 4/24/14. R98 received pain medication PRN:
- On 4/11/14, at 3:43 p.m.,
- On 4/12/14, at 6:27 p.m.,
- On 4/13/14, at 6:40 p.m.,
- On 4/15/14, at 6:30 a.m. and again at 12:36 p.m.,
- On 4/16/14, at 9:00 a.m.,
- On 4/17/14, at 12:45 a.m., 6:57 a.m. and 5:18 p.m.,
- On 4/19/14, at 9:32 a.m.,
- On 4/21/14, at 8:39 p.m., 12:52 p.m., and 4:45 p.m. The medication sheet did not indicate where the pain was, intensity of the pain, or effectiveness of the pain. Also the medication sheet did not indicate if non-pharmacological means had been used to elevate the pain.

R98's physician was interviewed on 4/23/14, at 2:10 p.m. it was brought to the attention of the physician that R98 was having pain during dressing changes on his Stage 4 pressure ulcer. R98's physician agreed to talk to the resident and

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addressed the pain during the dressing changes. The physician would evaluate if R98 should have a scheduled pain medication. Before the R98's physician assessed the resident for pain, the resident had a pain order for Percocet (oxycodone) tablet 5-325 mg, 1 tablet per gastric tube. R98 had " Special Instructions. Not to exceed 4000 mg /24 hours four times a day as needed."

RN-D was interviewed on 4/24/14, at 8:45 a.m. and confirmed R98's physician saw the resident yesterday, (4/23/14) and assessed R98 for pain during dressing changes. R98's physician wrote a doctor's order on 4/23/14, for Percocet one before each dressing change.

R98 was interviewed on 4/24/14, at 8:55 a.m. R98 stated the pain he experienced during the dressing change on 4/23/14, was at least a "7, maybe higher" when he had the dressing changes (the resident was aware that on a scale of 1 to 10, 10 would be the highest). The resident was informed he would now be getting pain medication before each dressing change. The resident mouthed "thank you" and smiled.

The director of nursing (DON) was interviewed on 4/24/14, at 11:40 a.m. was questioned about pain management, her response was, "I will have to get the policy and read it and get back to you." The DON declined comment on additional questions relating to pain assessments prior to treatments saying she had not read R98's chart and was not familiar with his cares.

RN-D was interviewed on 4/24/14, at 11:50 a.m. and confirmed R98 "can tell us when he is having pain and can ask for pain medication, he knows he has pain medication available." We do pain

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assessments on admission, 14 days, 30 days, and at 60 days. R98 answers were mostly reliable. The resident did not understand the depth and severity of how sick he was. RN-D confirmed the resident should have been asked before the dressing change if he had pain. "We do not routinely do pain assessments before treatments."

The pain management policy dated 12/2002, indicated that the standard was, "All residents who are experiencing pain, or may have conditions that may result in pain, will have a comprehensive assessment of pain symptoms and will have a treatment plan established to treat pain symptoms." The policy indicated the following, "1. Each resident will be provided with a consistent, accurate and timely comprehensive assessment of resident's comfort level as related to acute, chronic or suspected pain. 2. Each resident who experiences pain will have a pain prevention/intervention plan established and implemented. 3. A licensed nurse will complete a comprehensive pain assessment that will address a resident's pain origin, location, severity, alleviating and exacerbating factors, current treatment, and resident response to treatment." The procedure was as follows: "1. A licensed nurse will initiate pain assessments and reassessments. a. upon admission to the facility b. Quarterly c. Any significant change in condition d. Upon readmission to the facility e. With onset of resident verbalization of pain or discomfort f. Staff identifies presence of nonverbal indicators, changes in behavior states of non-verbal or demented residents g. Change in level of pain, breakthrough pain, or increased use of PRN analgesics. 2. The licensed nurse will perform a pain assessment using the Pain Management form. 3. The pain assessment will also include

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2 830	Continued From page 16 the use of pain scale to describe the resident's pain and amount of pain relief. 4. Ineffective pain management necessitates a change. This requires notification of the physician, and family, and documentation in the nursing notes and plan of care." SUGGESTED METHOD OF CORRECTION: The DON or her designee could develop polices and procedures regarding assessing and monitoring pressure related skin conditions. The DON or her designee could educate staff on the policies and procedures. The DON or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty-one (21) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain infection control practices to prevent possible cross contamination during catheter care for 1 of 2 residents (R98) who was observed for catheter care; failed to maintain equipment in a sanitary manner for 1 of 1 resident (R7) who received nutrition from a tube feeding; the facility failed to ensure proper hand washing was provided for 2	21375	-	6/7/14

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21375	Continued From page 17 of 2 residents (R44, R66) during cares which had the potential to affect 26 of 26 residents residing on the floor; and the facility failed to ensure reusable blood sugar monitors were cleaned to prevent cross contamination which had the potential to affect 4 of 8 residents (R40, R97, R53, R54) whose blood sugar was monitored. In addition, the facility failed to prevent ice packs used on resident body parts from being stored in the nourishment refrigerator which had the potential to affect 21 residents on the third floor. Findings include: During observation of catheter care the nursing assistant did not follow the facility's policy on catheter care which had the potential to introduce organisms into the urinary tract system. During observation of morning cares on 4/23/14 at 10:15 a.m. through 10:30 a.m. two nursing assistants (NAs), NA-E and NA-F were observed doing pericare and urinary catheter care for R98. NA-F explained to R98 that he was going to wash the resident's pericare area. NA-F put on gloves, took a clean wet wash cloth and added soap to the wash cloth from a squeeze bottle. NA-F then washed the pericare area to include the head of the penis. NA-F then discarded the wash cloth in the plastic lined garbage container used for linens. NA-F removed his gloves, discarded the gloves in a plastic lined garbage container used for garbage. NA-F put on a new pair of gloves, took a new wet wash cloth and added soap form the squirt bottle and washed the pericare area a second time. The NA then discarded the wash cloth in the appropriate receptacle. NA-F removed his gloves, put on new gloves and took a new wash cloth and wiped the area dry. NA-F repeated the drying process. NA-F then	21375		

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discarded the gloves and used a sanitizer on his hands and gloved with a new pair of gloves. NA-F then held on to the penis and washed the urinary catheter tubing approximately 8 inches above the head of the penis and worked down toward the head of the penis. NA-F repeated this process of washing the tubing and then going toward the head of the penis.

After NA-F and NA-E completed the pericare and catheter cares, they were questioned about their technique of washing the urinary catheter tubing down to the head of the penis. As soon as they were queried NA-E acknowledged that they should have washed from the head of the penis toward the urinary catheter tubing to prevent possible contamination. NA-E confirmed they had washed the urinary catheter in the wrong direction. NA-F confirmed he had washed the catheter first instead of washing the tubing after he had washed the head of the penis.

RN-G was interviewed on 4/23/14, at 10:40 a.m. and confirmed the NAs should have washed from the head of the penis to the tubing to prevent introducing bacteria into the urinary tract system.

RN-D was interviewed on 4/24/14, at 11:45 a.m. and confirmed that she had talked to NA-F and he told her that he had been washing something off the tubing. RN-D confirmed that she had already reviewed the policy/procedure with NA-F.

