#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

1 TJC

18/19 SNF

95

(L38)

3 Other

(L1)

(L2)

(L9)

6. DATE OF SURVEY

0 Unaccredited

From (a):

(b):

12. Total Facility Beds

13. Total Certified Beds

18 SNF

(L37)

See Attached Remarks 17. SURVEYOR SIGNATURE

Becky Wong, HFE NE II

19. DETERMINATION OF ELIGIBILITY

2 AOA

To

245266

196677400

8. ACCREDITATION STATUS:

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. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 7 (L8) (L3) BENEDICTINE HEALTH CENTER OF MINNEAPOLIS 1. Initial 2. Recertification (L4) **618 EAST 17TH STREET** 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 55404 (L5) MINNEAPOLIS, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7) 8. Full Survey After Complaint 01 Hospital 05 HHA 13 PTIP 09 ESRD 22 CLIA (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 06/10/2014 14 CORF FISCAL YEAR ENDING DATE: (L35)03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 16 HOSPICE 06/30 04 SNF 08 OPT/SP 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: Program Requirements 2. Technical Personnel \_\_ 6. Scope of Services Limit Compliance Based On: 3. 24 Hour RN 7. Medical Director 1. Acceptable POC 4. 7-Day RN (Rural SNF) **95** (L18) 8. Patient Room Size 5. Life Safety Code \_\_ 9. Beds/Room B. Not in Compliance with Program **95** (L17) Requirements and/or Applied Waivers: (L12)\* Code: A 15. FACILITY MEETS 14. LTC CERTIFIED BED BREAKDOWN 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)(L39) (L42) (L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): Date: 18. STATE SURVEY AGENCY APPROVAL Date: Anne Kleppe, Enforcement Specialist 06/24/2014<sub>(L20)</sub> 06/19/2014 (L19) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

21. 1. Statement of Financial Solvency (HCFA-2572)

2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)

20. COMPLIANCE WITH CIVIL

RIGHTS ACT:

2. Facility is not Eligible (L21)	
22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30)	
OF PARTICIPATION BEGINNING DATE ENDING DATE <u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u>	
<b>02/24/1984</b> 01-Merger, Closure 05-Fail to Meet Health/Safe	ty
(L24) (L25) 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 03-Risk of Involuntary Termination OTHER	
A. Suspension of Admissions: 04-Other Reason for Withdrawal 07-Provider Status Change	
(L44) 00-Active	
B. Rescind Suspension Date:	
(L45)	
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS	
03001	
(L28) (L31)	
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE	
(L32) 06/10/2014 (L33) DETERMINATION APPROVAL	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00960

**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.



#### 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, 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

Dre Klegge



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,

Dire Klegge

Anne Kleppe, Enforcement Specialist

Licensing and Certification Program, Division of Compliance Monitoring

Minnesota Department of Health Email: <a href="mailto:anne.kleppe@state.mn.us">anne.kleppe@state.mn.us</a>

Telephone: (651) 201-4124 Fax: (651) 215-9697

# State Form: Revisit Report (Y1) Provider / Supplier / CLIA / Identification Number 00960 Name of Facility BENEDICTINE HEALTH CENTER OF MINNEAPOLIS State Form: Revisit Report (Y2) Multiple Construction A. Building B. Wing (Y3) Date of Revisit 6/10/2014 Street Address, City, State, Zip Code 618 EAST 17TH STREET

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).

MINNEAPOLIS, MN 55404

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4)	Item		(Y5) D	ate
		Correction			Correction					Correction
ID Prefix	20565	Completed <b>06/10/2014</b>	ID Prefix	20020	Completed <b>06/10/2014</b>		ID Prefix	21275		Completed <b>06/10/2014</b>
		<del></del>			<del></del>					=
Reg. # LSC	MN Rule 4658.040	<del></del>	LSC	MN Rule 4658.0520					658.0800 Su	
		Correction			Correction					Correction
ID Prefix	21426	Completed <b>06/10/2014</b>	ID Prefix	21530	Completed <b>06/10/2014</b>		ID Prefix	21540		Completed <b>06/10/2014</b>
Reg. # LSC	MN St. Statute 14	4A.04 Su	Reg. # LSC	MN Rule 4658.1310	A.B.C		Reg. # LSC	MN Rule 46	658.1315 Su	bp.
		Correction Completed			Correction Completed					Correction Completed
ID Prefix	21610	06/10/2014	ID Prefix	21630	06/10/2014		ID Prefix	21695		06/10/2014
Reg. # LSC	MN Rule 4658.134		Reg. # LSC	MN Rule 4658.1350			Reg. # LSC		658.1415 Su	bp.
		Correction			Correction					Correction
ID Prefix	21710	Completed <b>06/10/2014</b>	ID Prefix	21800	Completed <b>06/10/2014</b>		ID Prefix	21810		Completed <b>06/10/2014</b>
Reg. # LSC	MN Rule 4658.14	15 Subp.	Reg. # LSC	MN St. Statute144.	651 Sub		Reg. # LSC	MN St. Sta	tute 144.651	Sul
ID Prefix		Correction Completed	ID Prefix		Correction Completed		ID Prefix			Correction Completed
Reg. # LSC			Reg. #				Reg. #			
Reviewed I	By Rev	iewed By	Date:	Signature of	Surveyor:	<u> </u>			Date:	
State Agen	cy GD	D/AK	06/19/20		-		30	951	06/10/	2014
Reviewed I		iewed By	Date:	Signature of	Surveyor:				Date:	
Followup t	o Survey Complet 4/24/201			Check for any U Uncorrected I	ncorrected Defi Deficiencies (CN					NO
	4/24/201			Dogg 1 of 1	•				F 10540	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245266	Identification Number  A. Building  01 - MAIN BUILDING 01		IN BUILDING 01	(Y3) Date of Revisit 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	(Y4) Item	(Y5	) Date	(Y4)	Item	(Y	<b>′</b> 5)	Date
ID Prefix	NEDA	Correction Completed 06/07/2014		NED 404	Correction Completed 06/07/2014		ID Prefix			
_	NFPA 101 K0012		LSC	NFPA 101 K0050	_		Reg. # LSC			_
ID Prefix Reg. #			ID Prefix Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed		ID Prefix Reg. # LSC			Correction Completed
ID Prefix Reg. # LSC			Reg. #				ID Prefix Reg. # LSC			
- Paviaurad I	Du Doui	ewed By	Date:	0:						
Reviewed E		•	06/19/201	Signature of Su	irveyor:		28120		Date:	9/2014
State Agen Reviewed E CMS RO		AK ewed By	Date:	Signature of Su	rveyor:		20120	1	Date:	9/2014
Followup t	o Survey Complete 4/25/2014			Check for any Unco			ies. Was a Summ 67) Sent to the Fac		YES	NO

### **REVISED**

Form Approved
OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245266	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/10/2014
Name of Facility		Street Address, City, State, Zip Code		
BE	NEDICTINE HEALTH CENTER OF N	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 Reg. # LSC	F0156 483.10(b)(5) -	· (10), 483.	Correction Completed 06/07/2014	ID Prefix Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 06/07/2014		ID Prefix Reg. # LSC	F0253 483.15(h)(2)		Correction Completed 06/07/2014
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(i	i)	Correction Completed 04/25/2014	ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 04/25/2014		ID Prefix Reg. #			Correction Completed 06/07/2014
ID Prefix Reg. # LSC	483.25(I)		Correction Completed 06/07/2014	ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 06/07/2014			F0431 483.60(b), (d)		Correction Completed 06/07/2014
	F0441 483.65		Correction Completed 06/07/2014	Reg. #								
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC								
Reviewed E State Agen Reviewed E	су	Reviewed GD/AI	X .	Date: 08/05/20	Signatur Signatur				30	0951	Date: 06/1	0/2014
CMS RO Followup t	o Survey Con 4/24/	•	n:							Summary of the Facility?	YES	NO

### Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245266	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/10/2014
Name of Facility		Street Address, City, State, Zip Code		
BE	NEDICTINE HEALTH CENTER OF N	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 Reg. # LSC	F0156 483.10(b)(5)	- (10), 483.	Correction Completed 06/07/2014	ID Prefix Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 06/07/2014		ID Prefix Reg. # LSC	F0253 483.15(h)(2)		Correction Completed 06/07/2014
ID Prefix Reg. # LSC	F0282 483.20(k)(3)(	ii)	Correction Completed 06/07/2014	ID Prefix Reg. # LSC	F0309 483.25		Correction Completed 06/07/2014		ID Prefix Reg. #			Correction Completed 06/07/2014
ID Prefix Reg. # LSC	483.25(I)		Correction Completed 06/07/2014	ID Prefix Reg. # LSC	F0428 483.60(c)		Correction Completed 06/07/2014			F0431 483.60(b), (d)		Correction Completed 06/07/2014
	F0441 483.65		Correction Completed 06/07/2014	Reg. #								
ID Prefix Reg. # LSC				ID Prefix Reg. # LSC								
Reviewed E		Reviewed	-	Date:	Signature	e of Sur	veyor:		20	0051	Date:	10/2014
State Agen	•	GD/Ak		06/19/20					30	)951		10/2014
Reviewed E	Зу	Reviewed	ву	Date:	Signature	e ot Sur	veyor:				Date:	
Followup t	o Survey Co 4/24	mpleted or /2014	1:							Summary of the Facility?	YES	NO

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 5J65

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY AGENCY		Facility ID: 00960
1. MEDICARE/MEDICAID PROVII (L1) 245266  2. STATE VENEOR OF MEDICAID  2. STATE VENEOR OF MEDICAID  3. STATE VENEOR OF MEDICAID  4. STATE VENEOR OF MEDICAID  5. STATE VENEOR OF MEDICAID  6.		3. NAME AND AI (L3) <b>BENEDICT</b> (L4) <b>618 EAST 1</b>	INE HEALTH	H CENTER	OF MINNEAPOLIS	4. TYPE OF AC	2. Recertification
2.STATE VENDOR OR MEDICAID (L2) <b>196677400</b>	NO.	(L5) MINNEAPO		L	(L6) <b>55404</b>	3. Termination 5. Validation 7. On-Site Visi	6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA		After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	<b>24/2014</b> (L34)(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR E	NDING DATE: (L35)
2 AOA 3 Other	ON.	10 TWE EL CH ITY	A 10 CERTIFIED				
11LTC PERIOD OF CERTIFICATION  From (a):  To (b):	JIN			AS:	And/Or Approved Waivers O 2. Technical Personne 3. 24 Hour RN		of Services Limit
12.Total Facility Beds	95 (L18)	1. A	cceptable POC	oram	4. 7-Day RN (Rural S 5. Life Safety Code		Room Size
13.Total Certified Beds	95 <sup>(L17)</sup>		ents and/or Appl		* Code: <b>B*</b>	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF <b>95</b>	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REI	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENC	Y APPROVAL	Date:
Becky Wong, HFE NE I	I		05/29/2014	(L19)	Anne Kleppe, Enforce	ment Specialist	06/05/2014 (L20
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE	STATE AGENCY	
19. DETERMINATION OF ELIGIB  1. Facility is Eligible to  2. Facility is not Eligib	Participate		IPLIANCE WITH	H CIVIL	21. 1. Statement of Fin 2. Ownership/Cont 3. Both of the Abov	rol Interest Disclosure	
	(L21)						
22. ORIGINAL DATE	23. LTC AGREEN	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION	N:	(L30)
OF PARTICIPATION <b>02/24/1984</b>	BEGINNING	G DATE	ENDING DA	ATE .	01-Merger, Closure	05-Fa	OLUNTARY il to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminat	ion	il to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI  A. Suspension	VE SANCTIONS n of Admissions:	(L44)		04-Other Reason for Withdrawa	<u>01H</u>	ovider Status Change
(L27)	B. Rescind Su	uspension Date:	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	CARRIER NO.		30. REMARKS		
		03001					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAI	L DATE			
	(L32)			(L33)	DETERMINATION API	PROVAL	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00960

**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.



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:

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

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

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

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

<u>Informal Dispute Resolution</u> - 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

Benedictine Health Center Of Minneapolis May 9, 2014 Page 4

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: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc\_idr.cfm</a>

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:

Benedictine Health Center Of Minneapolis May 9, 2014 Page 5

### 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

PRINTED: 05/29/2014 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		E SURVEY MPLETED
		245266	B. WING			04/	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		6	STREET ADDRESS, CITY, STATE, ZIP CODE 518 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	TS of correction (POC) will serve	FC	000			
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					
F 156 SS=D	on-site revisit of yo validate that substaregulations has been your verification. 483.10(b)(5) - (10)	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES	F 1	56			6/7/14
	and in writing in a launderstands of his regulations governing responsibilities dur facility must also protice (if any) of the §1919(e)(6) of the made prior to or up resident's stay. Re	form the resident both orally anguage that the resident or her rights and all rules and ang resident conduct and ing the stay in the facility. The rovide the resident with the estate developed under Act. Such notification must be son admission and during the receipt of such information, and to it, must be acknowledged in					
	entitled to Medicaic of admission to the resident becomes items and services facility services und which the resident other items and se	form each resident who is denefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing der the State plan and for may not be charged; those rvices that the facility offers					
LABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245266	B. WING		04	/24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	<b>.</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN O  (EACH CORRECTIVE AC  CROSS-REFERENCED TO  DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
F 156	and for which the retthe amount of charginform each resider the items and service (i)(A) and (B) of this.  The facility must infat the time of admist the resident's stay, facility and of chargincluding any chargincluding any chargincluding any charging under Medicare or I.  The facility must fur legal rights which in A description of the funds, under paraginal to request 1924(c) which deternon-exempt resour institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid exempts and the state life ombudsman program advocacy network, unit; and a stateme	esident may be charged, and ges for those services; and at when changes are made to ces specified in paragraphs (5) is section.  orm each resident before, or esion, and periodically during of services available in the es for those services, es for services not covered by the facility's per diem rate.  Thish a written description of cludes:  manner of protecting personal raph (c) of this section;  requirements and procedures ibility for Medicaid, including an assessment under section rmines the extent of a couple's ces at the time of and attributes to the community e share of resources which ed available for payment the institutionalized spouse's or her process of spending	F1	56		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG	` '	E SURVEY PLETED			
		245266	B. WING		04/	24/2014			
	PROVIDER OR SUPPLIE	R ITER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	•				
(X4) ID PREFIX TAG				(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION				N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 156	misappropriation facility, and non-codirectives required.  The facility must in name, specialty, aphysician response.  The facility must puritten information applicants for adminformation about Medicare and Me	g resident abuse, neglect, and of resident property in the ompliance with the advance	F 1	56					
	by: Based on intervier facility failed to provide rights notice on a termination of Meresidents (R37) residents (R37) residents include: R37 was admitted currently resided a Medicare Provide skilled services we facility provided the Advanced Benefici 3/28/14, which was	ew and document review, the ovide proper liability and appeal timely manner prior to dicare skilled services for 1 of 5 eviewed for liability notice and al rights.  If to the facility on 3/24/14, and at the facility. A Notice of r Non-Coverage indicated R37's ould end effective 3/29/14. The ne Skilled Nursing Facility ciary Notice (SNFABN) on as less than forty eight hours skilled services would be		All residents will receive up a notice of Medicare/Medic Medicare notice of denials issued no less than 48 houservices ending.  The business office managwill monitor compliance wit regulation with each Medic issued.  Random audits will be conthrough our Medicare commeetings.  Date of compliance June 7	caid benefits. are to be are prior to  ger or designee th this are denial  ducted monthly pliance audit				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		245266	B. WING _		04/	24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
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F 156	note: resident record on-going Medicare receive last dose of Condition has been Medicare denial not of coverage [LCD] 3 Con 4/22/14, at 2:54 registered nurse acheen given a 48 hor regulation and furth can do a notification compliance."  On 4/23/14, at 10:3 stated the facility diprovided a facility gof Medicare/Medical which indicated if the eligibility criteria had	d 3/28/14, indicated "Medicare d reviewed to determine coverage. Resident will abx [antibiotic] on 3-29-2014. stable since hospital return. tice will be issued with last day 3-29-14."  p.m. the Medicare/admission knowledged R37 had not turs notification per the er indicated "I will see if we in for reinstatement to maintain 6 a.m. business office staff d not have an actual policy but enerated handout titled Notice and Benefit dated 05/2013, the facility did not feel the did been met, the facility would	F 15	56		
F 246 SS=D	on the time frame the provided  When interviewed of director of nursing a should have been of for the denial notice 483.15(e)(1) REAS OF NEEDS/PREFE  A resident has the reservices in the facility accommodations of preferences, exceptions.	ONABLE ACCOMMODATION RENCES	F 24	16		6/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245266	B. WING		04/2	24/2014	
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS	(	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 246	Continued From pa endangered.	ge 4	F 246				
	by: Based on observar review, the facility f in reach for 2 of 40 sample.  Findings include: R24: On 4/21/14, at 2:49 setting in w/c on the light was observed side of the bed. The not reach the call light to wait for someone her. A nursing assis call light being out of R24's Minimum Da indicated R24 need with activities of da eating and wheelch independent with exambulate. R24's Br (BIMS- a test to der which depicted mod R12: On 4/21/14, at 2:53 observed on the flo bed.  A tour of the facility	tion, interview, and document ailed to ensure call lights were residents (R24, R12) in the p.m. R24 was observed a right side of the bed. The call around the side rail on the left around the side rail on the state (MDS) dated 4/7/14, led extensive to total assist ally living with the exception of the lair mobility. R24 was atting and R24 did not lief Interview for Mental Status termine cognition) was 7/15 derate cognition impairment.  In p.m. R12's call light was or between the wall and his		F 246 It is the practice of Benedictine Heace Center of Minneapolis to provide reservices with reasonable accommon of the resident is needs and prefer A. Call lights were placed within a for R12 and R24 on 4/21/14.  B. On 4/23/14 the Administrator and DON performed a full facility auditalight function and placement.  C. Reviewed expectation of call lighting placed at resident is location choice, within reach, with nursing a housekeeping staff.  D. Weekly random audits of call lighting placement directed by Director of Nor designee. Review of audit result Quality Council members for input. Compliance date: 6/7/14	esident odation rences. reach and for call ghts and ght und ght vind ght vind ght vind ght vind ght vind ght vind ght vind ght vind ght sind ght		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		245266	B. WING _		04/24/	2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
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F 246	in his room in his wother side of his becacross the bed. Who questioned about the turned around in towards the bed stalight.  R12's MDS dated 1 extensive to total as living with the excep mobility. R12 was in R12 did not ambula 15/15 which depicted.  Both of the director tour of the facility air residents should have all times.  483.15(h)(2) HOUS MAINTENANCE SETTHE facility must promaintenance service sanitary, orderly, are	commental services. R12 was heelchair watching TV on the droom. The call light was lying then the resident was he ability to reach his call light his wheel chair and went atting he could reach the call with a his wheel chair and went atting he could reach the call with activities of daily better the call with activities of daily better the call with eating and wheelchair and the confirmed the confirmed the confirmed the lights available at SEKEEPING &	F 24		6/7	7/14
	review, the facility fa	tion, interview, and document ailed to eliminate noxious sident rooms (R82, R45, R37, d noxious odors.		F253 It is the practice of Benedictine Heat Center of Minneapolis to provide housekeeping services necessary maintain a sanitary, orderly and comfortable interior.	to	
	Resident rooms 115	5, 116, 118, and 301 were		A. The specific areas identified in written comments have been clean		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
		245266	B. WING _		04/	24/2014	
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 253 F 282 SS=D	checked for noxious residents R82, R45 R82's Minimum Daindicated R82 was cognitively intact. R45's MDS dated a continent of bladded catheterized, and ways incontinent cognitively intact. R8's MDS dated always incontinent cognitively intact. R8's MDS dated acontinent of bladded a continent of bladd	is odors which affected 5, R37, R8 and R13. Ita Set (MDS) dated 3/6/14, continent of bladder and was 3/12/14, indicated R45 was er, was intermittently was cognitively intact. 3/28/14, indicated R37 was of bowel and bladder and was 1/12/14, indicated R8 was er and was cognitively intact. 3/5/14, indicated R13 was er and was cognitively intact. 3/5/14, indicated R13 was er and was cognitively intact. Fronmental services confirmed ous odors in the rooms. Ind 118 were confirmed to have by the director of vices stating housekeeping was odor and was working to try to s.  RVICES BY QUALIFIED	F 28	B. Review of expectations rela housekeeping were covered with housekeeping staff by the Enviro Services Director.  C. Weekly random audits of fa interior for compliance with expectant sanitary, orderly and comfortable will be conducted by the Envirom Services Director.  D. The Enviromental Services or designee is responsible for more results of audits and observations communicated to Quality Council further action.  Compliance Date 06/07/14	mental cility ctation of interior ental Director onitoring; s will be	6/7/14	
	by: Based on observareview, the facility and during an observareviews 2 residents (R98) a	NT is not met as evidenced tion, interview, and document failed to re-assess pain before erved dressing change for 1 of according to the care plan who have pain during a dressing		It is the practice of Benedictine F Center of Minneapolis to provide in accord with each resident's wri of care.	services		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING COMP	(X3) DATE SURVEY COMPLETED	
245266 B. WING 04/2	24/2014	
NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAPOLIS  STREET ADDRESS, CITY, STATE, ZIP CODE  618 EAST 17TH STREET  MINNEAPOLIS, MN 55404		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 the 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) NAE and NAF- 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 on his left side. NAE supported the resident on his left side. NAE supported the resident on his left side. NAE supported the resident on his left side while RN-G removed the old 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245266	B. WING			04/:	24/2014
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP ( 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPF	BE	(X5) COMPLETION DATE
F 282	of the resident beforchange. RN-G dorn (salt water) wound dressing and dabb procedure one mowound bed noted to oozing at the one of removed her soiled the plastic lined gawith facial grimacin surveyor if he was confirmed that he was asked if he had changes and he reduced the resident RN-G indicated shippain after she finis RN-G then put on packed the wound dressing gel that cenvironment) on a a Q-Tip to place the resident continued then removed her the sink in the bath and placed an ABE dressing) over the dressing to the resident, 4/23/14. RN cart and got a Percat 11:00 a.m. RN-G using a pain scale greatest.	did not inquire the pain status ore starting the dressing aned gloves, and put saline wash on a 4 x 4 gauge ed the wound and repeated the re time. Observation of the one and fresh red blood o'clock position. RN-G then digloves and discarded them in rhage can. R98 was observed and and was then asked by the having pain and R98 was having pain. The resident dignament pain with other dressing plied that he had pain with all RN-G acknowledged she state he was having pain. The would get him something for hed with the dressing change. It is a fresh pair of gloves and with SoloSite (a wound reates a moist wound 4 x 4 gauge dressing and used the dressing in the wound. The to facial grimace in pain. RN-G gloves, washed her hands in a froom. RN-G then came back of dressing (thick absorbent packing and taped the ident's skin. The dressing was led then went out to the med cocet (pain medication) for R98 did not do a pain evaluation of 1 to 10 with 10 being the wed after she gave the pain and confirmed she did not at for pain before starting the	F 2	282			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245266	B. WING		04	/24/2014
	PROVIDER OR SUPPLIE	R ITER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 282	dressing change received anything change. RN-G the both agreed they the status of his period change. RN-G con have a scheduled dressing change medication on an stated she would during a dressing R98's care plan depain/potential for " - Pain: alteration immobility and present the pr	and the resident had not for pain before the dressing en discussed with RN-D and should check with the resident pain before doing a dressing infirmed the resident did not pain medication(s) before the but there was an order for pain as needed basis (PRN). RN-G notify R98's physician of pain change.  ated 3/5/14, indicated R98 had pain. In in comfort level pain due to essure area enbalize good pain control and mal visible indicators of pain eloping coping mechanism armacological methods of pain eloping. Eliminate additional ces of discomfort, sleep and ate additional stressors or infort whenever possible assessment: annually, quarterly, and PRN (as needed) per MD orders of pain medication: sedation, ssion, N/V itching, increased the resident and family erve and record effectiveness of RN medications and update MD objective signs of pain:	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245266	B. WING _		04/	24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 282	scale if resident stapain, or point to face plan of care was not monitor R98 for sign change nor did the prior to the dressing.  The director of nurse 4/24/14, at 11:40 a. management, her reget the policy and reget the policy and reget the policy and restrictions relating to treatments saying sand was not familia.  RN-D was interview and confirmed R98 pain and can ask for he has pain medical assessments on account at 60 days. R98 reliable. The reside depth and severity confirmed the reside before the dressing	resident's rate pain on a 1-10 tes he/she was experiencing es of pain on a scale." The of followed as the staff did not as of pain during the dressing staff offer pain medication g change.  Sing (DON) was interviewed on m. was questioned about pain esponse was, "I will have to ead it and get back to you." comment on additional or pain assessments prior to she had not read R98's chart	F 28	32		
F 309 SS=G	483.25 PROVIDE OF HIGHEST WELL BE Each resident must provide the necessor maintain the high mental, and psychological statements.	CARE/SERVICES FOR EING  It receive and the facility must eary care and services to attain nest practicable physical, esocial well-being, in the comprehensive assessment	F 30	09		6/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245266	B. WING		04/2	24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS	6	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET MINNEAPOLIS, MN 55404	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 11	F 309			
	by: Based on observareview, the facility fand implement interduring wound care which resulted in a Findings include: R98 was admitted complicated past in chronic respiratory tracheotomy and civentilation, congestartery disease, take physical dated 2/16 Stage 4 pressure with extensive dest damage to muscle e.g., tendon, joint of sinus tracts also in pressure ulcers) or R98 was observed 4/23/14, at 10:45 a ulcer on the coccypassistants (NAs) N room who had just dressing change w (RN)-G. RN-G camfrom the bedside simaterials. RN-G exgoing to change the assisted RN-G to the continuous continu	to the facility 2/22/14, with a nedical history that included failure status post urrently on mechanical tive heart failure, coronary en from his history and 5/14. In addition, R98 had a alcer (Full thickness skin loss truction, tissue necrosis, or bone, or supporting structures capsule. Undermining and ay be associated with Stage 4		F309 It is the practice of Benedictine He Center of Minneapolis to provide a services to attain or maintain the hipracticable physical, mental and psychosocial well-being. A. On 4/23/14 the plan of care for was revised to include a scheduled of pain medication prior to dressing changes. B. The plan of care for other resident require treatments which may discomfort were reviewed and revisindicated. This review focused on whether there was ongoing observed assessment of treatment associate and if so, whether there was a schipain management treatment or may rior to treatment. C. Review/re-education with licental staff specific to expectation of ongus assessment or observation for vernonverbal signs or indications of passociated with treatments and if passociated with treatments and if passociated with treatments and if passociated to pain. D. Weekly random audits of medirecords as identified in B. The audiresults communicated to quality Cofor input. Compliance date: 6/7/2014	are and ighest  r R 98 d dose g dent s cause sed if ation or ed pain eduled odality sed oing bal or ain oresent, ew of tion ical it	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G		E SURVEY IPLETED
		245266	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 309	his left side while Indressing. RN-G incomplete the pair starting the dressing gloves, and put sate a 4 x 4 gauge dressing dressing drepeated the pair was observed grim the surveyor if he confirmed that he asked if he had parend he replied that changes. RN-G acresident state he windicated she would after she finished with the put on a fresh wound with Solosi creates a moist word gauge dressing and dressing in the word grimace in pain. For went out to the memodication for R9 RN-G was intervied medication to R98 assess the resider dressing change areceived anything change. RN-G the both agreed they status of his parend they status of hi	RN-G removed the old dicated the resident would let he was having pain. RN-G did in status of the resident beforeing change. RN-G donned line (salt water) wound wash on sing and dabbed the wound procedure one more time. R98 hacing and was then asked by was having pain and R98 was having pain. R98 was in with other dressing changes the had pain with all dressing knowledged she heard the was having pain. RN-G diget him something for pain with the dressing change. RN-G in pair of gloves and packed the te (a wound dressing gel that bound environment) on a 4 x 4 did used a Q-Tip to place the und. The resident continued to following the procedure, RN-G did cart and got a Percocet (pain	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245266	B. WING			04/	24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		61	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET IINNEAPOLIS, MN 55404	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	during a dressing of R98 had pain assess and 2/7/14. Each as having pain daily in assessments indical located in the coccy wound and a check distressing/miserab the pain assessment on Percocet 2 tabs for pain. Another pacompleted on 2/22/pain in the buttock a uncomfortable /ann was less than daily analgesic) 650 mg have the Tylenol as a 4th pain assessment of the material was once again area and the pain was noted to be effected in the G-tube was noted to be effected and it completed and it completed and it compain assessments with the Gare Area Assecognition loss/demonant indicated that a Brief Interview for Materials and indicated that a Brief Interview for Materials and committed the completed and indicated that a Brief Interview for Materials and Indicated	hange. ssments completed on 2/4/14 ssessment indicated he was the buttocks area. Both pain ated the resident's pain was //x area where there was a	F3	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245266	B. WING _		04	/24/2014
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	is able to mouth we cuff is deflated. Re Hearing is adequal well." Received a fon 4/7/14, indicate medication is avail in record that he defined in record in	ords and is understood when esident is able to write some. Ite, resident feels he can't hear ax dated 4/25/14, and the note d, "Resident knows pain able and documentation exists oes request it."  was done on 2/17/14, and ident report during pain continuous pain that can range is it is usually the coccyx area is that pain medication helps. D [four times a day] Percocet led] Percocet for breakthrough ated 3/5/14, indicated R98 had rain.  In comfort level pain due to ssure area ibalize good pain control and ral visible indicators of pain loping coping mechanism armacological methods of pain gery, distraction techniques, es, massage therapy hot or cold eriods to facilitate comfort on. Eliminate additional es of discomfort, sleep and the additional stressors or fort whenever possible assessment: annually, quarterly, and PRN of the property	F 3	09		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245266	B. WING		04/24/2014		
NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP COD 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 309	Nursing to obserscheduled and PR as indicated Observe for any moaning, groaning Resident uses T Staff to evaluate scale if resident stapain, or point to face the pain, or point to face the pain or point to the progress notes we for a 3/12/14, at 3:3 to his room and trace the pain to be done to Stage IV of the pain to coccyx. "Repressure to coccyx was on Percocet point of the pain in his butt white needed] Percocet point in his butt white needed] Percocet point in his butt white needed percocet point in his pain medication for on 3/26/14, at 2:4 pain medication for and Ativan for anxion on 4/7/14, at 7:05	objective signs of pain: I, grimacing I, gri	F 30	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		245266	B. WING		04	/24/2014		
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP C 618 EAST 17TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 309	occurs pain medica relieve it.  R98 had a physicial change of the coccorder was to do the "1. Cleanse coccyx Pack with gauze lo 3. Skin protectant the ABD."  R98 had a physicial Percocet (oxycodo II tablet: 5-325 milling gastric tube four time. A pain assessment 4/7/14, at 8:05 a.m. indicated the resides scheduled pain medications in the question was, "at a the resident received intervention for pain the area for descript When the resident pain or hurting at a answer was "Yes." pain occasionally a The indicators for procession of the R98's Minimum Daindicated R98 was	a.m. stated that when pain ation (Percocet) was good to an ation of the pain was left blank. Was asked "Have you had any time in the last 5 days?" the The resident indicated he had and the pain was moderate.	F 30	9				
	The MDS indicated	I R98 had occasional pain.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245266		A. BUILDING			COMPLETED		
		B. WING _		04	04/24/2014		
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP COE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 309	during dressing chapre-medicated with also had a chronic related in part to his cardiac output and  A progress note da indicated the follow [as needed] Percooprior to coccyx dreslater stated that this dressing change m The Medication Adipain medication us two weeks, 4/11/14 received pain medication us two weeks, 4/11/14, at 3:4 - On 4/11/14, at 6:3 - On 4/15/14, at 6:3 - On 4/15/14, at 6:3 p.m.  - On 4/16/14, at 9:3 - On 4/19/14, at 9:3 - On 4/21/14, at 8:3 p.m.  The MAR did not in intensity of the pain Also the MAR did non-pharmacologic elevate the pain.  R98's physician wa 2:10 p.m. and it was the physician that F	I him about identified pain anges and R98 would be Percocet in the future. R98 Stage 4 stage pressure ulcer debilitated condition poor prolonged bed rest.  Ited 4/24/14, at 3:26 p.m. ing: "Resident received PRN at at 0950 [9:50 a.m.] this shift is medication made the ore comfortable for him." ministration Record (MAR) for age was reviewed for the last through 4/24/14. R98 cation PRN: 3 p.m.  If p	F 30	9			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	<b>245266</b> B. WING			04/24/2014				
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE		
F 309	addressed the pain The physician woul a scheduled pain medicate a scheduled pain and can ask for he has pain medicate a scheduled pain assess and days, and at 60 mostly reliable. RNshould have been as scheduled pain medicate a scheduled pain and can ask for he has pain medicate and confirmed R98 pain and can ask for he has pain medicate and confirmed R98 pain and can ask for he has pain medicate and confirmed R98 pain and can ask for he has pain medicate and confirmed R98 pain and can ask for he has pain medicate and confirmed R98 pain and can ask for he has pain medicate and confirmed R98 pain and can ask for he has pain medicate and can ask for he has pain and can ask for he has pain and can ask	reed to talk to the resident and during the dressing changes. d evaluate if R98 should have redication.  Wed on 4/24/14, at 8:45 a.m. 's physician saw the resident) and assessed R98 for pain anges. R98's physician wrote a 23/14, for Percocet one rig change.  Ad on 4/24/14, at 8:55 a.m.  ys experienced pain during resident was aware that on a 4/23/14, the pain resident was aware that on a 4/23/14, the pain resident was aware that on a 4/23/14, the pain resident was aware that on a 4/23/14, the pain resident was aware that on a 4/23/14, the pain resident was aware that on a 4/23/14, the pain resident was aware that on a 4/23/14, the pain resident was aware that on a 4/23/14, the pain resident resident appears a 4/24/14, at 11:50 a.m.  To pain assessments prior to she had not read R98's chart rewith his cares.  Wed on 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.  To an tell us when he is having or pain medication, he knows ation available. Tended as a 4/24/14, at 11:50 a.m.	F 30	9				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
245266		B. WING		04/24/2014		
NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 323 SS=E	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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."  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 temporers for 4 of 4 residents (PAO P122).		F 309	It is the practice of Benedictine Ce		6/7/14
	temperatures for 4 R68, R28) who had	tiled to ensure safe water of 4 residents (R40, R122, concerns of hot water. This affect all 83 residents.		Minneapolis to ensure that the resi environment remains as free of ac hazards as is possible and each re receives adequate supervision and assistance devices to prevent acci	cident sident I	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245266	B. WING			04/2	24/2014	
NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404				0112112017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	Findings include:  On 4/21/14, at 3:30 unable to keep his because of the high used the bathroom water gets so hot "ip.m. the water at th 127.5 degrees.  The quarterly Minindated 3/24/14, included 3/24/14, includental Status (BIM intact), indicated Retoileting and was in set-up.  On 4/21/14, at 3:32 room 318 was 125.  On 4/21/14, at 3:50 room water at show and at the sink in s 129.2 degrees.  On 4/21/14, at 3:56 room water at show and at the sink in s 125.9 degrees.  On 4/21/14, at 4:00 room water at the sedgrees and at the degrees.  On 4/21/14, at 4:06 room 220 was 127.	p.m. R40 stated he was hands under the hot water in temperature. R40 stated he multiple times per day and the t burns your skin." At 3:47 he sink in R40's room was hum Data Set (MDS) for R40 lided a Brief Interview of IS) score of 15 (cognitively 40 was independent with dependent with bathing after the p.m. the water at the sink in 9 degrees.  In p.m. the third floor shower wer head was 120.2 degrees hower room the water was hower room the water was hower room the water was p.m. the second floor shower wer head was 114.8 degrees hower room the water was p.m. the second floor shower shower head was 121.8 sink the water at the faucet in p.m. the water at the faucet in	F3	23	When the Maintenance Director wa initially informed on 4/21/14 that the temperatures were too high, he immediately investigated and deter that the mixing valve had failed with any prior warning. The Maintenance Director immediately turned off the water supply to the building and not the staff of the situation. He then deservice plumber who came out right and replaced the mixing valve with mixing valve. This repair was compon 4/21/14. The Maintenance Director/designee will continue to mand log hot water temps on the mixing valve gauge during each week. The committee will continue to do quart random audits of water temperatur resident rooms. The Maintenance Director is responsible to monitor the process.  Date of compliance June 7, 2014	e water mined nout ce hot tiffied called a at away a new bleted monitor king e safety erly es in		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		MPLETED
		245266	B. WING		04	4/24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	room water at the sidegrees and at the degrees.  On 4/21/14, at 4:16 the maintenance mixing valve and it hour.  On 4/21/14, at 4:30 the women's bathrodegrees.  The admission MD indicated a BIMS so On 4/23/14, at 8:43 ambulating independent when interviewed of stated the water in 4th Floor West Windon 4/21/14, at 3:26 observation the water in was unable to keep to being hot. While asked R68 who was used the sink he structure in the water in was unable to keep to being hot. While asked R68 who was used the sink he structure in the water in the wat	chower head was 113.5 sink the water was 125.2  p.m. the administrator stated an had a call out to get a new should be here within the  p.m. the water at the sink in from on fifth floor was 121.2  S dated 4/11/14, for R122 core of 14 (cognitively intact). a.m. R122 was observed indently on the unit.  on 4/22/14, at 1:02 p.m. R122 the shower "gets too hot."  g p.m. during R68's room ter temperature in the very hot approximately eight ing the faucet on and surveyor hand/fingers under water due still in the room, surveyor is lying in bed at the time if he ated, "I do not go in there and ommate. The staff help us."	F3	23		
	totally dependent u moderately cognitiv	b/31/14, revealed R68 was pon staff for cares and was rely impaired.  p.m. registered nurse (RN)-A				
		ne maintenance director and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245266	B. WING _		04/	24/2014
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	,	_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	was asked to requivith him to the floor-At 3:29 p.m. main the floor went to Riused a scanning the temperature readir Maintenance direct the hot water temperature the hot water temperature to be hot approximately between the hot water temperature as with the maintained to be hot approximately between the water temperature as with the maintained the water temperature as with the maintained to concern at time this would go adjust the downstairs. He further the concern at time this would cause the R28's MDS dated a extensive assist froseverely cognitively.  On 4/21/14, at 3:36 returned to the floor valve and had made to come out to che stated "It's not safe will check later to read the property of the stated of the state of the	tenance director came up to 68's room with surveyor and hermometer and the 19 was 127 Fahrenheit (°F). The stated he was not aware of 19 c.  I p.m. during room observation on the water temperature was consimately ten seconds after During observation surveyor enance director who checked ture which was recording 123 tenance director stated he 19 temperature valve ther stated, "I was not aware of 19 temperature to go up."  3/31/14, revealed R28 received on staff for cares and was 19 impaired.  5 p.m. maintenance director or stated he had adjusted the 19 temperature to go up. The stated he had adjusted the 19 temperature to go up. The stated he had adjusted the 19 temperature to go up. The stated he had adjusted the 19 temperature up 19 temperatures up 19 temperatures up 19 temperatures	F 32			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245266	B. WING _		04	/24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CO 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	•	21/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	the mixing valve an engineer to replace 4/21/14, at 6:00 p.n arrived, replaced the Logs were requested sampling at the restemperatures were acceptable range at the water temperature 4/18/14, indicated 7 that spanned 126 do fo popped safety rethree days a notation documented. It was water temperatures recorn Fahrenheit. On 4/2 the maintenance lo revealed water temperatures recorn Fahrenheit. On 4/2 the mixing valve be which was necessatemperature hot en A review of the quality and October of water temperatures degrees Fahrenheit was completed 3/14 degrees Fahrenheit was completed 3/14 degrees Fahrenheit was reported the residents had retemperatures to the temperatures to the second solution.	and called the mechanical of the valve that afternoon. On the number of the valve that afternoon. On the mechanical engineer of the mixing valve.  The dof water temperature ident rooms to verify water maintained within the to the patient room. A review of the log from 12/13/14 to the patient room. A review of the log from 12/13/14 to the patient room and the log lays. On four days a notation of sief valves was document; on on of flame failure was a noted that dometic / hot had a recorded of 120 to 134 to 134 to 14, and Boiler/supply had water ded of 176 to 204 degrees 1/14, at 5:00 p.m. a review of the greatures were recorded at the log for water temperatures peratures were recorded at the log for water temperatures are the log for water temperatures were recorded at the log for water temperatures were recorded at log for water log for wa	F 3:	23		