The facility's policy/procedure, on Catheter Care - Urinary undated, listed the procedure for catheter care as:
"9. Put on gloves, 10. Wash genital area from front to back, rinsing frequently, 11. Dry thoroughly, 12. Hold catheter at meatus to prevent pulling, 13. Wipe downward away from

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21375	Continued From page 19 meatus, cleaning, approximately 4 inches of catheter tubing, 14. Secure drainage tubing (cath-secure, thigh strap) to thigh or to abdomen if a supra-pubic catheter. Remove gloves and wash hands after care is given." Housekeeping personnel failed to maintain a sanitary intravenous (IV) pole. During a tour of the facility on 4/24/14, at 10:05 a.m. a IV pole in P7's room was noted to have multiple areas of dried on white substance. The IV pole had a bag of Isosource (nutritional supplement) with tubing connected to the bag. The tube feeding solution was not being infused into P7 at the time of the tour. The tubing had been capped off. The environmental service director (ESD) was interviewed during the environmental tour of the facility and confirmed that housekeeping was responsible for wiping down the IV pole. The ESD confirmed that there was dried on white substance on multiple areas of the pole and should have been wiped off by housekeeping. R22 and R44 did not receive proper hand washing during cares. On 4/23/14, the following was observed during continuous observation: -At 8:10 a.m. observed the nursing assistant (NA)-A going to R44 ' s room. -At 8:12 a.m. observed the NA-A had set up water in a wash basin. NA removed resident gown and covered resident with a white sheet then took a wash towel cued R44 before she started to wipe his face with a wet wash towel and then dried off the face.	21375		

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21375	Continued From page 20 -At 8:15 a.m. observed NA-A cued R44 before starting to wash R44's torso, dried armpits and torso then applied deodorant. NA-A removed her gloves did not wash hands grabbed R44's shirt and re-applied gloves. -At 8:18 a.m. NA-A was observed tearing R44's pad off; squeezed extra water off the wash towel; provided front peri-care and then with the same gloves adjusted R44's pillow, linen, shirt and touched R44's head then turned R44 to his right side pulled the wet incontinent pad off complete peri-anal cares, applied cream, removed left glove and re-applied another glove on that hand and continued to apply a clean pad but never washed hands. -A 8:28 to 8:30 a.m. NA-A was observed assisting R44 to apply his pants and adjusted them. -At 8:33 a.m. NA-A observed leaving the room stated she was going to get someone to help her to transfer R44 in his chair. On the way out NA-A removed gloves never washed hands went down to the North Hallway. NA-A was observed standing outside another room then came walking down the hallway with NA-B -At 8:35 a.m. NA-A was observed going to the East Hallway grabbed the E-Z stand lift (machine used for transferring) then was observed going to R66's room with NA-C and shut the door. Surveyor knocked the door immediately and entered room. -At 8:36 a.m. NA-A was observed applying a pair of gloves never seen washing or cleansing hands. -At 8:38 a.m. observed standing by the E-Z stand as NA-B was observed standing by R66 at bedside. -At 8:40 a.m. NA-A removed gloves never washed hands tossed the used gloves in the trash then opened R66's door pushed the E-Z	21375		

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21375	Continued From page 21 stand out of room came outside the room to the alcove re-arranged lifts then grabbed a Hoyer lift and was observed going down the hallway to R44's room. -At 8:42 a.m. NA-A and NA-B were both observed going to R44's room. NA-A was observed with bare hands lifting the floor mat off the floor, folded it and kept it standing by the chair. NA-A then applied gloves never washed hands. -At 8:45 to 8:49 a.m. observed both NA-A and NA-B rolling R44 side to side applied the lift sheet and transferred R44 to the broad wheelchair (Specialized wheelchair). NA-C removed gloves tossed them in the trash and cleansed hands with hand sanitizer on his way out using hand sanitizer located in the room to the right of the door. -At 8:53 a.m. NA-A was observed applying R44's shoes. -At 8:54 a.m. NA-A finally removed gloves and cleansed her hands with hand sanitizer and left the room went outside the room to the alcove grabbed a towel briefly. -At 8:55 to 8:59 a.m. NA-A observed assisting R44 to brush his teeth, went back to the bathroom rinsed the basin and tooth brush then removed gloves never washed hands then came back from bathroom with comb and cued R44 she was going to comb his hair. -At 9:00 a.m. observed NA-A attempting to apply resident thigh pads but was not able then stated she was going to have someone come assist her and left the room without washing hands. -At 9:02 to 9:06 a.m. both NA-A and NA-C were observed applying gloves, repositioned R44 in the w/c. Then both removed gloves and NA-C asked NA-A to ask the registered nurse (RN)-A for prescribed cream for R44's scalp for itching. NA-A left the room went outside spoke briefly to RN-A then came back to room never washed hands.	21375		

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	00960	A. BUILDING: _____ B. WING _____	04/24/2014

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21375	Continued From page 22 -At 9:07 a.m. NA-A came back to room and was observed donning another pair of gloves and RN-A came to R44's room and was observed applying cream to R44's scalp as NA-A stood by. -At 9:08 a.m. DON came to room observed checking call lights when leaving cued both RN-A and NA-A to wash hands before leaving the room. -At 9:11 a.m. both NA-A and RN-A were observed removing gloves and cleansed hands with hand sanitizer in the room. When interviewed at 9:15 a.m. NA stated she was supposed to wash her hands before starting cares, leaving room and after removing gloves. NA further stated "I forgot." When interviewed at 9:17 a.m. RN-B stated the NA's are supposed to follow the hand hygiene policy and indicated he was going to find what the facility policy exactly directed. When interviewed on 4/24/14, at 11:18 a.m. RN-A stated her expectation was NA should have washed hands upon removing gloves, before entering, leaving the room and after doing pericare. When interviewed on 4/24/14, at 12:41 p.m. the director of nursing stated all the staff are supposed to follow hand washing procedure per CDC guidelines and are supposed to wash hands during cares, after removing gloves, before and after cares. The facility Handwashing policy dated 6/2002, directed "Procedures must be followed to prevent cross-contamination, including handwashing or changing gloves after providing personal care, or when performing tasks among individuals which provide the opportunity for cross contamination to	21375		

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21375	Continued From page 23 occur. The facility follows the CDC's Guideline for Handwashing..." Reusable blood sugar monitors were not cleaned as required to prevent cross-contamination between residents. During observations on 4/21/14, at 5:14 p.m. registered nurse (RN)-K checked R 40's blood sugar. RN-K wiped the blood sugar monitor with an alcohol wipe and placed the monitor in a basket. Without any additional cleaning of the blood sugar monitor, RN-K entered another room and checked R97's blood sugar. RN-K again wiped the blood glucose monitor with an alcohol wipe. When RN-K returned to the treatment cart, she stated now that she was done with the wing, she would disinfect the blood glucose monitor. RN-K was observed using a Sani-wipe to wipe off the blood glucose monitor. RN-K verified she checks all blood sugars on the west wing and only uses alcohol wipes until she is done with the wing. During observations on 4/23/14, at 7:39 a.m. RN-L was observed checking R97 's blood sugar and then placed the blood sugar monitor in her pocket. RN-L took the blood sugar monitor out of her pocket and without sanitizing the monitor she entered R 53's room and checked R53's blood sugar. RN-L placed the blood sugar monitor back in her pocket. RN-L returned to the treatment cart and used a Sani-wipe to clean the monitor. RN-L stated she used Sani-wipes when she was done with a round of blood sugar checks or at the end of the night when working night shift. When interviewed on 4/24/14, at 2:25 p.m. RN-I stated she expected blood sugar monitors to be cleaned between each patient with bleach wipes	21375		

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21375	Continued From page 24 (Sani-wipes). The facility Blood Glucose Meters Use and Disinfection policy (undated), directed the blood glucose meter will be cleaned and disinfected after each use. The policy directed to use the alcohol prep pads to cleanse the outside of the blood glucose meter and place on a new paper towel and then to use a disinfectant wipe when outside of the room. On 4/23/14, at 1:10 p.m. a blood glucose meter (meter) was used for R54 to obtain a blood glucose level. After using the meter, RN-E wiped the meter down with alcohol swab, placed it on a clean paper towel, and then used a PDA-Sani wipe to disinfect the meter. As RN-E was disinfecting the meter it was noted to have a soiled piece of tape securing the battery cover to the machine. RN-E carried the meter back to the med cart. RN-F stated the tape was to hold the cover on and did not affect the machine working. RN-D removed the meter from service since it was no longer able to be disinfected /cleaned between resident use. A new meter was obtained to replace the broken meter. The policy/procedure The Return demonstration of use and cleaning/disinfecting of a blood glucose meter (BGM) indicated (after use) dated 5/10. "1. With gloved hands, use alcohol pad to cleanse the outside of meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. Place clean meter on a new paper towel. 2. Remove all supplies into appropriate receptacles by gloving disposable non-sharp items that may contain small traces of blood into	21375		

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the garbage
3. Wash hands
Disinfect blood glucose meter (done at cart)
1. Take meter to the outside cart for disinfection.
2. Place the meter on paper towel barrier.
3. Don new gloves. Disinfect is toxic when absorbed through the skin, always wear gloves.
4. Get the disinfectant cloth from locked medication cart.
5. Wipe down the outside of the meter with this cloth until the entire surface is wet with disinfectant.
6. Wrap the cloth around the meter to maintain surface wetness for 2 minutes.
7. After 2 minutes (swell time) removed the disinfectant wipe and discard to the trash. Allow to air dry.
8. Blood glucose meter is now disinfected and ready to store or to use on another resident. "

The Blood Glucose Meters Use and Disinfection policy dated May 4/10.
"- With gloved hands, use alcohol pad to cleanse the outside of meter. Take extreme care not to get liquid in the test strip and key code ports of the meter. Place clean meter on a new paper towel.
- Remove all supplies into appropriate receptacles by gloving disposable non-sharp items that may contain small traces of blood into the garbage
- Wash hands
Disinfect blood glucose meter (done at cart)
- Take meter to the outside cart for disinfection.
- Place the meter on paper towel barrier.
- Don new gloves. Disinfect is toxic when absorbed through the skin, always wear gloves.
- Get the disinfectant cloth from locked medication cart.
- Wipe down the outside of the meter with this

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21375	Continued From page 26 cloth until the entire surface is wet with disinfectant. - Wrap the cloth around the meter to maintain surface wetness for 2 minutes. - After 2 minutes (swell time) removed the disinfectant wipe and discard to the trash. Allow to air dry. - Blood glucose meter is now disinfected and ready to store or to use on another resident. " Re-usable ice packs were stored in the third floor medication room refrigerator with ice cream and yogurt. On 4/24/14, at 10:56 a.m. during a tour of the third floor medication room three blue ice packs were observed in the freezer with ice cream and yogurt. RN-I stated the blue ice packs were used on resident's body parts and verified the findings. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures on infection control measures for catheter care, handwashing and appropriate cleaning techniques for multiple patient use equipment to prevent cross contamination. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty -one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and	21426		6/7/14

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21426	Continued From page 27 maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure Tuberculosis (TB) screening was complete prior to provision of direct resident care, for 3 of 5 employees reviewed for healthcare worker TB screenings. Findings include: Review of licensed practical nurse (LPN)-A's personnel record revealed a hire date of 1/10/14. The Tuberculosis Form for Healthcare Workers (HCW)/Volunteer was completed on 1/10/14, with the tuberculin skin test (TST) section left void. A chest x-ray was completed on 1/15/14, which indicated LPN-A had history of productive cough and influenza like symptoms for five days. The impression section indicated no acute airspace	21426	-	

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disease was present. LPN-A's personnel file lacked documentation of a medical evaluation to rule out a diagnosis of infectious TB disease.

Review of LPN-D's personnel record revealed a hire date of 3/25/14. The Tuberculosis Form for Healthcare Workers (HCW)/Volunteer dated 3/31/14, indicated LPN-D was born outside the United States and had a history of a positive reaction to TST. The date of LPN-D's last chest x-ray was noted as 1/29/10, with a negative result. The form noted LPN-D had received the BCG vaccine (bacille Calmette-Guerin-a vaccine for tuberculosis). LPN-D's personnel record lacked documentation of a medical evaluation to rule out a diagnosis of infectious TB disease.

Review of nursing assistant (NA)-A's personnel record revealed a hire date of 2/19/14. The Tuberculosis Form for Healthcare Workers (HCW)/Volunteer dated 2/20/14, noted, "Date of Mantoux [TST] conversion 10/04/13 (-)." The TST section of the form was left void. The form was reviewed and signed, noting the results were "Negative." NA-A's personnel file lacked complete documentation of two-step skin testing and measurement of induration.

When interviewed on 4/24/14, at 12:41 p.m. the director of nursing (DON) stated, "I did not fully understand the medical exam component of the regulation." DON indicated she had called the Department of Health educator that morning and it had been explained to her. DON further stated for the staff that had a chest x-ray with the cough and flu-like symptoms, the indication was not correct, but rather should have been due to a history of a positive TST or something close in relation to the regulation.

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21426	Continued From page 29 The facility's Tuberculosis Control Plan policy revised 2/13, directed, "Employees with a previous positive TST reaction need to provide documentation of the negative chest x-ray performed at any time during or since the initial evaluation of the positive TST and complete a TB Symptom Screen." The policy lacked direction for a medical examination to be completed in addition to a chest x-ray, prior to providing direct care to residents. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice all staff responsible for TB on the most current standards and requirements in regards to TB control. Facility policies and procedures related to TB could be reviewed and revised if necessary. An auditing system could be developed, with review by the quality assessment and assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any	21530		6/7/14

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21530	Continued From page 30 irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident specific target behavior and side effects monitoring was implemented with antipsychotic use for 3 of 3 residents (R28, R40, R44) reviewed for unnecessary medications. In addition, the facility failed to ensure a gradual dose reduction (GDR) was attempted or the clinical contraindication was documented for 1 of 5 residents (R40) who received multiple antipsychotic medications.	21530	-	

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21530	Continued From page 31 Findings include: R40 was not monitored for resident-specific target behaviors for the use of Lithium, Zyprexa and Saphris (antipsychotic medications) and did not have a GDR attempted or the clinical rationale for continuing the medications documented. On 4/23/14, at 7:22 a.m. R40 was observed awake and sitting in a chair in his room with the radio on. At 7:51 a.m. R40 was observed sitting in the day room are and was interacting pleasantly with the staff. At 7:53 a.m. R40 was observed telling the nurse that he did not want his " water pill " until after church. The Medication Regimen Review from 5/1/13 through 4/15/14, was reviewed and a GDR or clinical indication for continued use of antipsychotics was not recommended during that time. The psychiatrist notes dated 7/16/13, 10/15/13, 1/16/14, and 4/18/14, lacked documentation as to why a GDR was contraindicated and indicated R40 was " at baseline." Review of the medical record lacked evidence of identified target behaviors for antipsychotic use for R40. Review of the weekly summary charting from 1/1/14 through 4/24/14, lacked evidence of the frequency of any identified behaviors. The Psychosocial Well-Being Care Area Assessment (CAA) and the Behavioral Symptoms CAA dated 1/3/14, indicated a behavior of swearing at staff. The Psychotropic Medication Use CAA dated 1/3/14, indicated current medications in use and lacked documentation regarding a GDR or a clinical	21530		