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F 323	Continued From pa	ge 24	F 3:	23		
F.000	surveyor. Water ter room 423 at 108 de at 105 degrees Fah degrees Fahrenhei		5.00			0.774.4
F 329 SS=D	483.25(I) DRUG RE UNNECESSARY D	EGIMEN IS FREE FROM PRUGS	F 3	29		6/7/14
	unnecessary drugs drug when used in duplicate therapy); without adequate mindications for its us adverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs used therapy is necessary as diagnosed and crecord; and resident drugs receive gradus behavioral interven	g regimen must be free from . An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any ereasons above.  The ensive assessment of a must ensure that residents antipsychotic drugs are not unless antipsychotic drug ry to treat a specific condition documented in the clinical its who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these				
	by: Based on observa	NT is not met as evidenced tion, interview and document ailed to ensure resident		F329 It is the philosophy of Benedicti	ne Health	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY PLETED
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F 329	monitoring was impuse for 3 of 3 resid for unnecessary macality failed to ensign (GDR) was attempt contraindication was residents (R40) whantipsychotic media. Findings include: R40 was not monit target behaviors for and Saphris (antipsychotic media rationale for continuationale for continuational for an authority and the staff. At 7 telling the nurse that pill " until after church through 4/15/14, we clinical indication for antipsychotics was time.  The psychiatrist not 1/16/14, and 4/18/4 why a GDR was continuational residuation for an authority and the staff. At 7 telling the nurse that pill " until after church was a staff and the st	avior and side effects blemented with antipsychotic ents (R28, R40, R44) reviewed edications. In addition, the sure a gradual dose reduction ted or the clinical as documented for 1 of 5 to received multiple cations.  ored for resident-specific resident the use of Lithium, Zyprexa sychotic medications) and did tempted or the clinical uing the medications  2 a.m. R40 was observed an a chair in his room with the em. R40 was observed sitting in and was interacting pleasantly in the did not want his "water urch.  agimen Review from 5/1/13 as reviewed and a GDR or or continued use of not recommended during that other dated and indicated and indicated	F 329	Center of Minneapolis that the managemen helps promote or maintain resident is highest practicable management in physical, and psychosocial well-lidentified by the resident and or representatives in collaboration interdisciplinary team.  A. Monitoring and clarification muse of psychoactive medications R 28 and R44 has been implemed B. Residents using psychotropic medications will have monitoring OBRA MDS 3.0 cycle.  C. Monthly random audits of management may be residents received by psychotropic medications by meather interdisciplinary team.  D. DON or designee responsibes monitoring, audit results community the Quality council for input.  Compliance date: 6/7/2014	ain the nental, being as with the elated to for R 40, ented. c with the edical ring mbers of e for	

	EMENT OF DEFICIENCIES PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 329	the frequency of an The Psychosocial Nassessment (CAA) Symptoms CAA da behavior of swearin Medication Use CA current medications documentation regrontraindication for The psychotropic of 1/6/14, identified Remedications, the relowest effective documents objectively documents objectively documents of the medications of the medications of the medications of the medications of the medication of the quarterly Mining 3/24/14, included a Status (BIMS) scorrevealed delusions concerns did not of the medication and the	A 4/24/14, lacked evidence of by identified behaviors.  Well-Being Care Area and the Behavioral ted 1/3/14, indicated a gat staff. The Psychotropic A dated 1/3/14, indicated in use and lacked arding a GDR or a clinical rone.  Trug use care plan dated 40 was receiving antipsychotic sident will be prescribed the se of medication and directed ment the resident's behavior.  Cal doctor progress note dated practitioner note dated practitioner note dated psychiatric issues were chiatrist.  Thum Data Set (MDS) dated Brief Interview of Mental e of 15 (cognitively intact) and hallucinations and behavioral	F 32	9		

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F 329	for R40 indicated a and included diagnoschizophrenia, bipo When interviewed oregistered nurse (R sheets to monitor to behavior document progress notes or in verified the weekly each resident and a Nursing assistant (I 4/24/14, at 1:32 p.m of care terminal, sto behavior document The nurse manage 4/24/14, at 1:55 p.m documented in the summary and specidentified. RN-I stateducation provide behaviors to look for pharmacist recomm when a GDR was molocate a GDR requestionical contraindical when interviewed of director of nursing (not monitor target behavior target behavior target behavior target behavior target behavior of nursing (not monitor target behavior target behavior target behavior target behavior of nursing (not monitor target behavior target behavior target behavior target behavior of nursing (not monitor target behavior target b	ssion Record dated 4/24/14, an admission date of 6/19/10, oses of paranoid lar disorder, and anxiety.  On 4/24/14, at 1:24 p.m.  N)-M stated there are no flow arget behaviors and any ation would be done in the in the weekly charting. RN-M charting are not specific to are general to all residents.  NA)-G was interviewed on in. and after reviewing the point ated there was no required ation for R40.  T, RN-I was interviewed on in. and stated behavior is progress notes and weekly iffic target behaviors are not ated staff training and clues" as to what target or. RN-I stated the consultant intendations are used to identify eeded and she was unable to est or documentation of a ation for R40.  On 4/24/14, at 2:49 p.m. the EDON) stated the facility did behaviors daily with and the weekly charting was	F 3.	29		
	R28's specific beha effects were not be	viors and potential side ing monitored.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 329	his wheelchair (w/c observed to be caling past other residents dining room (DR).  On 4/23/14, at 8:38 observed sitting at eating his breakfas conversing to staff -At 9:18 a.m. R28 whimself down the h -At 9:19 a.m. observed the common areaAt 9:20 a.m. observed back to his room st bathroom.  -At 9:22 a.m. observed door looking down -At 9:23 a.m. observed door looking down -At 9:26 a.m. observed activity in his room sit the door.  On 4/23/14, at 9:38 sitting at the DR tall therapeutic recreat newspaper as R28 -At 9:48 observed activity propelled se-At 9:53 a.m. survey elevator when asker R28 stated "I like to hang around."	is a.m. R28 observed propelling (a) down the hallway. R28 m and pleasant as he went is and staff before getting to the staff wheeling R28 to staff wheeling R28 to staff wheeling himself stated he was going to the staff on his w/c outside the staff on his w/c outside the the hallway. The staff nursing assistant shut the door. The NA-C coming out of room observed watching television staff on his w/c calmly facing staff was reading the	F 32	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 329	problems. R28's a plan dated 4/6/12, medication related striking out at staff and lack of impuls directed to monitor quantitatively and behavior. The care behavior/mood as R28's psychotropic 7/11/13, identified depression and Psand anxiety. The Opresented with syrwould be physicall at times. In addition required use of mounder control direct observe for adversible Review of the facil Review dated 8/7/side effects and synot been identified Review of the Med (MARs) and Treate (TARs) dated 4/1/10 momonitoring of b	pression due to multiple ntipsychotic medication care indicated R28 received to agitation as evidenced by swearing, verbally abusive e control. The care plan R28's behaviors and objectively document R28's e plan directed to document indicated.  It medication CAA dated R28 had diagnoses of sychosis as well as agitation CAA indicated R28 often inptoms of tearfulness and y and verbally abusive to staff in, the CAA indicated R28 edication to keep his symptoms of tearfulness and interest of medications.  It will be received to medications.	F 329					
	taking daily.  R28's diagnoses in psychosis/agitation encephalopathy da	ncluded dementia, unspecified n, anxiety, depression and amage obtained from the ed 4/8/14. In addition, the MDS						

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F 329	indicated R28 recei anti-depressant me behavioral symptom or verbal symptoms of hitting and kicking at R28's Physician Or indicated R28 recei once a day for depression once a day for depression occurs. During further docubehavior charting we progress Notes datif thappened and in using the facility gesheets dated 1/4/14 we checking off the but the sheets lack specific behaviors a used.  When interviewed of stated R28 did not monitored daily but behavior in the progression of the progr	ved anti-psychotic and edications. R28 exhibited in which included physical and irected towards other such as among others.  der Report dated 4/8/14, ved Lexapro 10 mg orally ression and Risperdal (an eation) 3 mg oral three times a structions: Please call MD if its."  Imment review it was revealed as being completed in the red 9/5/13, through 4/24/14, as also one to two times weekly inerated "Behavior/Mood" 14, through 4/18/14, which staff is behaviors, interventions listed and interventions that were in a 4/23/14, at 1:17 p.m. RN-N have specific behaviors to be the nurses would complete gress notes.	F3	329		

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F 329	be dosing on and o calm no behavior of R44's care plan dat potential for alterating pychotropic medical R44 "Will not have psychotropic medication associated behavior The CAA dated 7/2 psychotropic medical increased risk for famonitor for side effects and specific been identified as larecord.  R44's diagnoses included the control of t	e area. R44 was observed to ff looking around and was bserved.  ed 9/17/12, indicated he had on in cognition due to use of ation. The goal for R44 was adverse effects from ations." Care plan directed nedications as ordered, s administration and any rs of side effects.  9/13, indicated R44 was on ations which did put him at alls and directed staff to ects of medications.  Medication Regimen Review ugh 4/2/14, revealed side behavior monitoring had not acking in R44's medical  cluded dementia, psychotic mellitus, cerebrovascular miplegia and seizure disorder quarterly MDS dated 1/21/14. S indicated R44 was receiving anti-depressant medications.  der Report dated 3/26/14, ved Seroquel (an cation) 25 mg by mouth (PO) one 25 mg PO every bedtime insomnia and Zoloft 50 mg	F 3	329			