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21530	Continued From page 32 contraindication for one. The psychotropic drug use care plan dated 1/6/14, identified R40 was receiving antipsychotic medications, the resident will be prescribed the lowest effective dose of medication and directed to objectively document the resident's behavior. Review of the medical doctor progress note dated 2/19/14, and nurse practitioner note dated 4/23/14, indicated psychiatric issues were followed by the psychiatrist. The quarterly Minimum Data Set (MDS) dated 3/24/14, included a Brief Interview of Mental Status (BIMS) score of 15 (cognitively intact) and revealed delusions, hallucinations and behavioral concerns did not occur. A progress note dated 3/28/14, written by the licensed social worker indicated R40 exhibited negative comments over the past quarter. The Medication Administration History dated 4/1/14 through 4/24/14, included Saphris 10 milligrams (mg) twice daily, Lithium 900 mg at bedtime and Zyprexa 5 mg every evening and 30 mg at bedtime. The Resident Admission Record dated 4/24/14, for R40 indicated an admission date of 6/19/10, and included diagnoses of paranoid schizophrenia, bipolar disorder, and anxiety. When interviewed on 4/24/14, at 1:24 p.m. registered nurse (RN)-M stated there are no flow sheets to monitor target behaviors and any behavior documentation would be done in the progress notes or in the weekly charting. RN-M verified the weekly charting are not specific to	21530		

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21530	Continued From page 33 each resident and are general to all residents. Nursing assistant (NA)-G was interviewed on 4/24/14, at 1:32 p.m. and after reviewing the point of care terminal, stated there was no required behavior documentation for R40. The nurse manager, RN-I was interviewed on 4/24/14, at 1:55 p.m. and stated behavior is documented in the progress notes and weekly summary and specific target behaviors are not identified. RN-I stated staff training and education provide "clues" as to what target behaviors to look for. RN-I stated the consultant pharmacist recommendations are used to identify when a GDR was needed and she was unable to locate a GDR request or documentation of a clinical contraindication for R40. When interviewed on 4/24/14, at 2:49 p.m. the director of nursing (DON) stated the facility did not monitor target behaviors daily with antipsychotic use and the weekly charting was used to monitor residents. The consultant pharmacist was interviewed on 4/24/14, at 2:58 p.m. and stated she expected the psychiatrist to monitor antipsychotic medications as they are the expert. The consultant pharmacist stated she only expected antipsychotic monitoring if there were behaviors. R28's specific behaviors and potential side effects were not being monitored. On 4/23/14, at 7:55 a.m. R28 observed propelling his wheelchair (w/c) down the hallway. R28 observed to be calm and pleasant as he went past other residents and staff before getting to the dining room (DR).	21530		

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21530	Continued From page 34 On 4/23/14, at 8:38 a.m. to 9:11 a.m. R28 was observed sitting at the dining room (DR) table eating his breakfast observed to be calm and conversing to staff during the meal. -At 9:18 a.m. R28 was observed propelling himself down the hallway to his room -At 9:19 a.m. observed a staff wheeling R28 to the common area. -At 9:20 a.m. observed R28 wheeling himself back to his room stated he was going to the bathroom. -At 9:22 a.m. observed the call light in room on R28 was observed sitting on his w/c outside the door looking down the hallway. -At 9:23 a.m. observed a staff nursing assistant going to room and shut the door. -At 9:26 a.m. observed NA-C coming out of room door and R28 was observed watching television (TV) in his room sitting on his w/c calmly facing the door. On 4/23/14, at 9:38 to 9:47 a.m. observed R28 sitting at the DR table area calmly listening as the therapeutic recreation staff was reading the newspaper as R28 asked questions. -At 9:48 observed R28 leaving the table after the activity propelled self towards the elevator. -At 9:53 a.m. surveyor and R28 got on the elevator when asked what floor he was going to R28 stated "I like to go downstairs to smoke and hang around." The care plan dated 3/13/12, identified R28 was diagnosed with depression due to multiple problems. R28's antipsychotic medication care plan dated 4/6/12, indicated R28 received medication related to agitation as evidenced by striking out at staff, swearing, verbally abusive and lack of impulse control. The care plan	21530		

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directed to monitor R28's behaviors and quantitatively and objectively document R28's behavior. The care plan directed to document behavior/mood as indicated.

R28's psychotropic medication CAA dated 7/11/13, identified R28 had diagnoses of depression and Psychosis as well as agitation and anxiety. The CAA indicated R28 often presented with symptoms of tearfulness and would be physically and verbally abusive to staff at times. In addition, the CAA indicated R28 required use of medication to keep his symptoms under control directed nursing staff to continue to observe for adverse side effects of medications.

Review of the facility CP Medication Regimen Review dated 8/7/13 through 4/15/14, revealed side effects and specific behavior monitoring had not been identified as lacking.

Review of the Medication Administration Record (MARs) and Treatment Administration Record (TARs) dated 4/1/14, through 4/24/14, revealed no monitoring of behavior and side effects were being monitored daily for both anti-depressant and anti-psychotropic medications R28 was taking daily.

R28's diagnoses included dementia, unspecified psychosis/agitation, anxiety, depression and encephalopathy damage obtained from the quarterly MDS dated 4/8/14. In addition, the MDS indicated R28 received anti-psychotic and anti-depressant medications. R28 exhibited behavioral symptoms which included physical and verbal symptoms directed towards other such as hitting and kicking among others.

R28's Physician Order Report dated 4/8/14,

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indicated R28 received Lexapro 10 mg orally once a day for depression and Risperdal (an antipsychotic medication) 3 mg oral three times a day with "Special Instructions: Please call MD if any agitation occurs."

During further document review it was revealed behavior charting was being completed in the Progress Notes dated 9/5/13, through 4/24/14, as it happened and in also one to two times weekly using the facility generated "Behavior/Mood" sheets dated 1/4/14, through 4/18/14, which staff we checking off the behaviors, interventions listed but the sheets lacked R28's individualized specific behaviors and interventions that were used.

When interviewed on 4/23/14, at 1:17 p.m. RN-N stated R28 did not have specific behaviors to be monitored daily but the nurses would complete behavior in the progress notes.

R44's specific behaviors and side effects were not being monitored
On 4/23/14, at 8:12 a.m. to 9:11 a.m. during continuously morning cares observation R44 was observed to be calm, pleasant, cooperative, thanking NA-A and asking NA-A same question where was and when "Mom" was coming.

On 4/23/14, at 10:30 a.m. observed R44 sitting on his broad chair (a specialized wheelchair) at the television lounge area. R44 was observed to be dosing on and off looking around and was calm no behavior observed.

R44's care plan dated 9/17/12, indicated he had potential for alteration in cognition due to use of psychotropic medication. The goal for R44 was R44 "Will not have adverse effects from

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21530	Continued From page 37 psychotropic medications." Care plan directed staff to administer medications as ordered, monitor medications administration and any associated behaviors of side effects. The CAA dated 7/29/13, indicated R44 was on psychotropic medications which did put him at increased risk for falls and directed staff to monitor for side effects of medications. Review of the CP Medication Regimen Review dated 9/12/13, through 4/2/14, revealed side effects and specific behavior monitoring had not been identified as lacking in R44's medical record. R44's diagnoses included dementia, psychotic disorder, diabetes mellitus, cerebrovascular accident (CVA), hemiplegia and seizure disorder obtained from the quarterly MDS dated 1/21/14. In addition, the MDS indicated R44 was receiving anti-psychotic and anti-depressant medications. R44's Physician Order Report dated 3/26/14, indicated R44 received Seroquel (an antipsychotic medication) 25 mg by mouth (PO) twice daily, Trazodone 25 mg PO every bedtime for depression and insomnia and Zoloft 50 mg PO once daily for depression. Review of the Treatment Administration Record (TAR) dated 4/1/14, through 4/24/14, revealed the only behaviors indicated in the TAR were refusing medications and meals and staff were directed to record R44's food intake percentage. The TAR lacked information on the side effects for both anti-depressants and anti-psychotropic medications R44 was taking daily. During further document review was revealed	21530		

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21530	Continued From page 38 behavior charting was being completed one to two times weekly using the facility generated "Behavior/Mood" sheets dated 11/05/13, through 4/19/14, with staff checking off the behaviors, interventions listed and wrote additional comments/descriptions. The sheet lacked R44's specific behaviors and interventions that worked for R44. When interviewed on 4/23/14, at 1:23 p.m. the director of social services stated residents who received any anti-psychotropic medication the staff would document the behaviors as they see them. Surveyor asked the director you mean by exception the director of social service stated "Yes." She further stated there was also weekly behavior charting that was completed for residents using the facility generic behavior charting. When interviewed on 4/23/14, at 2:00 p.m. RN-B stated "Normally we don't have the specific side effects to monitor if during the shift we notice side effects we would write a progress note and let the nurse practitioner know and then they would give us orders." When interviewed on 4/25/14, at 11:27 a.m. RN-A was also the nurse manager, stated the facility protocol is to use weekly behavior nursing assessment for monitoring resident's behaviors. RN-A further stated because the facility is small the staff would be aware of any change in a resident and would chart on it as indicated or as it happened. RN-A indicated for the side effects the Abnormal Involuntary Movement Scale (AIMS) for anti-psychotropic medications were completed every six months or as indicated if otherwise but no daily monitoring of side effects and behavior was being documented only as it happened.	21530		

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21530	Continued From page 39 When interviewed on 4/25/14, at 12:38 a.m. the DON stated currently "Symptom" charting was being done weekly. DON indicated the facility worked closely with clinical Psychologist for some of the residents on antipsychotic medications regularly that monitored residents closely. DON further stated she had listened to a phone conference sometime last year 2013, not sure when exactly offered by Minnesota Department of Health and had the impression "Symptom" monitoring was to be done on a periodic basis as long as the staff were aware of the resident exact concerns and done consistently it was sufficient enough. When interviewed on 4/25/14, at 3:01 p.m. the consultant pharmacist stated the nurses are supposed to monitor and document side effects as they see them in the progress note. CP indicated the facility does other side effects monitoring such as the AIMS which was completed every six months. CP indicated because of the resident population diagnoses at the facility psychotic behavior monitoring in only done when there was a concern or rather behavior episode. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is monitored and that residents are not taking unnecessary drugs. An auditing tool could be developed to monitor compliance, with involvement of the facility's consultant pharmacist, to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty -one	21530		

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21530	Continued From page 40 (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Nelson, Sandra Based on observation, interview and document review, the facility failed to ensure resident specific target behavior and side effects monitoring was implemented with antipsychotic use for 3 of 3 residents (R28, R40, R44) reviewed for unnecessary medications. In addition, the facility failed to ensure a gradual dose reduction	21540	-	6/7/14

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21540	Continued From page 41 (GDR) was attempted or the clinical contraindication was documented for 1 of 5 residents (R40) who received multiple antipsychotic medications. Findings include: R40 was not monitored for resident-specific target behaviors for the use of Lithium, Zyprexa and Saphris (antipsychotic medications) and did not have a GDR attempted or the clinical rationale for continuing the medications documented. On 4/23/14, at 7:22 a.m. R40 was observed awake and sitting in a chair in his room with the radio on. At 7:51 a.m. R40 was observed sitting in the day room are and was interacting pleasantly with the staff. At 7:53 a.m. R40 was observed telling the nurse that he did not want his " water pill " until after church. The Medication Regimen Review from 5/1/13 through 4/15/14, was reviewed and a GDR or clinical indication for continued use of antipsychotics was not recommended during that time. The psychiatrist notes dated 7/16/13, 10/15/13, 1/16/14, and 4/18/14, lacked documentation as to why a GDR was contraindicated and indicated R40 was " at baseline." Review of the medical record lacked evidence of identified target behaviors for antipsychotic use for R40. Review of the weekly summary charting from 1/1/14 through 4/24/14, lacked evidence of the frequency of any identified behaviors. The Psychosocial Well-Being Care Area Assessment (CAA) and the Behavioral Symptoms CAA dated 1/3/14, indicated a	21540		

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21540	Continued From page 42 behavior of swearing at staff. The Psychotropic Medication Use CAA dated 1/3/14, indicated current medications in use and lacked documentation regarding a GDR or a clinical contraindication for one. The psychotropic drug use care plan dated 1/6/14, identified R40 was receiving antipsychotic medications, the resident will be prescribed the lowest effective dose of medication and directed to objectively document the resident's behavior. Review of the medical doctor progress note dated 2/19/14, and nurse practitioner note dated 4/23/14, indicated psychiatric issues were followed by the psychiatrist. The quarterly Minimum Data Set (MDS) dated 3/24/14, included a Brief Interview of Mental Status (BIMS) score of 15 (cognitively intact) and revealed delusions, hallucinations and behavioral concerns did not occur. A progress note dated 3/28/14, written by the licensed social worker indicated R40 exhibited negative comments over the past quarter. The Medication Administration History dated 4/1/14 through 4/24/14, included Saphris 10 milligrams (mg) twice daily, Lithium 900 mg at bedtime and Zyprexa 5 mg every evening and 30 mg at bedtime. The Resident Admission Record dated 4/24/14, for R40 indicated an admission date of 6/19/10, and included diagnoses of paranoid schizophrenia, bipolar disorder, and anxiety. When interviewed on 4/24/14, at 1:24 p.m. registered nurse (RN)-M stated there are no flow	21540		

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21540	Continued From page 43 sheets to monitor target behaviors and any behavior documentation would be done in the progress notes or in the weekly charting. RN-M verified the weekly charting are not specific to each resident and are general to all residents. Nursing assistant (NA)-G was interviewed on 4/24/14, at 1:32 p.m. and after reviewing the point of care terminal, stated there was no required behavior documentation for R40. The nurse manager, RN-I was interviewed on 4/24/14, at 1:55 p.m. and stated behavior is documented in the progress notes and weekly summary and specific target behaviors are not identified. RN-I stated staff training and education provide "clues" as to what target behaviors to look for. RN-I stated the consultant pharmacist recommendations are used to identify when a GDR was needed and she was unable to locate a GDR request or documentation of a clinical contraindication for R40. When interviewed on 4/24/14, at 2:49 p.m. the director of nursing (DON) stated the facility did not monitor target behaviors daily with antipsychotic use and the weekly charting was used to monitor residents. The consultant pharmacist was interviewed on 4/24/14, at 2:58 p.m. and stated she expected the psychiatrist to monitor antipsychotic medications as they are the expert. The consultant pharmacist stated she only expected antipsychotic monitoring if there were behaviors. Jares, Magdalene R28's specific behaviors and potential side	21540		