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F 329	only behaviors indice refusing medication directed to record F. The TAR lacked infor both anti-deprese medications R44 w.  During further docubehavior charting we two times weekly u. "Behavior/Mood" st. 4/19/14, with staff content interventions listed comments/descript specific behaviors afor R44.  When interviewed director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would do	, through 4/24/14, revealed the cated in the TAR were as and meals and staff were R44's food intake percentage. Formation on the side effects as and anti-psychotropic	F3	29			

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F 329	RN-A further stated the staff would be a resident and would happened. RN-A in Abnormal Involunta anti-psychotropic mevery six months on o daily monitoring was being documed. When interviewed a DON stated current being done weekly, worked closely with of the residents on regularly that monit further stated she had conference sometimed when exactly offered Health and had the monitoring was to be long as the staff we concerns and done enough.  When interviewed a consultant pharmac supposed to monitor as they see them in indicated the facility monitoring such as completed every six because of the resitue facility psychotic done when there we behavior episode.	initoring resident's behaviors. I because the facility is small aware of any change in a chart on it as indicated or as it dicated for the side effects the ary Movement Scale (AIMS) for redications were completed as indicated if otherwise but of side effects and behavior inted only as it happened.  On 4/25/14, at 12:38 a.m. the aty "Symptom" charting was DON indicated the facility in clinical Psychologist for some antipsychotic medications ored residents closely. DON and listened to a phone in last year 2013, not sure and by Minnesota Department of impression "Symptom" be done on a periodic basis as are aware of the resident exact a consistently it was sufficient on 4/25/14, at 3:01 p.m. the cist stated the nurses are or and document side effects in the progress note. CP of does other side effects the AIMS which was a months. CP indicated dent population diagnoses at the behavior monitoring in only as a concern or rather	F 3.	29			

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F 428 SS=D	responsible for comrecommendations of frames. When antip the resident is moneffectiveness of the for possible adversive antipsychot clinically contraindice reductions must be medical record by the 483.60(c) DRUG RIRREGULAR, ACT.  The drug regimen of reviewed at least of pharmacist.  The pharmacist must be medical record by the drug regimen of t	d the "consultant pharmacist is immunicating GDR consistent with regulatory time osychotic therapy is initiated, itored to determine the emedication and to observe e reactions. Gradual dose mended for all residents who ic medications, unless cated. Contraindication to dose described in the resident's he MD/NP or Psychiatrist."	F 42			6/7/14
	by: Based on observatoreview, the facility for specific target behamonitoring was impuse for 3 of 3 reside for unnecessary metacility failed to ensign (GDR) was attempted.	NT is not met as evidenced tion, interview and document ailed to ensure resident avior and side effects elemented with antipsychotic ents (R28, R40, R44) reviewed edications. In addition, the ure a gradual dose reduction ted or the clinical s documented for 1 of 5		F428 It is the practice of Benedictine Heat Center of Minneapolis to have the consultant pharmacist report irregulas part of the review of the drug regulated These reports are provided to the attending physician and the director nursing.	larities gimen.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 428	Continued From paresidents (R40) whantipsychotic media	o received multiple	F 428	Refer to the plan of action that wa	as	
	Findings include: R40 was not monit target behaviors fo and Saphris (antips not have a GDR at	ored for resident-specific r the use of Lithium, Zyprexa sychotic medications) and did tempted or the clinical uing the medications		Complaince date is 06/07/2014		
	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."					
	identified target be for R40. Review of from 1/1/14 through	ical record lacked evidence of haviors for antipsychotic use the weekly summary charting h 4/24/14, lacked evidence of my identified behaviors.				
	Assessment (CAA) Symptoms CAA da	Well-Being Care Area ) and the Behavioral ted 1/3/14, indicated a ng at staff. The Psychotropic				

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	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIF 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	, CODE		
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F 428	current medications documentation regacontraindication for The psychotropic d 1/6/14, identified Remedications, the relowest effective dos to objectively docur Review of the medications, the relowest effective dos to objectively docur Review of the medications of the medication of the medication of the quarterly Mining 3/24/14, included a Status (BIMS) scorrevealed delusions concerns did not of the Medication Addicensed social worn egative comments.  The Medication Addicensed social worn egative comments.  The Medication Addicensed social worn egative comments.  The Resident Admit for R40 indicated a and included diagnoschizophrenia, biposition when interviewed of the psychological programments.	A dated 1/3/14, indicated in use and lacked arding a GDR or a clinical one.  rug use care plan dated 40 was receiving antipsychotic sident will be prescribed the se of medication and directed ment the resident's behavior.  cal doctor progress note dated practitioner note dated practitioner note dated posychiatric issues were chiatrist.  num Data Set (MDS) dated Brief Interview of Mental e of 15 (cognitively intact) and hallucinations and behavioral ccur.  ted 3/28/14, written by the ker indicated R40 exhibited sover the past quarter.  ministration History dated 1/14, included Saphris 10 ce daily, Lithium 900 mg at xa 5 mg every evening and 30 ssion Record dated 4/24/14, in admission date of 6/19/10,	F 4	28			

. ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		245266	B. WING		04/	/24/2014	
	PROVIDER OR SUPPLIER	FER OF MINNEAPOLIS	STREET ADDRESS, CITY, STATE, ZIP COD 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		<u>-</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 428	behavior document progress notes or verified the weekly each resident and Nursing assistant (4/24/14, at 1:32 p. of care terminal, stock behavior document The nurse manage 4/24/14, at 1:55 p. documented in the summary and specidentified. RN-I stateducation provide behaviors to look final pharmacist recommends and GDR was locate a GDR required clinical contraindic. When interviewed director of nursing not monitor target antipsychotic used a used to monitor resultant pharmacist to more as they are the expectation of the ex	tation would be done in the in the weekly charting. RN-M charting are not specific to are general to all residents.  (NA)-G was interviewed on m. and after reviewing the point atted there was no required tation for R40.  Ar, RN-I was interviewed on m. and stated behavior is progress notes and weekly cific target behaviors are not atted staff training and "clues" as to what target or. RN-I stated the consultant mendations are used to identify needed and she was unable to lest or documentation of a ation for R40.  On 4/24/14, at 2:49 p.m. the (DON) stated the facility did behaviors daily with and the weekly charting was sidents.  Armacist was interviewed on m. and stated she expected the litor antipsychotic medications pert. The consultant pharmacist pected antipsychotic monitoring viors.	F 4	28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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F 428	On 4/23/14, at 7:55 his wheelchair (w/c) observed to be calripast other residents dining room (DR).  On 4/23/14, at 8:38 observed sitting at teating his breakfast conversing to staff (-At 9:18 a.m. R28 whimself down the harman and the common areaAt 9:19 a.m. observed to his room structure to his room structure to his room structure to his room and season and R28 was observed door looking down to have a structure to his room sitted door.  On 4/23/14, at 9:38 sitting at the DR table the door.  On 4/23/14, at 9:38 sitting at the DR table therapeutic recreating the high season and R28 was observed activity propelled season and R28 was also at 11 like to hang around."	a.m. R28 observed propelling down the hallway. R28 in and pleasant as he went and staff before getting to the a.m. to 9:11 a.m. R28 was the dining room (DR) table to observed to be calm and during the meal. Was observed propelling fallway to his room wed a staff wheeling R28 to wed R28 wheeling himself atted he was going to the wed the call light in room on sitting on his w/c outside the the hallway. Wed a staff nursing assistant shut the door. Wed NA-C coming out of room observed watching television ting on his w/c calmly facing to 9:47 a.m. observed R28 ole area calmly listening as the on staff was reading the	F4	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		245266	B. WING _		04	/24/2014
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F 428	problems. R28's a plan dated 4/6/12, medication related striking out at staff and lack of impuls directed to monito quantitatively and behavior. The care behavior/mood as R28's psychotropi 7/11/13, identified depression and Psand anxiety. The Opresented with syrwould be physical at times. In addition required use of mounder control directly observe for adversible Review of the facion Review of the facion Review of the Medical Review of	pression due to multiple intipsychotic medication care indicated R28 received to agitation as evidenced by fi, swearing, verbally abusive e control. The care plan r R28's behaviors and objectively document R28's e plan directed to document indicated.  It medication CAA dated R28 had diagnoses of sychosis as well as agitation CAA indicated R28 often in mptoms of tearfulness and ly and verbally abusive to staff on, the CAA indicated R28 edication to keep his symptoms of tear of the continue to se side effects of medications.  It is the continue to se side effects of medications and through 4/15/14, revealed opecific behavior monitoring had	F 42	28		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245266	B. WING _		04	/24/2014	
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP C 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		- 11 - 1	
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F 428	indicated R28 rece anti-depressant m behavioral symptoms werbal symptoms of hitting and kicking R28's Physician C indicated R28 rece once a day for dep antipsychotic med day with "Special I any agitation occu During further door behavior charting Progress Notes da it happened and ir using the facility g sheets dated 1/4/1 we checking off the but the sheets lack specific behaviors used.	eived anti-psychotic and edications. R28 exhibited ms which included physical and directed towards other such as among others.  Inder Report dated 4/8/14, eived Lexapro 10 mg orally pression and Risperdal (an ication) 3 mg oral three times a instructions: Please call MD if irs."  Inder Report dated 4/8/14, eived Lexapro 10 mg orally pression and Risperdal (an ication) 3 mg oral three times a instructions: Please call MD if irs."  Inder Report dated 4/8/14, as instructions it was revealed was being completed in the ented 9/5/13, through 4/24/14, as in also one to two times weekly enerated "Behavior/Mood" 4, through 4/18/14, which staff it is behaviors, interventions listed and interventions that were  Index of the distribution of the enterty of the property of the property of the enterty of	F 42	,			
	monitored daily bubehavior in the pro	thave specific behaviors to be at the nurses would complete orgress notes.  aviors and side effects were					
	not being monitore On 4/23/14, at 8:1 continuously morn observed to be ca thanking NA-A and where was and wh On 4/23/14, at 10:						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404				
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F 428	be dosing on and of calm no behavior of R44's care plan data potential for alterating psychotropic medical R44 "Will not have psychotropic medication associated behavior The CAA dated 7/2 psychotropic medical increased risk for famonitor for side efform Review of the CP Mated 9/12/13, throeffects and specific been identified as larecord.  R44's diagnoses in disorder, diabetes raccident (CVA), herobtained from the control in addition, the MD anti-psychotic and a R44's Physician Or indicated R44 receivantipsychotic medical twice daily, Trazodo for depression and PO once daily for depression and PO once daily for definition in the same properties of the control in the same properties of the same properties	the area. R44 was observed to ff looking around and was bserved.  Ited 9/17/12, indicated he had on in cognition due to use of cation. The goal for R44 was adverse effects from cations." Care plan directed medications as ordered, is administration and any ors of side effects.  9/13, indicated R44 was on cations which did put him at calls and directed staff to ects of medications.  Medication Regimen Review ugh 4/2/14, revealed side is behavior monitoring had not acking in R44's medical cluded dementia, psychotic mellitus, cerebrovascular miplegia and seizure disorder quarterly MDS dated 1/21/14. Sindicated R44 was receiving anti-depressant medications.  der Report dated 3/26/14, ived Seroquel (an cation) 25 mg by mouth (PO) one 25 mg PO every bedtime insomnia and Zoloft 50 mg	F 4	28			

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F 428	only behaviors indice refusing medication directed to record F. The TAR lacked infor both anti-depress medications R44 w.  During further docubehavior charting we two times weekly u. "Behavior/Mood" st. 4/19/14, with staff conterventions listed comments/descript specific behaviors afor R44.  When interviewed director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director of social sereceived any anti-p staff would docume them. Surveyor ask exception the director "Yes." She further stoehavior charting the charting.  When interviewed of stated "Normally we effects to monitor if effects we would we nurse practitioner keywas also the nurse	through 4/24/14, revealed the cated in the TAR were as and meals and staff were at 4/s food intake percentage. Formation on the side effects as and anti-psychotropic	F 4	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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F 428	RN-A further stated the staff would be resident and would happened. RN-A in Abnormal Involunts anti-psychotropic revery six months on daily monitoring was being documed. When interviewed DON stated currer being done weekly worked closely with of the residents on regularly that monifurther stated she conference sometic when exactly offers Health and had the monitoring was to long as the staff we concerns and done enough.  When interviewed consultant pharma supposed to monit as they see them i indicated the facility monitoring such as completed every such as completed every such as the facility psychoty.	onitoring resident's behaviors. It because the facility is small aware of any change in a lichart on it as indicated or as it indicated for the side effects the ary Movement Scale (AIMS) for medications were completed or as indicated if otherwise but the office of the side effects and behavior ented only as it happened.  On 4/25/14, at 12:38 a.m. the otherwise but the facility in clinical Psychologist for some antipsychotic medications to the facility in clinical Psychologist for some antipsychotic medications to the facility in clinical Psychologist for some antipsychotic medications to do a phone in the facility in clinical Psychologist for some antipsychotic medications to do a phone in the sidents closely. DON in the last year 2013, not sure end by Minnesota Department of the impression "Symptom" be done on a periodic basis as the done on a periodic basis as the error and document side effects in the progress note. CP by does other side effects in the progress note. CP by does other side effects in the progress note. CP by does other side effects in the progress note. CP by does other side effects in the progress note of the clinicated ident population diagnoses at the behavior monitoring in only was a concern or rather	F 4	28		
F 431	•	DRUG RECORDS,	F 4	31		6/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 431 SS=E	The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in orde controlled drugs is reconciled.  Drugs and biological abeled in accordant professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartmer controls, and perminate access to the The facility must prepermanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whele package drug districts.	reploy or obtain the services of cist who establishes a system and disposition of all sufficient detail to enable and cion; and determines that drug and that an account of all maintained and periodically als used in the facility must be acceved with currently accepted ales, and include the ory and cautionary are expiration date when  State and Federal laws, the all drugs and biologicals in ants under proper temperature at only authorized personnel to keys.  To vide separately locked, a compartments for storage of the discontinuous and other drugs subject to an the facility uses single unit bution systems in which the inimal and a missing dose can	F 4	31			
	by:	NT is not met as evidenced ion, interview and document		F 431			

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F 431	medications were (R62, R53, R57, R facility failed to ensat the proper temp medication refriger R57 medications.  Findings include:  During observation medication cart on tablets of Prochlor milligrams (mg) for 11/19/13, were four verified the finding expired."  R62's Minimum Daindicated R82 had making skills and had making skills and had the third floor med 4/24/14, at 10:44 anoted; a multi-use diabetes) for R53 and 3/4/14, and a multifor tuberculosis) days after open R53's MDS dated cognitively intact and On 4/24/14, at 11:1 medication cart was (used to treat Asth date of November 1	failed to ensure expired removed for 5 of 5 residents 89, R98). In addition, the sure medications were stored erature in 1 of 4 (1st floor) rators which affected R13 and a 4/23/14, at 1:58 p.m. six perazine (used for nausea) 10 r R62 with an expiration date of nd. Registered nurse (RN)-B and stated "they are definitely at a Set (MDS) dated 3/6/14, severely impaired decision and a diagnosis of epilepsy.  dication room was observed on a.m. and the following were vial of Aspart insulin (for with an expiration date of use vial of Aplisol (used to test ated as opened 3/4/14 (expired ing). RN-I verified the findings.  3/12/14, indicated R53 was and had a diagnosis of diabetes.  11 a.m. the first floor as observed. A Xopenex inhaler ma) for R57 with an expiration 2013 was found. Licensed 2N)-B verified the findings.	F 4:	It is the practice of Benedicti Center of Minneapolis to sto biologicals under proper tem controls and to remove or diexpired meds on a timely ba A. The refrigerator on 1st fl replaced and the identified newere removed.  B. Medications rooms are opresence of expired medicate temperature log for medicate refrigerators in place.  C. Review with licensed nuexpectations related to remodisposal of expired meds  D. Weekly random audits of for presence of expired or died meds and for refrigerator ter documentation. Results com Quality council for input.  Compliance date: 6/7/2014	re drugs and aperature spose of siss. loor was nedications checked for tions. Daily ons rsing staff the oval and of med rooms scontinued aperature log	