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21540	Continued From page 44 effects were not being monitored. On 4/23/14, at 7:55 a.m. R28 observed propelling his wheelchair (w/c) down the hallway. R28 observed to be calm and pleasant as he went past other residents and staff before getting to the dining room (DR). On 4/23/14, at 8:38 a.m. to 9:11 a.m. R28 was observed sitting at the dining room (DR) table eating his breakfast observed to be calm and conversing to staff during the meal. -At 9:18 a.m. R28 was observed propelling himself down the hallway to his room -At 9:19 a.m. observed a staff wheeling R28 to the common area. -At 9:20 a.m. observed R28 wheeling himself back to his room stated he was going to the bathroom. -At 9:22 a.m. observed the call light in room on R28 was observed sitting on his w/c outside the door looking down the hallway. -At 9:23 a.m. observed a staff nursing assistant going to room and shut the door. -At 9:26 a.m. observed NA-C coming out of room door and R28 was observed watching television (TV) in his room sitting on his w/c calmly facing the door. On 4/23/14, at 9:38 to 9:47 a.m. observed R28 sitting at the DR table area calmly listening as the therapeutic recreation staff was reading the newspaper as R28 asked questions. -At 9:48 observed R28 leaving the table after the activity propelled self towards the elevator. -At 9:53 a.m. surveyor and R28 got on the elevator when asked what floor he was going to R28 stated "I like to go downstairs to smoke and hang around."	21540		

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21540	Continued From page 45 The care plan dated 3/13/12, identified R28 was diagnosed with depression due to multiple problems. R28's antipsychotic medication care plan dated 4/6/12, indicated R28 received medication related to agitation as evidenced by striking out at staff, swearing, verbally abusive and lack of impulse control. The care plan directed to monitor R28's behaviors and quantitatively and objectively document R28's behavior. The care plan directed to document behavior/mood as indicated. R28's psychotropic medication CAA dated 7/11/13, identified R28 had diagnoses of depression and Psychosis as well as agitation and anxiety. The CAA indicated R28 often presented with symptoms of tearfulness and would be physically and verbally abusive to staff at times. In addition, the CAA indicated R28 required use of medication to keep his symptoms under control directed nursing staff to continue to observe for adverse side effects of medications. Review of the facility CP Medication Regimen Review dated 8/7/13 through 4/15/14, revealed side effects and specific behavior monitoring had not been identified as lacking. Review of the Medication Administration Record (MARs) and Treatment Administration Record (TARs) dated 4/1/14, through 4/24/14, revealed no monitoring of behavior and side effects were being monitored daily for both anti-depressant and anti-psychotropic medications R28 was taking daily. R28's diagnoses included dementia, unspecified psychosis/agitation, anxiety, depression and encephalopathy damage obtained from the quarterly MDS dated 4/8/14. In addition, the MDS	21540		

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21540	Continued From page 46	21540		

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R28's Physician Order Report dated 4/8/14, indicated R28 received Lexapro 10 mg orally once a day for depression and Risperdal (an antipsychotic medication) 3 mg oral three times a day with "Special Instructions: Please call MD if any agitation occurs."

During further document review it was revealed behavior charting was being completed in the Progress Notes dated 9/5/13, through 4/24/14, as it happened and in also one to two times weekly using the facility generated "Behavior/Mood" sheets dated 1/4/14, through 4/18/14, which staff we checking off the behaviors, interventions listed but the sheets lacked R28's individualized specific behaviors and interventions that were used.

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On 4/23/14, at 10:30 a.m. observed R44 sitting on his broad chair (a specialized wheelchair) at the television lounge area. R44 was observed to

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21540	Continued From page 47 be dosing on and off looking around and was calm no behavior observed. R44's care plan dated 9/17/12, indicated he had potential for alteration in cognition due to use of psychotropic medication. The goal for R44 was R44 "Will not have adverse effects from psychotropic medications." Care plan directed staff to administer medications as ordered, monitor medications administration and any associated behaviors of side effects. The CAA dated 7/29/13, indicated R44 was on psychotropic medications which did put him at increased risk for falls and directed staff to monitor for side effects of medications. Review of the CP Medication Regimen Review dated 9/12/13, through 4/2/14, revealed side effects and specific behavior monitoring had not been identified as lacking in R44's medical record. R44's diagnoses included dementia, psychotic disorder, diabetes mellitus, cerebrovascular accident (CVA), hemiplegia and seizure disorder obtained from the quarterly MDS dated 1/21/14. In addition, the MDS indicated R44 was receiving anti-psychotic and anti-depressant medications. R44's Physician Order Report dated 3/26/14, indicated R44 received Seroquel (an antipsychotic medication) 25 mg by mouth (PO) twice daily, Trazodone 25 mg PO every bedtime for depression and insomnia and Zoloft 50 mg PO once daily for depression. Review of the Treatment Administration Record (TAR) dated 4/1/14, through 4/24/14, revealed the only behaviors indicated in the TAR were	21540		

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21540	Continued From page 48	21540		

refusing medications and meals and staff were directed to record R44's food intake percentage. The TAR lacked information on the side effects for both anti-depressants and anti-psychotropic medications R44 was taking daily.

During further document review was revealed behavior charting was being completed one to two times weekly using the facility generated "Behavior/Mood" sheets dated 11/05/13, through 4/19/14, with staff checking off the behaviors, interventions listed and wrote additional comments/descriptions. The sheet lacked R44's specific behaviors and interventions that worked for R44.

When interviewed on 4/23/14, at 1:23 p.m. the director of social services stated residents who received any anti-psychotropic medication the staff would document the behaviors as they see them. Surveyor asked the director you mean by exception the director of social service stated "Yes." She further stated there was also weekly behavior charting that was completed for residents using the facility generic behavior charting.

When interviewed on 4/23/14, at 2:00 p.m. RN-B stated "Normally we don't have the specific side effects to monitor if during the shift we notice side effects we would write a progress note and let the nurse practitioner know and then they would give us orders."

When interviewed on 4/25/14, at 11:27 a.m. RN-A was also the nurse manager, stated the facility protocol is to use weekly behavior nursing assessment for monitoring resident's behaviors. RN-A further stated because the facility is small the staff would be aware of any change in a

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21540	Continued From page 49 resident and would chart on it as indicated or as it happened. RN-A indicated for the side effects the Abnormal Involuntary Movement Scale (AIMS) for anti-psychotropic medications were completed every six months or as indicated if otherwise but no daily monitoring of side effects and behavior was being documented only as it happened. When interviewed on 4/25/14, at 12:38 a.m. the DON stated currently "Symptom" charting was being done weekly. DON indicated the facility worked closely with clinical Psychologist for some of the residents on antipsychotic medications regularly that monitored residents closely. DON further stated she had listened to a phone conference sometime last year 2013, not sure when exactly offered by Minnesota Department of Health and had the impression "Symptom" monitoring was to be done on a periodic basis as long as the staff were aware of the resident exact concerns and done consistently it was sufficient enough. When interviewed on 4/25/14, at 3:01 p.m. the consultant pharmacist stated the nurses are supposed to monitor and document side effects as they see them in the progress note. CP indicated the facility does other side effects monitoring such as the AIMS which was completed every six months. CP indicated because of the resident population diagnoses at the facility psychotic behavior monitoring in only done when there was a concern or rather behavior episode. SUGGESTED METHOD OF CORRECTION: The director of nursing and or designee could assure that policies and procedures are updated and that staff training has been completed to assure each resident's drug regimen is	21540		

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21540	Continued From page 50 monitored and that residents are not taking unnecessary drugs. An auditing tool could be developed to monitor compliance. TIME PERIOD FOR CORRECTION: Twenty -one (21) days.	21540		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored at the proper temperature in 1 of 4 (1st floor) medication refrigerators which affected R13 and R57 medications. Findings include: On 4/24/14, at 11:20 a.m. the first floor medication refrigerator was observed to have a temperature of 50 degrees. The refrigerator included two unopened vials of Novolog insulin (used to treat diabetes) for R13 and R57 had Compro suppositories (used for nausea). LPN-B verified the findings and stated she was not sure what the safe storage temperature for insulin was. R13's Minimum Data Set (MDS) dated 3/5/14, indicated R13 had a diagnosis of diabetes and was cognitively intact.	21610	-	6/7/14

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21610	Continued From page 51 Review of the Insulin Storage Recommendations dated 9/30/13; revealed unopened Novolog was good until the expiration date when stored between 36 and 46 degrees and was only good for 28 days when stored at room temperature between 59 and 86 degrees. When interviewed on 4/24/14, at 2:49 p.m. the director of nursing (DON) stated she expected medications to be removed and discarded when expired and stated there were no temperature logs for the first floor medication refrigerator. The DON stated a new refrigerator had been purchased to replace the one on first floor. The consultant pharmacist was interviewed on 4/24/14, at 3:12 p.m. and stated 50 degrees would be above refrigerator temperature and Novolog insulin would only be good for thirty days at that temperature. The facility Storage of Medications policy dated April, 2007, directed " the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." The package insert for Aspart insulin from Physicians Total Care, Inc. last revised 1/12/12, read "Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Opened vials may be refrigerated." The package insert information for the Aplisol from JHP Pharmaceuticals, LLC dated November 2013, informed users that "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect	21610		

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21610	Continued From page 52 potency." The package insert information for the Compro suppositories from PD-Rx Pharmaceuticals, Inc. last revised 12/22/10, read, "Store at 20° to 25°C (68° to 77°F)." SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to monitor refrigerated medications and temperatures. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must	21630		6/7/14

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21630	Continued From page 53 be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired medications were removed for 5 of 5 residents (R62, R53, R57, R89, R98). Findings include: During observation of the fourth floor East wing medication cart on 4/23/14, at 1:58 p.m. six tablets of Prochlorperazine (used for nausea) 10 milligrams (mg) for R62 with an expiration date of 11/19/13, were found. Registered nurse (RN)-B verified the findings and stated "they are definitely expired." R62's Minimum Data Set (MDS) dated 3/6/14, indicated R82 had severely impaired decision making skills and had a diagnosis of epilepsy. The third floor medication room was observed on 4/24/14, at 10:44 a.m. and the following were noted; a multi-use vial of Aspart insulin (for diabetes) for R53 with an expiration date of 3/4/14, and a multi-use vial of Aplisol (used to test for tuberculosis) dated as opened 3/4/14 (expired 30 days after opening). RN-I verified the findings. R53's MDS dated 3/12/14, indicated R53 was cognitively intact and had a diagnosis of diabetes.	21630	-	

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21630	Continued From page 54 On 4/24/14, at 11:11 a.m. the first floor medication cart was observed. A Xopenex inhaler (used to treat Asthma) for R57 with an expiration date of November 2013 was found. Licensed practical nurse (LPN)-B verified the findings. R57's MDS dated 2/5/14, indicated R57 was cognitively intact and had a diagnosis of asthma. During observation of the second floor medication room and East medication cart on 4/24/14, at 11:26 a.m. the following was observed; a bottle of liquid Metoprolol (used to treat high blood pressure for R89 with an expiration date of 4/17/14, and Glucagen (used for low blood sugar) for R98 dated as expired 3/2014, with the expiration date circled in black. LPN-C and RN-J verified the findings. R89's MDS dated 2/27/14, indicated R89 was moderate cognitively impaired and had a diagnosis of cardiac dysthymia. R98's MDS dated 4/7/14, indicated R98 was severely cognitively impaired and had a diagnosis of diabetes. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to remove expired medications. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		

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21695	Continued From page 55	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to eliminate noxious orders in 5 of 40 resident rooms (R82, R45, R37, R8, R13) which had noxious odors. Findings include: Resident rooms 115, 116, 118, and 301 were checked for noxious odors which affected residents R82, R45, R37, R8 and R13. R82's Minimum Data Set (MDS) dated 3/6/14, indicated R82 was continent of bladder and was cognitively intact. R45's MDS dated 3/12/14, indicated R45 was continent of bladder, was intermittently catheterized, and was cognitively intact. R37's MDS dated 3/28/14, indicated R37 was always incontinent of bowel and bladder and was cognitively intact. R8's MDS dated 3/12/14, indicated R8 was continent of bladder and was cognitively intact. R13's MDS dated 3/5/14, indicated R13 was continent of bladder and was cognitively intact. The director of environmental services confirmed the pervasive noxious odors in the rooms. Rooms 115, 116, and 118 were confirmed to have strong urine odors by the director of	21695	-	6/7/14

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21695	Continued From page 56 environmental services stating housekeeping was aware of the urine odor and was working to try to eliminate the odors. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure resident rooms and bathrooms are kept clean and free of urine odors. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21710	MN Rule 4658.1415 Subp. 7 Plant Housekeeping, Operation, & Maintenance Subp. 7. Hot water temperature. Hot water supplied to sinks and bathing fixtures must be maintained within a temperature range of 105 degrees Fahrenheit to115 degrees Fahrenheit at the fixtures. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure safe water temperatures for 4 of 4 residents (R40, R122, R68, R28) who had concerns of hot water. This had the potential to affect all 83 residents. Findings include: On 4/21/14, at 3:30 p.m. R40 stated he was unable to keep his hands under the hot water	21710	-	6/7/14

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21710	Continued From page 57 because of the high temperature. R40 stated he used the bathroom multiple times per day and the water gets so hot "it burns your skin." At 3:47 p.m. the water at the sink in R40's room was 127.5 degrees. The quarterly Minimum Data Set (MDS) for R40 dated 3/24/14, included a Brief Interview of Mental Status (BIMS) score of 15 (cognitively intact), indicated R40 was independent with toileting and was independent with bathing after set-up. On 4/21/14, at 3:32 p.m. the water at the sink in room 318 was 125.9 degrees. On 4/21/14, at 3:50 p.m. the third floor shower room water at shower head was 120.2 degrees and at the sink in shower room the water was 129.2 degrees. On 4/21/14, at 3:56 p.m. the fourth floor shower room water at shower head was 114.8 degrees and at the sink in shower room the water was 125.9 degrees. On 4/21/14, at 4:00 p.m. the second floor shower room water at the shower head was 121.8 degrees and at the sink the water was 126.5 degrees. On 4/21/14, at 4:06 p.m. the water at the faucet in room 220 was 127.7 degrees. On 4/21/14, at 4:13 p.m. the first floor shower room water at the shower head was 113.5 degrees and at the sink the water was 125.2 degrees. On 4/21/14, at 4:16 p.m. the administrator stated	21710		