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	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
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F 431	During observation room and East med 11:26 a.m. the follo liquid Metoprolol (upressure for R89 w 4/17/14, and Gluca for R98 dated as expiration date circ verified the findings R89's MDS dated 2 moderate cognitive diagnosis of cardiad R98's MDS dated 4 severely cognitively of diabetes.  On 4/24/14, at 11:2 medication refrigers temperature of 50 dincluded two unoped (used to treat diabed Compro suppositor verified the findings what the safe storal was.  R13's Minimum Daindicated R13 had a was cognitively inta Review of the Insul dated 9/30/13; revegood until the expir between 36 and 46	2/5/14, indicated R57 was and had a diagnosis of asthma.  of the second floor medication dication cart on 4/24/14, at wing was observed; a bottle of sed to treat high blood with an expiration date of gen (used for low blood sugar) expired 3/2014, with the led in black. LPN-C and RN-J s.  2/27/14, indicated R89 was by impaired and had a condition date of gen dysthymia.  3/7/14, indicated R98 was by impaired and had a diagnosis of a.m. the first floor ator was observed to have a degrees. The refrigerator ened vials of Novolog insuling etes) for R13 and R57 had and stated she was not sure ge temperature for insuling the set (MDS) dated 3/5/14, a diagnosis of diabetes and	F 43			

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		
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	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		61	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET IINNEAPOLIS, MN 55404	CCTION (X. IOULD BE COMPL	
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F 431	director of nursing (medications to be rexpired and stated logs for the first flood DON stated a new purchased to replace The consultant phate 4/24/14, at 3:12 p.n. would be above ref Novolog insulin wor at that temperature The facility Storage April, 2007, directed discontinued, outdate biologicals. All such dispensing pharma The package insert Physicians Total Caread "Vials: After in temperatures below days, but should not heat or sunlight. Operfrigerated."  The package insert from JHP Pharmace 2013, informed uses 30 days should be coxidation and degrapotency."  The package insert from JHP Pharmace 2013, informed uses 30 days should be coxidation and degrapotency."	degrees.  on 4/24/14, at 2:49 p.m. the (DON) stated she expected emoved and discarded when there were no temperature or medication refrigerator. The refrigerator had been be the one on first floor.  rmacist was interviewed on an and stated 50 degrees rigerator temperature and all only be good for thirty days of Medications policy dated do " the facility shall not use atted, or deteriorated drugs or a drugs shall be returned to the cy or destroyed."  for Aspart insulin from are, Inc. last revised 1/12/12, itial use a vial may be kept at w 30°C (86°F) for up to 28 bt be exposed to excessive		31			

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F 431	Continued From pa last revised 12/22/1 25°C (68° to 77°F).	0, read, " Store at 20° to	F4	131			
F 441 SS=D	483.65 INFECTION SPREAD, LINENS	I CONTROL, PREVENT	F4	141			6/7/14
	Infection Control Pr safe, sanitary and c	tablish and maintain an cogram designed to provide a comfortable environment and development and transmission ction.					
	Program under whi (1) Investigates, coin the facility; (2) Decides what preshould be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must	cion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted					
		ndle, store, process and as to prevent the spread of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			E SURVEY PLETED
		245266	B. WING		04/2	24/2014
NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAPOLIS    X49   ID   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404					
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	•	age 49	F 441	<b>S</b>		
	by: Based on observer review the facility control practices to contamination dur residents (R98) we care; failed to main manner for 1 of 1 nutrition from a tule ensure proper har of 2 residents (R44 the potential to affor the floor; and the potential to affect R53, R54) whose addition, the facility used on resident the nourishment repotential to affect Findings include:  During observation assistant did not for catheter care which organisms into the During observation at 10:15 a.m. thro assistants (NAs), doing pericare and	ation, interview, and document failed to maintain infection or prevent possible crossing catheter care for 1 of 2 ho was observed for catheter ntain equipment in a sanitary resident (P7) who received be feeding; the facility failed to not washing was provided for 2 4, R66) during cares which had ect 26 of 26 residents residing the facility failed to ensure gar monitors were cleaned to tamination which had the 4 of 8 residents (R40, R97, blood sugar was monitored. In y failed to prevent ice packs body parts from being stored in efrigerator which had the 21 residents on the third floor.  In of catheter care the nursing collow the facility's policy on the had the potential to introduce the urinary tract system.  In of morning cares on 4/23/14 augh 10:30 a.m. two nursing		It is the practice of Benedictine Hear Center of Minneapolis to practice in control measures with care delivery. A. The finger stick blood glucose with a defective battery cover was replaced on 4/23. Just in time review catheter care and handwashing at level during this time frame.  B. Remaining blood glucose meter were checked for any defects. Revipolicies related to handwashing, cacare, blood glucose meter disinfect were reviewed and revised.  C. Expectations related to infection control practices were reviewed dustaff meetings.  D. Weekly random audits of infection control practices via direct observation processed and results communicated to Quality Council for	nfection y. meter ew of the unit ers view of atheter tion ring tion tion by	

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245266	B. WING			04/	24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		61	TREET ADDRESS, CITY, STATE, ZIP CODE I8 EAST 17TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	took a clean wet was the wash cloth from washed the pericar the penis. NA-F the the plastic lined gar linens.NA-F remove gloves in a plastic lifor garbage. NA-F took a new wet was the squirt bottle and second time. The N cloth in the appropriemoved his gloves a new wash cloth a repeated the drying discarded the glove hands and gloved with the held on to the catheter tubing apphead of the penis. Now washing the tubing head of the penis. After NA-F and NA-catheter cares, they technique of washing down to the head of were queried NA-E should have washed toward the urinary direction. NA-F con catheter first instea he had washed the	are area. NA-F put on gloves, ash cloth and added soap to a squeeze bottle. NA-F then e area to include the head of an discarded the wash cloth in bage container used for ed his gloves, discarded the ined garbage container used but on a new pair of gloves, sh cloth and added soap formed washed the pericare area a lathen discarded the wash diate receptacle. NA-F as put on new gloves and took and wiped the area dry. NA-F are process. NA-F then are and used a sanitizer on his with a new pair of gloves. NA-F penis and washed the urinary roximately 8 inches above the nd worked down toward the NA-F repeated this process of and then going toward the vere questioned about their and the urinary catheter tubing if the penis. As soon as they acknowledged that they defrom the head of the penis catheter tubing to prevent tion. NA-E confirmed they had catheter in the wrong firmed he had washed the dof washing the tubing after	F	141			

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONS	(X3) DATE SURVEY COMPLETED		
		245266	B. WING			04/	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		618 EAS	ADDRESS, CITY, STATE, ZIP CODE ST 17TH STREET APOLIS, MN 55404	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD PROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 441	the head of the per introducing bacterial RN-D was interview and confirmed that he told her that he off the tubing. RN-I already reviewed the The facility's policy. Urinary undated, list care as:  "9. Put on gloves, 1 front to back, rinsing thoroughly, 12. Hold prevent pulling, 13. meatus, cleaning, a catheter tubing, 14. (cath-secure, thigh if a supra-pubic cath wash hands after control wash hands after control buring a tour of the a.m. a IV pole in Promultiple areas of did IV pole had a bag of supplement) with the tube feeding so into P7 at the time been capped off.  The environmental interviewed during	NAs should have washed from his to the tubing to prevent a into the urinary tract system.  Wed on 4/24/14, at 11:45 a.m. she had talked to NA-F and had been washing something D confirmed that she had he policy/procedure with NA-F.  Procedure, on Catheter Care-sted the procedure for catheter  O. Wash genital area from a gfrequently, 11. Dry d catheter at meatus to wipe downward away from approximately 4 inches of a Secure drainage tubing strap) to thigh or to abdomen theter. Remove gloves and are is given."	F 4	41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	245266  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404  ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  FREFIX TAG  TAG  F 441  STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404  ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  F 441  F 441  F 441  TAG  TAG  THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 441  THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 441  THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  THE APPROPRIATE OF THE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		` '	E SURVEY IPLETED	
		245266	B. WING			04/	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		618 EAST 17TH STREET	<sup>2</sup> CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	PREFI)	X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	ON SHOULD HE APPROPR	BE	(X5) COMPLETION DATE
F 441	ESD confirmed that substance on multiplications with a web been with a washing during care.  On 4/23/14, the follocontinuous observations and to be enviored to be environmental	ing down the IV pole. The there was dried on white ple areas of the pole and wiped off by housekeeping.  out receive proper handles.  owing was observed during ation:  ved the nursing assistant 4's room.  ved the NA-A had set up water A removed resident gown and ith a white sheet then took a 44 before she started to wipe wash towel and then dried off ved NA-A cued R44 before 4's torso, dried armpits and deodorant. NA-A removed her in hands grabbed R44's shirt es.	F 4		2		
	pad off; squeezed of provided front perigloves adjusted R4 touched R44's head side pulled the wet peri-anal cares, applied and continued to applied and continued to apply his parant washed hands.  -A8:28 to 8:30 a.m. R44 to apply his parant and care and care and care and continued to apply his parant and care and car	was observed tearing R44's extra water off the wash towel; care and then with the same 4's pillow, linen, shirt and d then turned R44 to his right incontinent pad off complete olied cream, removed left d another glove on that hand oply a clean pad but never  . NA-A was observed assisting nts and adjusted them. observed leaving the rooming to get someone to help her is chair. On the way out NA-A ver washed hands went down					

_	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE COI	NSTRUCTION		E SURVEY IPLETED
		245266	B. WING			04/:	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		618 EA	T ADDRESS, CITY, STATE, ZIP CODE AST 17TH STREET EAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	standing outside ar walking down the h-At 8:35 a.m. NA-A East Hallway grabb used for transferrin R66's room with N Surveyor knocked entered room.  -At 8:36 a.m. NA-A of gloves never see hands.  -At 8:38 a.m. obser as NA-B was obserbedside.  -At 8:40 a.m. NA-A washed hands toss trash then opened stand out of room calcove re-arranged and was observed R44's room.  -At 8:42 a.m. NA-A going to R44's roor bare hands lifting thit and kept it standiapplied gloves never the hands lifting the it and kept it standiapplied gloves never the hands sanitizer on hold located in the room cated in t	y. NA-A was observed nother room then came allway with NA-B was observed going to the wed the E-Z stand lift (machine g) then was observed going to A-C and shut the door. The door immediately and was observed applying a pair on washing or cleansing wed standing by the E-Z stand wed standing by R66 at removed gloves never sed the used gloves in the R66's door pushed the E-Z stand outside the room to the lifts then grabbed a Hoyer lift going down the hallway to and NA-B were both observed in. NA-A was observed with the floor mat off the floor, foldeding by the chair. NA-A then	F 4	41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION		` '	E SURVEY PLETED
		245266	B. WING			04/	24/2014
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD O THE APPROPR	BE	(X5) COMPLETION DATE
F 441	R44 to brush his te bathroom rinsed the removed gloves ne back from bathroom she was going to coract 9:00 a.m. observed applying w/c. Then both removed donning a RN-A to ask the resprescribed cream for NA-A left the room RN-A then came be hands.  -At 9:07 a.m. NA-A observed donning a RN-A came to R44 applying cream to F-At 9:08 a.m. DON checking call lights and NA-A to wash I was supposed to w cares, leaving room NA further stated "I When interviewed a NA's are supposed	efly.  n. NA-A observed assisting eth, went back to the e basin and tooth brush then ver washed hands then came in with comb and cued R44 omb his hair.  I ved NA-A attempting to apply but was not able then stated ave someone come assist her ithout washing hands.  In. both NA-A and NA-C were gloves, repositioned R44 in the loved gloves and NA-C asked gistered nurse (RN)-A for or R44's scalp for itching.  I went outside spoke briefly to ack to room never washed another pair of gloves and show another pair of gloves and show and was enother pair of gloves and show and was observed when leaving cued both RN-A mands before leaving the room.  NA-A and RN-A were observed and cleansed hands with hand in.  at 9:15 a.m. NA stated she ash her hands before starting and after removing gloves.	F 4	41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION  NG		MPLETED
		245266	B. WING _		04	1/24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	stated her expectate washed hands upon entering, leaving the pericare.  When interviewed director of nursing supposed to follow CDC guidelines and during cares, after after cares.  The facility Handward directed "Procedure cross-contamination changing gloves afform when performing the provide the opportution occur. The facility for Handwashing"  Reusable blood sugas required to previous between residents.  During observation registered nurse (Risugar, RN-K wiped an alcohol wipe and basket. Without an blood sugar monitor and checked R97's	y directed.  on 4/24/14, at 11:18 a.m. RN-A tion was NA should have n removing gloves, before e room and after doing  on 4/24/14, at 12:41 p.m. the stated all the staff are hand washing procedure per d are supposed to wash hands removing gloves, before and ashing policy dated 6/2002, the must be followed to prevent an, including handwashing or ter providing personal care, or asks among individuals which unity for cross contamination to ollows the CDC's Guideline for gar monitors were not cleaned the tross-contamination  s on 4/21/14, at 5:14 p.m.  center of the staff are hand washing or ter providing personal care, or asks among individuals which unity for cross contamination to ollows the CDC's Guideline for gar monitors were not cleaned the tross-contamination.	F 44	11		
	and checked R97's wiped the blood glu wipe. When RN-K she stated now tha					

_	OF DEFICIENCIES OF CORRECTION	` '			(X2) MULTIPLE CONSTRUCTION A. BUILDING				
		245266	B. WING			04/:	24/2014		
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		618	EET ADDRESS, CITY, STATE, ZIP CODE EAST 17TH STREET INEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 441	Continued From pa	ge 56	F 4	41					
	RN-K was observed the blood glucose r checks all blood su	d using a Sani-wipe to wipe off nonitor. RN-K verified she gars on the west wing and vipes until she is done with the							
	RN-L was observed and then placed the pocket. RN-L took ther pocket and with entered R 53's roor sugar. RN-L placed in her pocket. RN-L and used a Sani-wi stated she used Sa	s on 4/23/14, at 7:39 a.m. d checking R97 's blood sugar e blood sugar monitor in her the blood sugar monitor out of nout sanitizing the monitor she m and checked R53's blood I the blood sugar monitor back returned to the treatment cart pe to clean the monitor. RN-L uni-wipes when she was done od sugar checks or at the end working night shift.							
	stated she expecte	on 4/24/14, at 2:25 p.m. RN-I d blood sugar monitors to be ach patient with bleach wipes							
	Disinfection policy ( glucose meter will to after each use. The alcohol prep pads to blood glucose meters)	Glucose Meters Use and (undated), directed the blood one cleaned and disinfected expolicy directed to use the or cleanse the outside of the extra and place on a new paper see a disinfectant wipe when it.							
	(meter) was used for glucose level. After the meter down with clean paper towel,	p.m. a blood glucose meter or R54 to obtain a blood using the meter, RN-E wiped h alcohol swab, placed it on a and then used a PDA-Sani e meter. As RN-E was							

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

PRINTED: 05/29/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	` '	E SURVEY MPLETED
		245266	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	soiled piece of tape the machine. RN-E med cart. RN-F sta cover on and did n RN-D removed the was no longer able between resident to replace the broke. The policy/procedu of use and cleanin glucose meter (BC 5/10.  "1. With gloved has cleanse the outside not to get liquid in ports of the meter. paper towel.  2. Remove all suppreceptacles by glovitems that may conthe garbage  3. Wash hands Disinfect blood glu  1. Take meter to the garbage  3. Wash hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take meter to the garbage  3. Word hands Disinfect blood glu  1. Take	eter it was noted to have a se securing the battery cover to a securing the meter back to the ated the tape was to hold the ot affect the machine working. It is to be disinfected /cleaned ase. A new meter was obtained ase. A new meter was obtained and and a long of a blood and indicated (after use) dated and as a long of meter. Take extreme care the test strip and key code. Place clean meter on a new oblies into appropriate wing disposable non-sharp atain small traces of blood into a cose meter (done at cart) are outside cart for disinfection. On paper towel barrier.  Disinfect is toxic when the skin, always wear gloves are the cost of the meter with this around the meter to maintain around the meter to maintain.	F 44			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245266	B. WING		04	/24/2014	
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP C 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	-		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 441	ready to store or to The Blood Glucos policy dated May a "- With gloved har the outside of merget liquid in the te the meter. Place of towel.  Remove all suppreceptacles by gloitems that may conthe garbage  Wash hands Disinfect blood glu  Take meter to the Place the meter  Don new gloves absorbed through  Get the disinfect medication cart.  Wipe down the or cloth until the entiful disinfectant.  Wrap the cloth a surface wetness of the After 2 minutes of disinfectant wipe a disinfectant wipe a disinfectant wipe a disinfectant wipe a disinfectant of the control of the con	meter is now disinfected and o use on another resident. "  The Meters Use and Disinfection 4/10.  The Meters Use and Disinfection to cleanse the extreme care not to start the extreme care not to start the strip and key code ports of clean meter on a new paper colles into appropriate eving disposable non-sharp eving disposable non-shar	F 4	41			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245266	B. WING	·	04/	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, Z 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		= " <b>-v</b> · ·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	were observed in the yogurt. RN-I stated	age 59 on room three blue ice packs ne freezer with ice cream and the blue ice packs were used parts and verified the findings.	F 4	.41		

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

PRINTED: 05/28/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 245266 04/25/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAPOLIS MINNEAPOLIS, MN 55404 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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: (X6) DATE

**Electronically Signed** 

TITLE

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245266	B. WING			04/	25/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		618	REET ADDRESS, CITY, STATE, ZIP CODE B EAST 17TH STREET NNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the deficit  2. The actual, or pr  3. The name and/oresponsible for correct	tate.mn.us  RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	K	000			
K 012 SS=F	Type II(000) construction and is fully fire springly fire springly fire springly fire springly fire corridors and such at is monitored for notification. The fact and had a census of the requirement at NOT MET as evident NFPA 101 LIFE SAR Building construction.	g was determined to be of uction. It has a full basement nklered throughout. The facility stem with smoke detection in paces open to the corridors or automatic fire department cility has a capacity of 95 beds of 82 at the time of the survey.  1.42 CFR, Subpart 483.70(a) is enced by: 1.FETY CODE STANDARD  2.1.6.2, 19.1.6.3, 19.1.6.4,	K	012			6/7/14
	Based on observa	s not met as evidenced by: tion and interview, this building requirement for construction			Correction not needed. Benedic Health Center of Minneapolis has		

Event ID: 5J6521

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

PRINTED: 05/28/2014 FORM APPROVED OMB NO. 0938-0391

TATEMENT	S FOR MEDICARE OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			) DATE	SURVEY PLETED
		245266	B. WING			04/25/2014	
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		6	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET HNNEAPOLIS, MN 55404	7TH STREET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
K 012	type and height. This deficient pract Findings include:	age 2 ice could affect all residents. veen 9:30 AM and 11:45 AM	K	012	achieved a passing FSES score.		
	on 04/25/2014, obs 5-story, non-combi- construction does in construction requiral height. The roof of fire rating.	servation revealed that this ustible facility of Type II(000) not meet the minimum ements for a building of this the facility does not have a					
	Note: This deficier FSES can establishevel of fire safety of the Life Safety Coo						0/7/44
K 050 SS=F	Fire drills are held varying conditions, The staff is familian that drills are part of Responsibility for passigned only to coqualified to exercise conducted between	at unexpected times under at least quarterly on each shift. with procedures and is aware of established routine. Idanning and conducting drills is ompetent persons who are e leadership. Where drills are in 9 PM and 6 AM a coded y be used instead of audible	K	050			6/7/14
	Based on record r	is not met as evidenced by: eview and interview, it was e facility failed to provide			Benedictine Health Center of Minnea will conduct unannounced fire drills at	polis	

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

PRINTED: 05/28/2014 FORM APPROVED OMB NO. 0938-0391

FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 01 - MAIN BUILI			(X3) DATE SURVEY COMPLETED	
		245266	B. WING			04/2	25/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		6	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	D BE	(X5) COMPLETIO DATE
K 050	quarterly drills for e period in accordance Section 19.7.1.2. T affect how staff rea Improper reaction be residents.  Findings include:  On facility tour betwon 04/25/2014, receivers was no AM sl of 2013 and no PM quarter of 2013.  This deficient pract	each shift in the last 12-month ce with NFPA 101 LSC (00) his deficient practice could act in the event of a fire. By staff would affect all eveen 9:30 AM and 11:45 AM ord review revealed that the hift fire drill for the 2nd quarter I shift fire drill for the 3rd etice was verified by the etime of the inspection.	K	050	least quarterly on each shift. The Maintenance Director has created schedule matrix to plan and track on a quarterly basis on each shift. Maintenace Director will be responder auditing this schedule and met requirements of NFPA 101 LSC (CSection 19.7.1.2.  Compliance date: June 7, 2014	fire drills The nsible eting the	

Facility ID: 00960

#### 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	ER OF MINNEAR	17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
****ATTENTION*****						
	NH LICENSING CORRECTION ORDER					
	144A.10, this corre pursuant to a surve found that the deficion herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	p participate in the electronic ensure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. I to	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/22/14

TITLE

**Electronically Signed** 

(X6) DATE

5J6511

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	4/2014	
	PROVIDER OR SUPPLIER	FR OF MINNEAR 618 EAST	DRESS, CITY, 3 17TH STRE				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIMED DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Department of Hearyou electronically. Is necessary for Starenter the word "corrected. You must then State licensure proceompletion date, the corrected prior to el Minnesota Department On 4/21/14, throug Department's staff, the following corrected prior to el Minnesota Department on 4/21/14, throug Department's staff, the following correction that you	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the	2 000	The assigned tag number appears far left column entitled "ID Prefix The state statute/rule out of compl listed in the "Summary Statement Deficiencies" column and replaces Comply" portion of the correction of This column also includes the find which are in violation of the state safter the statement, "This Rule is ras evidence by." Following the surfindings are the Suggested Method Correction and Time period for Complement of the States, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Fag." iance is of the "To order. ings statute not met veyors d of rrection. DING OF THIS		
2 565	Plan of Care; Use Subp. 3. Use. A co	omprehensive plan of care personnel involved in the	2 565			6/7/14	
	by: Based on observati	ent is not met as evidenced on, interview, and document ailed to re-assess pain before		-			

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00960	B. WING		04/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	OLIS, MN 5	PROVIDER'S PLAN OF CORRECTION	)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 2	2 565			
	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:					
	complicated past methodic respiratory tracheotomy and conventilation, congest artery disease, take physical dated 2/16 Stage 4 decubitus with extensive dest damage to muscle, e.g., tendon, joint convenience.	urrently on mechanical live heart failure, coronary en from his history and 1/14. In addition, R98 had a lucer (Full thickness skin loss ruction, tissue necrosis, or bone, or supporting structures apsule. Undermining and ay be associated with Stage 4				
	4/23/14, at 10:45 a. ulcer on the coccyx assistants (NAs) Naroom who had just dressing change was (RN)-G. RN-G camfrom the bedside st materials. RN-G exgoing to change the assisted RN-G to to onto his left side. Nhis left side while R dressing. RN-G the dressings in the plathen removed her chands in the bathrowas asked if that w	during a dressing change on m. to the Stage 4 pressure and the completed morning cares. The as done by registered nurse into R98's room, took gloves and that had dressing plained to R98 that she was a dressing on his wound. NA-E arn and position the resident A-E supported the resident on N-G removed the old and discarded the soiled listic lined waste basket and gloves. RN-G then washed her om sink in R98's room. RN-G as a clean or sterile dressing atted that she was going to do a				

Minnesota Department of Health

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PRINTED: 05/29/2014 FORM APPROVED

Minneso	ota Department of He	ealth				
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00960	B. WING		04/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE Polis, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	resident would let the having pain. RN-G of the resident befor change. RN-G done (salt water) wound dressing and dabbe procedure one more wound bed noted be oozing at the one or removed her soiled the plastic lined gar with facial grimacin surveyor if he was a confirmed that he was asked if he had changes and he reperformed that he was asked if he had changes and he reperformed the resident should be a confirmed that he was asked if he had changes and he reperformed that he was asked if he had changes and he reperformed the resident should be a confirmed that creating gel that creating gel that creating gel that creating the place the resident continued the resident continued.	nge. RN-G indicated the hem know when he was did not inquire the pain status ore starting the dressing ned gloves, and put saline wash on a 4 x 4 gauge ed the wound and repeated the retime. Observation of the one and fresh red blood o'clock position. RN-G then I gloves and discarded them in rbage can. R98 was observed ag and was then asked by the having pain and R98 was having pain. The resident d pain with other dressing plied that he had pain with all RN-G acknowledged she state he was having pain. The would get him something for ned with the dressing change. The resident with SoloSite (a wound eates a moist wound 4 x 4 gauge dressing and used the dressing in the wound. The to facial grimace in pain. RN-G				
	the sink in the bath and placed an ABD dressing) over the processing to the residated, 4/23/14. RN-cart and got a Percat 11:00 a.m. RN-Gusing a pain scale of greatest.	gloves, washed her hands in room. RN-G then came back dressing (thick absorbent packing and taped the ident's skin. The dressing was -G then went out to the med cocet (pain medication) for R98 did not do a pain evaluation of 1 to 10 with 10 being the				

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Minnesota Department of Health STATE FORM

medication to R98 and confirmed she did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00960	B. WING		04/2	24/2014
	PROVIDER OR SUPPLIER	FR OF MINNEAR 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	dressing change ar received anything for change. RN-G them both agreed they state the status of his parchange. RN-G confinate a scheduled paressing change by medication on an a stated she would not during a dressing change by medication on an a stated she would not during a dressing change by "- Pain: alteration immobility and presume the state of the st	a for pain before starting the and the resident had not or pain before the dressing a discussed with RN-D and hould check with the resident in before doing a dressing irmed the resident did not pain medication(s) before the at there was an order for pain as needed basis (PRN). RN-G otify R98's physician of pain hange.  Med 3/5/14, indicated R98 had ain.  In comfort level pain due to sour area and alize good pain control and all visible indicators of pain poing coping mechanism remacological methods of pain pain and print and additional sof discomfort, sleep and and additional stressors or cort whenever possible seessment: annually, quarterly, and PRN (as needed) are MD orders pain medication: sedation, ion, N/V itching, increased resident and family are and record effectiveness of a medications and update MD objective signs of pain: and grimacing	2 565			

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00960	B. WING		04/2	4/2014	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
BENEDICTINE HEALTH CENTER O	DE MINNE∆P(	17TH STRE DLIS, MN 5				
PREFIX (EACH DEFICIENCY MUST	ENT OF DEFICIENCIES ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
scale if resident states h pain, or point to faces of plan of care was not follomonitor R98 for signs of change nor did the staff prior to the dressing cha.  The director of nursing (14/24/14, at 11:40 a.m. was management, her respondent the policy and read it. The DON declined common questions relating to pair treatments saying she has and was not familiar with.  RN-D was interviewed on and confirmed R98 "can pain and can ask for pair he has pain medication assessments on admission and at 60 days. R98 ans reliable. The resident did depth and severity of how confirmed the resident side before the dressing chard do not routinely do pain a treatments."  SUGGESTED METHOD. The administrator or designation of the system to educate staff a system to ensure staff and directed by the written plant.	dent's rate pain on a 1-10 ne/she was experiencing f pain on a scale." The lowed as the staff did not f pain during the dressing offer pain medication ange.  (DON) was interviewed on was questioned about pain onse was, "I will have to it and get back to you." ment on additional in assessments prior to had not read R98's chart h his cares.  on 4/24/14, at 11:50 a.m. In tell us when he is having in medication, he knows available." We do pain sion, 14 days, 30 days, swers were mostly d not understand the low sick he was. RN-D should have been asked large if he had pain. "We assessments before  D OF CORRECTION: signee could develop a and develop a monitoring are providing care as	2 565				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILBING.			
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ige 6	2 830			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General		2 830			6/7/14
	receive nursing car custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from to resident must remain in the second of the	ent is not met as evidenced ion, interview, and document ailed to re-assess pain before erved dressing change for 1 of to the facility 2/22/14, with a nedical history that included				

Minnesota Department of Health

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PRINTED: 05/29/2014 FORM APPROVED

Minneso	<u>ota Department of He</u>	ealth earth					
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUI	MBER:	A. BUILDING:		COMPI	LETED
		00960		B. WING		04/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER		STDEET VD	DDESS CITY S	STATE, ZIP CODE		
NAME OF F	-NOVIDEN ON SOFFEIER			17TH STRE			
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAP		OLIS, MN 5			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	S	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMA	(TION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
2 830	Continued From pa	ige 7		2 830			
	R98 was observed	during a dressing cha	ange on				
		.m. to the Stage 4 pre					
		c. There were two nur					
		A-E and NA-F in the					
		completed morning of					
		as done by registered					
		ne into R98's room, to					
		tand that had dressin					
		plained to R98 that s					
		e dressing on his wou					
		urn and position the r					
		IA-E supported the re				l	
		tN-G removed the old en discarded the soile					
		astic lined waste bask					
		gloves. RN-G then wa				l	
		oom sink in R98's roo					
		as a clean or sterile o				l	
		ated that she was goi					
		nge. RN-G indicated					
		hem know when he v					
		did not inquire the pa					
		ore starting the dressi					
		ned gloves, and put s				l	
		wash on a 4 x 4 gaug					
		ed the wound and rep					
		e time. Observation of					
		one and fresh red blo					
		o'clock position. RN-G I gloves and discarde				l	
		rbage can. R98 was o					
		then asked by the su					
		and R98 confirmed				l	
		he resident was aske					
		dressing changes ar					
		pain with all dressing					
		knowledged she hear					
		as having pain. RN-0					
		d get him something t					

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00960	B. WING		04/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ED OF MINNEAD 618 EAST	17TH STRE	ET		
BENEDIC	CTINE HEALTH CENT	MINNEAP	OLIS, MN 5	5404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	then put on a fresh wound with SoloSite creates a moist wor gauge dressing and dressing in the wou grimace in pain. RN washed her hands in RN-G then came be dressing (thick absorpacking and taped skin. The dressing then went out to the (pain medication) for	with the dressing change. RN-G pair of gloves and packed the e (a wound dressing gel that and environment) on a 4 x 4 d used a Q-Tip to place the nd. The resident continued to I-G then removed her gloves, in the sink in the bathroom. ack and placed an ABD orbent dressing) over the the dressing to the resident's was dated, 4/23/14. RN-G e med cart and got a Percocet or R98 at 11:00 a.m. RN-G did ation using a pain scale of 1 to e greatest.				
	medication to R98 a assess the resident dressing change ar received anything for change. RN-G then both agreed they shad the status of his pair change. RN-G confinate a scheduled processing change burnedication on an asstated she would not during a dressing change of R98 had pain assess and 2/7/14. Each as having pain daily in Both pain assessment was located in the cowound and a check	essments completed on 2/4/14 seessment indicated he was the buttocks area and 2/7/14. ents stated the resident's pain coccyx area where there was a				

Minnesota Department of Health

the pain assessments indicated the resident was

STATE FORM 5899 5J6511 If continuation sheet 9 of 66

NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAP  618 EAST 17TH STREET	STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
BENEDICTINE HEALTH CENTER OF MINNEAP			00960	B. WING		04/2	4/2014
BENEDICTINE HEALTH CENTER OF MINNEAP	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	BENEDI	CTINE HEALTH CENT	FR OF MINNEAP				
MINNEAPOLIS, MN 55404	240.15	CLIMMA DV CTA		-		ONI	()(5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
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 /another pain assessment was completed on 2/22/14, and indicated R98 had pain in the buttock area and the pain was uncomfortable /another pain was uncomfortable /another pain was uncomfortable /another pain 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 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 twite 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	2 830	on Percocet 2 tabs for pain. Another pace completed on 2/22/pain in the buttock uncomfortable /ann was less than daily analgesic) 650 mg have the Tylenol as a 4th pain assessmain was once again area and the pain we (moderate pain). The through the G-tube was noted to be effected did not have a time completed and it compain assessments with interview or in conjutreatments.  The Care Area Asses cognition loss/demond indicated that a Brief Interview for Meshowed impaired on that was drawn undicated the follow oriented. Understant to follow instruction time. He is able to a understood when completed in the can't hear well." and the note on 4/7 knows pain medicated documentation exist request it."	per the G-tube every 4 hours ain assessment was (14, and indicated R98 had area and the pain was roying (mild pain) and the pain and the Tylenol (a mild was effective and he could a needed for pain. On 2/25/14, rent was completed and the in noted to be in the buttocks was distressing/miserable he resident could have Tylenol every 4 hours for pain and it ective. The pain assessments when the assessments were build not be determined if the was only completed by function with cares and essment (CAA) done for entia was done on 2/11/14, area triggered because the Mental Status (BIMS) score ognition (9/15). The conclusion der Analysis of Findings ing: "Resident is alert and and communication and is able s. Resident is on ventilator full mouth words and is uff is deflated. Resident is able ring is adequate, resident feels Received a fax dated 4/25/14, indicated, "Resident tion is available and ats in record that he does	2 830			