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21710	Continued From page 58 the maintenance man had a call out to get a new mixing valve and it should be here within the hour. On 4/21/14, at 4:30 p.m. the water at the sink in the women's bathroom on fifth floor was 121.2 degrees. The admission MDS dated 4/11/14, for R122 indicated a BIMS score of 14 (cognitively intact). On 4/23/14, at 8:43 a.m. R122 was observed ambulating independently on the unit. When interviewed on 4/22/14, at 1:02 p.m. R122 stated the water in the shower "gets too hot." 4th Floor West Wing On 4/21/14, at 3:26 p.m. during R68's room observation the water temperature in the bathroom sink was very hot approximately eight seconds after turning the faucet on and surveyor was unable to keep hand/fingers under water due to being hot. While still in the room, surveyor asked R68 who was lying in bed at the time if he used the sink he stated, "I do not go in there and neither does my roommate. The staff help us." R68's MDS dated 3/31/14, revealed R68 was totally dependent upon staff for cares and was moderately cognitively impaired. On 4/21/14, at 3:27 p.m. registered nurse (RN)-A was asked to call the maintenance director and was asked to request him to bring a thermometer with him to the floor. -At 3:29 p.m. maintenance director came up to the floor went to R68's room with surveyor and used a scanning thermometer and the	21710		

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21710	Continued From page 59 temperature reading was 127 Fahrenheit (°F). Maintenance director stated he was not aware of the hot water temps. On 4/21/14, at 3:31 p.m. during room observation R28's bathroom sink water temperature was noted to be hot approximately ten seconds after turning the faucet. During observation surveyor was with the maintenance director who checked the water temperature which was recording 123 °F -At 3:32 p.m. maintenance director stated he would go adjust the temperature valve downstairs. He further stated, "I was not aware of the concern at times the valve would be filled and this would cause the temperature to go up." R28's MDS dated 3/31/14, revealed R28 received extensive assist from staff for cares and was severely cognitively impaired. On 4/21/14, at 3:36 p.m. maintenance director returned to the floor stated he had adjusted the valve and had made a call out to have someone to come out to check the concern. He further stated "It's not safe when it creeps up like that. I will check later to make sure the temperatures have gone down as it took time." On 4/21/14, at 3:18 p.m. Hot water temps 127 to 129.2 degrees Fahrenheit were noted on the 4th floor. At 4:40 p.m. the director of maintenance (DM) stated he had lowered the temperature at the mixing valve and called the mechanical engineer to replace the valve that afternoon. On 4/21/14, at 6:00 p.m. the mechanical engineer arrived, replaced the mixing valve.	21710		

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21710	Continued From page 60 Logs were requested of water temperature sampling at the resident rooms to verify water temperatures were maintained within the acceptable range at the patient room. A review of the water temperature log from 12/13/14 to 4/18/14, indicated 77 entries were made in a log that spanned 126 days. On four days a notation of popped safety relief valves was document; on three days a notation of flame failure was documented. It was noted that dometic / hot had water temperatures recorded of 120 to 134 degrees Fahrenheit, and Boiler/supply had water temperatures recorded of 176 to 204 degrees Fahrenheit. On 4/21/14, at 5:00 p.m. a review of the maintenance logs for water temperatures revealed water temperatures were recorded at the mixing valve between 124 and 130 degrees which was necessary to keep the water temperature hot enough at the patient rooms. A review of the quarterly safety checks in April, July and October of 2013, indicated all room water temperatures were recorded at < 120 degrees Fahrenheit. Last quarterly safety check was completed 3/14/14, indicated 108 to 115 degrees Fahrenheit. The incident and accidents reports were reviewed going back six months from 4/21/14, and no burns were reported. It could not be determined if the residents had reported the hot water temperatures to the facility. At 7:11 p.m. a tour of the facility was conducted by the administrator, maintenance director and surveyor. Water temperatures were recorded in room 423 at 108 degrees Fahrenheit, room 202 at 105 degrees Fahrenheit, and room 121 at 108 degrees Fahrenheit.	21710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	04/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21710	Continued From page 61 SUGGESTED METHOD OF CORRECTION: The facility maintenance supervisor, administrator and/or a designee could develop policies and procedures related to management of safe water temperatures for resident accessible fixtures. Maintenance employees could be educated on new policies and procedures. A monitoring system could be implemented and reviewed by the facility's quality assessment and assurance committee to ensure ongoing compliance with safe water temperatures. TIME PERIOD FOR CORRECTION: Seven (7) days.	21710		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and	21800		6/7/14

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21800	Continued From page 62 local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice on a timely manner prior to termination of Medicare skilled services for 1 of 5 residents (R37) reviewed for liability notice and beneficiary appeal rights. Findings include: R37 was admitted to the facility on 3/24/14, and currently resided at the facility. A Notice of Medicare Provider Non-Coverage indicated R37's skilled services would end effective 3/29/14. The facility provided the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) on 3/28/14, which was less than forty eight hours before Medicare skilled services would be terminated. Progress Note dated 3/28/14, indicated "Medicare note: resident record reviewed to determine on-going Medicare coverage. Resident will receive last dose of abx [antibiotic] on 3-29-2014. Condition has been stable since hospital return. Medicare denial notice will be issued with last day of coverage [LCD] 3-29-14."	21800	-	

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21800	Continued From page 63 On 4/22/14, at 2:54 p.m. the Medicare/admission registered nurse acknowledged R37 had not been given a 48 hours notification per the regulation and further indicated "I will see if we can do a notification for reinstatement to maintain compliance." On 4/23/14, at 10:36 a.m. business office staff stated the facility did not have an actual policy but provided a facility generated handout titled Notice of Medicare/Medicaid Benefit dated 05/2013, which indicated if the facility did not feel the eligibility criteria had been met, the facility would issue a denial notice. The form lack information on the time frame the denial notice would be provided When interviewed on 4/25/14, at 12:44 p.m. the director of nursing acknowledged the resident should have been given 48 hours per regulation for the denial notice. SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate staff on the process of providing liability notices and resident appeals rights. The administrator or designee could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their	21810		6/7/14

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21810	Continued From page 64 highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure call lights were in reach for 2 of 40 residents (R24, R12) in the sample. Findings include: R24: On 4/21/14, at 2:49 p.m. R24 was observed setting in w/c on the right side of the bed. The call light was observed around the side rail on the left side of the bed. The resident confirmed she could not reach the call light and stated she would have to wait for someone to come by and check on her. A nursing assistant (NA) was notified of the call light being out of reach for the resident. R24's Minimum Data Set (MDS) dated 4/7/14, indicated R24 needed extensive to total assist with activities of daily living with the exception of eating and wheelchair mobility. R24 was independent with eating and R24 did not ambulate. R24's Brief Interview for Mental Status (BIMS- a test to determine cognition) was 7/15 which depicted moderate cognition impairment. R12: On 4/21/14, at 2:53 p.m. R12's call light was observed on the floor between the wall and his bed. A tour of the facility was conducted on 4/24/14, at	21810	-	

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21810	Continued From page 65 10:05 a.m. with the director of maintenance and the director of environmental services. R12 was in his room in his wheelchair watching TV on the other side of his bedroom. The call light was lying across the bed. When the resident was questioned about the ability to reach his call light he turned around in his wheel chair and went towards the bed stating he could reach the call light. R12's MDS dated 1/27/14, indicated R12 needed extensive to total assist with activities of daily living with the exception of eating and wheelchair mobility. R12 was independent with eating and R12 did not ambulate. R12's BIMS score was 15/15 which depicted no cognition impairment. Both of the directors were interviewed during the tour of the facility and both confirmed the residents should have their call lights available at all times. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure call lights are kept within resident reach. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
May 12, 2014

Mr. David Brennan, Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, Minnesota 55404

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5266025

Dear Mr. Brennan:

The above facility was surveyed on April 21, 2014 through April 24, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File