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00960	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	FR OF MINNEAP	DRESS, CITY, S' 17TH STREE POLIS, MN 55	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	interview he has co from 7 to 10. States that hurts. Reports Was started on QIE with PRN Percocet  R98's care plan dat pain/potential for pair- Pain: alteration in immobility and preserved will have minimal resident will verter for will have minimal relaxation exercises compress. Rest persident exactions are great at the pain as significant change are monitor for SE [seedation, respirator and vomiting] itchined the complete pain as significant change are monitor for SE [seedation, respirator and vomiting] itchined the complete pain are significant change are monitor for SE [seedation, respirator and vomiting] itchined the complete pain are significant change are monitor for SE [seedation, respirator and vomiting] itchined the complete pain are significant change are monitor for SE [seedation, respirator and vomiting] itchined the complete pain are significant change are monitor for SE [seedation, respirator and vomiting] itchined the complete pain are significant change are	ntinuous pain that can range is it is usually the coccyx area that pain medication helps. If our times a day] Percocet for breakthrough pain."  sed 3/5/14, indicated R98 had ain. In comfort level pain due to esure area palize good pain control and all visible indicators of pain coping coping mechanism remacological methods of pain ery, distraction techniques, is, massage therapy hot or cold riods to facilitate comfort on. Eliminate additional is of discomfort, sleep and it is additional stressors or cort whenever possible is essessment: annually, quarterly, and PRN er MD [physician] orders ide effects] of pain medication: by depression, N/V [nausea g, increased confusion, and family or and record effectiveness of it medications and update MD objective signs of pain: grimacing	2 830			

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAR	17TH STRE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	nge 11	2 830			
	prior to the dressing	g change.				
	Progress notes well - On 3/12/14, at 3:5 to his room and tra (Resident returned had some pain to be done to Stage IV comeasurements done edges and had und Bone was palpable mattress MA95Z well and right at this time. On 3/17/14, at 4:2 pain to coccyx. "Repressure to coccyx was on Percocet propositalized 3/9/14 pneumonia."  On 3/20/14, at 7:0 pain in his "butt" where experienced administer somewhat effective pain at '5/10'."  On 3/26/14, at 2:4 pain medication for and Ativan for anxious or and Ativan for anxious o'clock, 2.6 at 6 to granulation."  On 4/7/14, at 7:05 pain in low back an (6:30 a.m.).  On 4/7/14, at 8:11	re reviewed for R98. 60 p.m. the resident settled in insferred to facility ventilator. from the hospital). Stated he tack side. "Dressing change occyx ulcer and wound inc. Wound was macerated at lermining from 9 to 3 o'clock.  R98 was on specialty ith 20 degrees rotation to left e." 21 p.m. Resident stated he had issident does have stage IV upon re-admission. Resident for pain. Resident was to 3/12/14 with diagnosis of 10 p.m. Resident stated he had inch he rated 6/10". "PRN itered via G-Tube at 0515 with the results. Resident requested back ache at 2:00 p.m. 102 p.m. resident requested back ache at 1320 [1:20 p.m.]				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE OLIS, MN 5			
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2 830	Continued From pa	ge 12	2 830			
	change of the cocc order was to do the "1. Cleanse coccyx Pack with gauze log 3. Skin protectant to ABD." Review of the docu a Physician's Order (oxycodone-acetant 5-325 milligrams (n four times a day PF					
	4/7/14, at 8:05 a.m. indicated the reside scheduled pain me However, R98 had medications in the question was, "at a the resident receive intervention for pair the area for descrip When the resident pain or hurting at an answer was "Yes." pain occasionally a The indicators for pair answer than the resident pair or hurting at an answer was "Yes."	ast five days. The next ny time in the last 5 days, has ed any non-medication n?" The answer was "Yes" but oftion of the pain was left blank. was asked "Have you had ny time in the last 5 days?" the The resident indicated he had not the pain was moderate. Join was blank.				
	indicated R98 was and had an unheale The MDS indicated R98's Physician No electrically signed a	ta Set (MDS) dated 4/7/14, severely cognitively impaired ed pressure ulcer at Stage 4. R98 had occasional pain.  Ite dated 4/23/14, and at 3:30 p.m. indicated a nurse about identified pain during				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	FR OF MINNEAP 618 EAST	DRESS, CITY, S 17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	pre-medicated with also had a chronic related in part to his cardiac output and good improvement physician confirmed resident was having his attention by the A progress note daindicated the follow Percocet at 0950 the dressing change. This medication mac comfortable for him The Medication Adripain medication us two weeks, 4/11/14 received pain medication us two weeks, 4/11/14, at 3:4 - On 4/11/14, at 6:3 p.m., - On 4/16/14, at 6:3 p.m., - On 4/16/14, at 9:0 - On 4/17/14, at 12: p.m., - On 4/19/14, at 8:3 p.m. The medication the pain was, intenseffectiveness of the sheet did not indicated means had been us R98's physician was 2:10 p.m. it was brophysician that R98 dressing changes of the sheet did not indicated means had been us R98's physician was 2:10 p.m. it was brophysician that R98 dressing changes of the sheet did not indicated means had been us R98's physician was 2:10 p.m. it was brophysician that R98 dressing changes of the sheet did not indicated means had been us R98's physician was 2:10 p.m. it was brophysician that R98 dressing changes of the sheet did not indicated means had been us R98's physician was 2:10 p.m. it was brophysician that R98 dressing changes of the sheet did not indicated means had been us R98's physician was 2:10 p.m. it was brophysician that R98 dressing changes of the sheet did not indicated the follows are the first that R98 dressing changes of the sheet did not indicated the follows are the first that R98 dressing changes of the sheet did not indicated the follows are the first that R98 dressing changes of the first th	Percocet in the future. R98 Stage 4 stage decubitus ulcer is debilitated condition poor prolonged bed rest. "Position with auto-debridement." R98's dispain until it was brought to surveyor.  Ited 4/24/14, at 3:26 p.m. ing: "Resident received PRN his shift prior to coccyx he resident later stated that de the dressing change more h."  ministration Record (MAR) for age was reviewed for the last through 4/24/14. R98 cation PRN: 3 p.m., 127 p.m., 100 a.m. and again at 12:36  100 a.m., 12:52 p.m., and 4:45 n sheet did not indicate where	2 830			

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NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAP	T 17TH STRE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	addressed the pain The physician would a scheduled pain in physician assessed resident had a pain (oxycodone) tablet tube. R98 had " Spexceed 4000 mg /2 needed."  RN-D was interviewed and confirmed R98 yesterday, (4/23/14) during dressing chard doctor's order on 4 before each dressing charge or maybe higher" when changes (the reside of 1 to 10, 10 would was informed he with medication before resident mouthed "  The director of nurse 4/24/14, at 11:40 at management, her riget the policy and right the policy a	a during the dressing changes. Id evaluate if R98 should have nedication. Before the R98's difference the resident for pain, the norder for Percocet 5-325 mg, 1 tablet per gastric pecial Instructions. Not to 24 hours four times a day as eved on 4/24/14, at 8:45 a.m. By physician saw the resident end assessed R98 for pain anges. R98's physician wrote a evaluate and assessed R98 for pain anges. R98's physician wrote a evaluate and assessed R98 for pain anges. R98's physician wrote a evaluate and assessed R98 for pain anges. R98's physician wrote and 23/14, for Percocet one and change. The he had the dressing ent was aware that on a scale doe the highest). The resident ould now be getting pain each dressing change. The thank you" and smiled.  Sing (DON) was interviewed on the each dressing end about pain esponse was, "I will have to be ead it and get back to you." comment on additional on pain assessments prior to she had not read R98's chart				
	and confirmed R98 pain and can ask for	wed on 4/24/14, at 11:50 a.m. "can tell us when he is having or pain medication, he knows ation available." We do pain				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	24/2014
	PROVIDER OR SUPPLIER	FR OF MINNEAR 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
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2 830	assessments on ac and at 60 days. R96 reliable. The reside depth and severity confirmed the resid before the dressing do not routinely do treatments."  The pain managemindicated that the si who are experiencic conditions that may comprehensive assand will have a treat pain symptoms." The following, "1. Each consistent, accurate assessment of resident who exper prevention/interven implemented. 3. A I comprehensive pair a resident's pain or alleviating and exact treatment, and resident's pain or alleviating and exact treatment, and resident was nurse will initiate pareassessments. a. b. Quarterly c. Any d. Upon readmission of resident verbalized Staff identifies presidents breakthrough pain, analgesics. 2. The pain assessment uses the pain assessment uses a several pain assessment uses and at the pain at	ge 15 Imission, 14 days, 30 days, 8 answers were mostly nt did not understand the of how sick he was. RN-D ent should have been asked change if he had pain. "We pain assessments before  ent policy dated 12/2002, tandard was, "All residents and pain, or may have result in pain, will have a sessment of pain symptoms the policy indicated the resident will be provided with a seand timely comprehensive dent's comfort level as related suspected pain. 2. Each itences pain will have a pain tion plan established and icensed nurse will complete a nassessment that will address igin, location, severity, the period of pain, or increased use of PRN itensed in assessments and upon admission to the facility estation of pain or discomfort for the facility e. With onset action of pain or discomfort for ence of nonverbal indicators, or states of non-verbal or segonal control of pain, or increased use of PRN itensed nurse will perform a sing the Pain Management assessment will also include	2 830			

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COM		SURVEY	
7.1.12 . 2.11	o. cozo		A. BUILDING:			
		00960	B. WING		04/2	24/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	the use of pain sca pain and amount of management neces requires notification and documentation of care."  SUGGESTED MET DON or her designe procedures regardi pressure related sk designee could edu procedures. The Do develop a monitorir receive the appropri	le to describe the resident's f pain relief. 4. Ineffective pain ssitates a change. This of the physician, and family, in the nursing notes and plan. THOD OF CORRECTION: The ee could develop polices and ng assessing and monitoring in conditions. The DON or her ucate staff on the policies and ON or her designee could ng system to ensue residents riate care.	2 830			
21375	Program  Subpart 1. Infection home must establist control program desanitary environme  This MN Requirements: Based on observation review the facility factoric practices to contamination during residents (R98) which care; failed to main manner for 1 of 1 resulting from a tube.	on control program. A nursing sh and maintain an infection signed to provide a safe and nt.  ent is not met as evidenced ion, interview, and document ailed to maintain infection prevent possible crossing catheter care for 1 of 2 o was observed for catheter tain equipment in a sanitary esident (R7) who received a feeding; the facility failed to discontinuous manufactured washing was provided for 2	21375			6/7/14

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	FR OF MINNFAP 618 EAST	DRESS, CITY, S 17TH STRE			
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21375	of 2 residents (R44 the potential to affe on the floor; and the reusable blood sugprevent cross contapotential to affect 4 R53, R54) whose be addition, the facility used on resident bothe nourishment respondential to affect 2 Findings include:  During observation assistant did not fol catheter care which organisms into the  During observation at 10:15 a.m. througasistants (NAs), Not doing pericare and NA-F explained to fit the resident's perication took a clean wet was the wash cloth from washed the pericanthe penis. NA-F the the plastic lined garlinens. NA-F removes gloves in a plastic lift or garbage. NA-F took a new wet was the squirt bottle and second time. The Not cloth in the approprime removed his gloves a new wash cloth a	ge 17  R66) during cares which had ct 26 of 26 residents residing a facility failed to ensure ar monitors were cleaned to amination which had the of 8 residents (R40, R97, lood sugar was monitored. In failed to prevent ice packs ody parts from being stored in rigerator which had the 1 residents on the third floor.  of catheter care the nursing low the facility's policy on 1 had the potential to introduce urinary tract system.  of morning cares on 4/23/14 gh 10:30 a.m. two nursing A-E and NA-F were observed urinary catheter care for R98. R98 that he was going to wash are area. NA-F put on gloves, ash cloth and added soap to a squeeze bottle. NA-F then area to include the head of an discarded the wash cloth in bage container used for ed his gloves, discarded the ned garbage container used out on a new pair of gloves, the cloth and added soap form a washed the pericare area a lA then discarded the wash iate receptacle. NA-F, put on new gloves and took and wiped the area dry. NA-F process. NA-F then	21375			

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		00960	B. WING		04/2	24/2014
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21375	discarded the glove hands and gloved withen held on to the catheter tubing apphead of the penis. It washing the tubing head of the penis. After NA-F and NA-catheter cares, they technique of washing down to the head of were queried NA-E should have washed toward the urinary direction. NA-F concatheter first insteathe had washed the NR-G was interview and confirmed the It the head of the penintroducing bacterial RN-D was interview and confirmed that he told her that he I off the tubing. RN-D already reviewed the The facility's policy/Urinary undated, liscare as:  "9. Put on gloves, 1 front to back, rinsin thoroughly, 12. Hold	es and used a sanitizer on his with a new pair of gloves. NA-F penis and washed the urinary roximately 8 inches above the nd worked down toward the NA-F repeated this process of and then going toward the  -E completed the pericare and were questioned about their ng the urinary catheter tubing f the penis. As soon as they acknowledged that they d from the head of the penis catheter tubing to prevent tion. NA-E confirmed they had catheter in the wrong firmed he had washed the d of washing the tubing after	21375			

		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE OLIS, MN 5			
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21375	meatus, cleaning, a catheter tubing, 14. (cath-secure, thigh if a supra-pubic cat wash hands after continuous after continuous observation and supplement) with the tube feeding so into P7 at the time obeen capped off.  The environmental interviewed during facility and confirmed responsible for wiping ESD confirmed that substance on multiple should have been with the tube feeding so into P7 at the time of the continuous observation and the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of the tube feeding so into P7 at the time of tube feeding so into P7 at the time of the tube feeding so into P7 at the time of tube feeding so into P7 at the time of tube feeding so into P7 at the time of tube feeding so into P7 at the tube feeding so into P	approximately 4 inches of Secure drainage tubing strap) to thigh or to abdomen heter. Remove gloves and are is given."  sonnel failed to maintain a so (IV) pole.  If facility on 4/24/14, at 10:05 r's room was noted to have ied on white substance. The of Isosource (nutritional abing connected to the bag. Dutton was not being infused of the tour. The tubing had service director (ESD) was the environmental tour of the ed that housekeeping was ng down the IV pole. The there was dried on white ple areas of the pole and wiped off by housekeeping.  Out receive proper hand es.  Owing was observed during ation: wed the nursing assistant	21375			

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00960		B. WING		04/2	4/2014
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDICTINE HEALTH CEN	TER OF MINNEAP	17TH STRE			
PREFIX (EACH DEFICIENCE	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
starting to wash R torso then applied gloves did not was and re-applied glotate and re-applied glotate and re-applied front per gloves adjusted R touched R44's he side pulled the we peri-anal cares, and glove and re-applied and continued to a washed hands.  -A 8:28 to 8:30 a. assisting R44 to a them.  -At 8:33 a.m. NA-stated she was go to transfer R44 in removed gloves not to the North Hallw standing outside a walking down the entered gloves not the North Hallw standing outside a walking down the standing outside a walking down the entered room.  -At 8:35 a.m. NA-East Hallway grabused for transferring R66's room with Surveyor knocked entered room.  -At 8:36 a.m. NA-of gloves never see hands.  -At 8:38 a.m. observables.  -At 8:38 a.m. observables.  -At 8:40 a.m. NA-A	erved NA-A cued R44 before 44's torso, dried armpits and deodorant. NA-A removed her sh hands grabbed R44's shirt ves.  A was observed tearing R44's extra water off the wash towel; i-care and then with the same 44's pillow, linen, shirt and ad then turned R44 to his right to incontinent pad off complete oplied cream, removed left ed another glove on that hand apply a clean pad but never m. NA-A was observed pply his pants and adjusted A observed leaving the rooming to get someone to help her his chair. On the way out NA-A ever washed hands went down ay. NA-A was observed unother room then came	21375			

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  618 EAST 17TH STREET  MINNEAPOLIS, MN 55404   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  (EACH DEFICIENCY)  PREFIX TAG  COMPLETE  TAG  PROVIDER'S PLAN OF CORRECTION COMPLETE  COMPLETE  TAG  PROVIDER'S PLAN OF CORRECTION COMPLETE  COMPLETE  DATE  21375  Continued From page 21  21375	STATEME	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAP  (X4) ID PREFIX TAG  (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  -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 was observed ploves and cleansed her hands with hand sanitizer and left the room went outside the room to the alcove re-arranged lift of the alcove re-arranged 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	00960		B. WING		04/2	4/2014	
SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   TAG   DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   DEFICIENCY   DEFICIENCY   DEFICIENCY    21375   Continued From page 21   21375    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.	NAME OF	DDOVIDED OD SLIDDLIED		DDECC CITY O	STATE ZID CODE		.,2011
XA   ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX   (EACH DEFICIENCY WINTS EE PRECEDED BY PULL TAG   TAG   CACH DEFICIENCY WINTS EE PRECEDED BY PULL TAG   CEACH DEFICIENCY WINTS EE PRECEDED BY PULL TAG   CEACH DEFICIENCY WINTS EE PRECEDED BY PULL TAG   CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE    21375   Continued From page 21   21375    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 8:53 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   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   At 8:55 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   At 8:55 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   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   At 8:55 a.m. NA-A finally removed gloves and cleansed her hands with hand sanitizer and left   At 8:55 a.m. NA-A finally removed gloves   At 8:55 a.m. NA-A finally removed gloves   At 8:5	NAME OF	PROVIDER OR SUPPLIER		, ,	•		
SUMMARY STATEMENT OF DEFICIENCIES   ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION    PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	BENEDI	CTINE HEALTH CENT	FR OF MINNEAP				
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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	21375	stand out of room of alcove re-arranged and was observed R44's room.  -At 8:42 a.m. NA-A going to R44's room bare hands lifting the it and kept it standing applied gloves never -At 8:45 to 8:49 a.m. NA-B rolling R44 si and transferred R4 (Specialized wheeld tossed them in the hand sanitizer on holocated in the room -At 8:53 a.m. NA-A shoes.  -At 8:54 a.m. NA-A cleansed her hands the room went outs grabbed a towel brite -At 8:55 to 8:59 a.m. R44 to brush his te bathroom rinsed the removed gloves ne back from bathroom she was going to coract 9:00 a.m. observed applying w/c. Then both rem NA-A to ask the regprescribed cream for the standard from the standard from the standard from the standard from well and left the room well an	came outside the room to the lifts then grabbed a Hoyer lift going down the hallway to and NA-B were both observed in. NA-A was observed with the floor mat off the floor, foldeding by the chair. NA-A then er washed hands. In observed both NA-A and de to side applied the lift sheet 4 to the broad wheelchair chair). NA-C removed gloves trash and cleansed hands with is way out using hand sanitizer to the right of the door. It was observed applying R44's finally removed gloves and swith hand sanitizer and left side the room to the alcove effly. In NA-A observed assisting eth, went back to the e basin and tooth brush then ver washed hands then came in with comb and cued R44 omb his hair. It washed hands then stated ave someone come assist her without washing hands. In both NA-A and NA-C were gloves, repositioned R44 in the loved gloves and NA-C asked gistered nurse (RN)-A for or R44's scalp for itching.				

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NAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAP  THE TO SUMMARY STATEMENT OF DEPOSITIONS OF PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SUMMARY STATEMENT OF DEPOSITION) (EACH CORRECTION AUXILIARY TAG)  BENEDICTINE HEALTH CENTER OF MINNEAP  THE TO SUMMARY STATEMENT OF DEPOSITIONS OF PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE (EACH CORRECTION COMMETTE THAN THE TOWN OR LISC IDENTIFYING INFORMATION)  THE TOWN OR LISC IDENTIFYING INFORMATION)  THE TOWN OR LISC IDENTIFYING INFORMATION)  THE TOWN OR LISC IDENTIFYING INFORMATION (EACH CORRECTION SHOULD BE COROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)  21375  2	AND DUAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER  BENEDICTINE HEALTH CENTER OF MINNEAP  (A) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  CONTINUED FROM THE MEDICAL SCHOOL OF THE MEDICAL SCH			A. BUILDING:				
SUMMARY STATEMENT OF DEFICIENCIES   MINNEAPOLIS, MN 55404			00960	B. WING		04/2	24/2014
XAI   ID   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE PRETED TAGE   PRETENT TAGE   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PRETENT TAGE   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE   DEFICIENCY	NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  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 donning another pair of gloves and checking call lights when leaving cued both RN-A and NA-A to wash hands before leaving the roomAt 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.	BENEDI	CTINE HEALTH CENT	I ER OE MINNEAP				
-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 byAt 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 roomAt 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.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
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	21375	-At 9:07 a.m. NA-A observed donning a RN-A came to R44 applying cream to III. At 9:08 a.m. DON checking call lights and NA-A to wash III. At 9:11 a.m. both III. Temoving gloves ar sanitizer in the roor. When interviewed a was supposed to w cares, leaving room NA further stated "III. When interviewed a NA's are supposed policy and indicated facility policy exactl. When interviewed a stated her expectate washed hands upo entering, leaving the pericare.  When interviewed director of nursing supposed to follow CDC guidelines and during cares, after after cares.  The facility Handward directed "Procedure cross-contaminatio changing gloves after after cares.	a came back to room and was another pair of gloves and 's room and was observed R44's scalp as NA-A stood by. came to room observed when leaving cued both RN-A hands before leaving the room. NA-A and RN-A were observed and cleansed hands with hand m.  at 9:15 a.m. NA stated she wash her hands before starting and after removing gloves. I forgot."  at 9:17 a.m. RN-B stated the It to follow the hand hygiene dhe was going to find what the Ity directed.  on 4/24/14, at 11:18 a.m. RN-A tion was NA should have an removing gloves, before the room and after doing  on 4/24/14, at 12:41 p.m. the stated all the staff are hand washing procedure per diare supposed to wash hands removing gloves, before and ashing policy dated 6/2002, es must be followed to prevent on, including handwashing or iter providing personal care, or iter providing personal care, or				

Minnesota Department of Health

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
	00960		B. WING		04/2	24/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0-1/2	1,2014
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP 618 EAST	17TH STRE	ET		
BENEDI	T	MINNEAP	OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	Continued From pa	ge 23	21375			
	occur. The facility for Handwashing"	ollows the CDC's Guideline for				
		gar monitors were not cleaned ent cross-contamination				
	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.					
	RN-L was observed and then placed the pocket. RN-L took ther pocket and with entered R 53's roor sugar. RN-L placed in her pocket. RN-L and used a Sani-wistated she used Sa	s on 4/23/14, at 7:39 a.m. d checking R97 's blood sugar e blood sugar monitor in her the blood sugar monitor out of nout sanitizing the monitor she m and checked R53's blood the blood sugar monitor back returned to the treatment cart pe to clean the monitor. RN-L ni-wipes when she was done od sugar checks or at the end torking night shift.				
	stated she expecte	on 4/24/14, at 2:25 p.m. RN-I d blood sugar monitors to be ach patient with bleach wipes				

AND DIAN OF CODDECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
		00960	B. WING		04/2	4/2014				
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
BENEDI	CTINE HEALTH CENT	LER OF MINNEAR	T 17TH STRE POLIS, MN 5							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE				
21375	Continued From pa	age 24	21375							
	(Sani-wipes).									
	Disinfection policy glucose meter will lafter each use. The alcohol prep pads the blood glucose meters.	Glucose Meters Use and (undated), directed the blood be cleaned and disinfected e policy directed to use the to cleanse the outside of the er and place on a new paper use a disinfectant wipe when n.								
	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.									
	of use and cleaning glucose meter (BG 5/10.  "1. With gloved hat cleanse the outside not to get liquid in the ports of the meter. paper towel.  2. Remove all suppreceptacles by gloven.	are The Return demonstration g/disinfecting of a blood alm) indicated (after use) dated ands, use alcohol pad to be of meter. Take extreme care also the test strip and key code allowed Place clean meter on a new allowed blies into appropriate ving disposable non-sharp atain small traces of blood into								

Minnesc	<u>ita Department of He</u>	<u>ealth</u>					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPL		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION N	UMBER:	A. BUILDING:		COMP	LETED
	00960		B. WING		04/24/2014		
		00300				04/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			618 EAST	17TH STRE	ET		
BENEDIO	CTINE HEALTH CENT	ER OF MINNEAP		OLIS, MN 5			
0/0.15	CLIMMA DV CTA	ATEMENT OF DEFICIENCE		1		ON	()(5)
(X4) ID PREFIX		ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORM		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
24275	Cantinuad Framana	OF		21375			
21373	Continued From pa	age 25		21373			
	the garbage						
	3. Wash hands						
		cose meter (done at	cart)				
		e outside cart for dis					
		on paper towel barr					
		Disinfect is toxic w					
		he skin, always wea					
		ant cloth from locke					
	medication cart.		<del>-</del>				
		outside of the meter	with this				
	-	e surface is wet with					
	disinfectant.	o di ida i i i i i i i i i i i i i i i i					
		round the meter to	maintain				
	surface wetness fo		mannann				
		(swell time) remove	d the				
		nd discard to the tra					
	to air dry.	na alcoara to the tra	511. 7 til <b>5 ti</b>				
		eter is now disinfec	ted and				
		use on another res					
	loady to otoro or to	doo on another rec	idorit.				
	The Blood Glucose	Meters Use and Di	sinfection				
	policy dated May 4/						
		ds, use alcohol pad	to cleanse				
		er. Take extreme car					
		t strip and key code					
	the meter. Place cle						
	towel.	can motor on a new	paper				
	- Remove all suppli	ies into annronriate					
	receptacles by glov		sharn				
		tain small traces of					
	the garbage	tain sinai traces or	biood into				
	- Wash hands						
		cose meter (done at	cart)				
	- Take meter to the						
		on paper towel barrie					
		Disinfect is toxic wh					
		the skin, always wea					
	_	ne skin, always wea	-				
		in dom nom locked	I				
	medication cart.	staida of the meter:	with this				
	- wipe down the ot	utside of the meter v	vitri triiS				

STATE FORM 6899 If continuation sheet 26 of 66 5J6511

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED	
			A. BUILDING.			
		00960	B. WING		04/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAR	17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21375	disinfectant.  - Wrap the cloth are surface wetness for a feer 2 minutes (so disinfectant wipe are to air dry.  - Blood glucose me ready to store or to stor	e surface is wet with  ound the meter to maintain r 2 minutes. well time) removed the nd discard to the trash. Allow eter is now disinfected and use on another resident. "  as were stored in the third floor efrigerator with ice cream and the blue ice packs ne freezer with ice cream and the blue ice packs were used parts and verified the findings.  THOD OF CORRECTION: sing or her designee could mplement policies and ction control measures for dwashing and appropriate s for multiple patient use ent cross contamination.  Sing or her designee could oppropriate staff for adherence	21375			
21426	(21) days.  MN St. Statute 144  Prevention And Co.	A.04 Subd. 4 Tuberculosis ntrol	21426			6/7/14
	(a) A nursing home	e provider must establish and				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			CD.	IPLE CONSTRUCTION NG:		E SURVEY PLETED
		00960	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER	FR OF MINNFAP	TREET ADDRESS, CIT 18 EAST 17TH ST IINNEAPOLIS, MN	REET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
21426	infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu- Health shall provide regarding implement	nensive tuberculosis ogram according to the sinfection control guided States Centers for Dition (CDC), Division of lation, as published in Cality Weekly Report (Minclude a tuberculosis in that covers all paid a contractors, students, inteers. The Department etechnical assistance intation of the guidelines ance with this subdivision.	elines sease CDC's MWR). and t of			
	by: Based on interview facility failed to ens screening was comdirect resident care reviewed for health Findings include: Review of licensed personnel record retained the Tuberculosis F (HCW)/Volunteer with the tuberculin skin to chest x-ray was conindicated LPN-A ha and influenza like s	and document review, ure Tuberculosis (TB) plete prior to provision, for 3 of 5 employees care worker TB screening practical nurse (LPN)-A evealed a hire date of 1 form for Healthcare Worms completed on 1/10/2 est (TST) section left with the productive of the prod	the of ings. A's /10/14. rkers 14, with oid. A ich cough The	-		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
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		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAP	17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	Continued From pa	ige 28	21426			
21420	disease was presel lacked documentat rule out a diagnosis Review of LPN-D's hire date of 3/25/14 Healthcare Worker 3/31/14, indicated L United States and Freaction to TST. TI x-ray was noted as result. The form no BCG vaccine (bacil for tuberculosis). L lacked documentat rule out a diagnosis	nt. LPN-A's personnel file ion of a medical evaluation to s of infectious TB disease.  personnel record revealed a late. The Tuberculosis Form for s (HCW)/Volunteer dated LPN-D was born outside the nad a history of a positive ne date of LPN-D's last chest 1/29/10, with a negative of the LPN-D had received the le Calmette-Guerin-a vaccine LPN-D's personnel record ion of a medical evaluation to s of infectious TB disease.	21720			
	record revealed a harderculosis Form (HCW)/Volunteer dand Mantoux [TST] con TST section of the was reviewed and substitution "Negative." NA-A's complete document and measurement when interviewed director of nursing understand the meregulation." DON in Department of Healith had been explained for the staff that had and flu-like symptomicorrect, but rather substitutions.	fire date of 2/19/14. The for Healthcare Workers ated 2/20/14, noted, "Date of version 10/04/13 (-)." The form was left void. The form signed, noting the results were personnel file lacked tation of two-step skin testing of induration.  on 4/24/14, at 12:41 p.m. the (DON) stated, "I did not fully dical exam component of the indicated she had called the lith educator that morning and ed to her. DON further stated d a chest x-ray with the cough ms, the indication was not should have been due to a eTST or something close in				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY	
			A. BUILDING:			
		00960	B. WING		04/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	ER OF MINNEAP	17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	The facility's Tubers revised 2/13, direct previous positive Tous documentation of the performed at any time evaluation of the performed a creation of the performed at the evaluation to a chest care to residents.  SUGGESTED METOURISHED METOURISHED AND TOURISHED	culosis Control Plan policy red, "Employees with a ST reaction need to provide the negative chest x-ray me during or since the initial positive TST and complete a TB. The policy lacked direction sination to be completed in x-ray, prior to providing direct.  THOD OF CORRECTION: The could inservice all staff on the most current standards in regards to TB control. If procedures related to TB and revised if necessary. An and revised if necessary. An and the developed, with review the sement and assurance re ongoing compliance.  R CORRECTION: Twenty One	21426			
21530	A. The drug regim reviewed at least mourrently licensed by This review must by Appendix N of the Surveyor Procedure Requirements in Lotthe Department of Health Care Finance This standard is in available through the system. It is not su	o A.B.C Drug Regimen Review then of each resident must be nonthly by a pharmacist by the Board of Pharmacy. The done in accordance with state Operations Manual, the est for Pharmaceutical Service tong-Term Care, published by Health and Human Services, being Administration, April 1992. The Corporated by reference. It is the Minitex interlibrary loan subject to frequent change.	21530			6/7/14

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	irregularities to the and the attending p must be acted upon physician visit, or supharmacist. For puupon" means the arreport and the signiof nursing services  C. If the attend with the pharmacist not provide adequal pharmacist believes being adversely afferefer the matter to the if the medical direct physician. If the medical direct physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter to must refer the matter to assessment and as by part 4658.0070. The medical direct must refer the matter to assessment and as by part 4658.0070. The medical direct must refer the matter to assessment and as by part 4658.0070. The medical direct must refer the matter to assessment and as by part 4658.0070. The medical direct must refer the matter to assessment and as by part 4658.0070. The medical direct must refer the matter to assessment and as by part 4658.0070. The medical direct must refer the matter to assess ment and as by part 4658.0070. The medical direct must refer the matter to assess ment and as by part 4658.0070. The medical direct must refer the matter to assess ment and as by part 4658.0070. The medical direct must refer the matter to assess ment and as by part 4658.0070. The medical direct must refer the matter to assess ment and as by part 4658.0070. The medical direct must refer the matter to assess ment and as by part 4658.0070. The medical direct must refer the matter to assess ment and as by part 4658.0070.	director of nursing services hysician, and these reports in by the time of the next coner, if indicated by the arposes of this part, "acted acceptance or rejection of the ing or initialing by the director and the attending physician. ing physician does not concur it's recommendation, or does the justification, and the is the resident's quality of life is ected, the pharmacist must the medical director for review tor is not the attending edical director determines that cian does not have adequate order and if the attending change the order, the matter is review to the quality esurance committee required. If the attending physician is or, the consulting pharmacist er directly to the quality esurance committee.  The consulting pharmacist er directly to the quality esurance committee.  The consulting pharmacist er directly to the quality esurance committee.  The consulting pharmacist er directly to the quality esurance committee.  The consulting pharmacist er directly to the quality esurance committee.  The consulting pharmacist er directly to the quality esurance committee.	21530			

Minnesota Department of Health

A. BUILDING:	
00960 B. WING 04/24/	/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDICTINE HEALTH CENTER OF MINNEAP 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 a behavior of swearing at staff. The Psychotropic Medication is use and lacked	

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	4/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE				
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21530	Continued From pa	ge 32	21530				
	contraindication for	one.					
	1/6/14, identified Remedications, the relowest effective dos to objectively docur.  Review of the medi 2/19/14, and nurse 4/23/14, indicated pfollowed by the psy.  The quarterly Minin 3/24/14, included a Status (BIMS) scorrevealed delusions concerns did not of A progress note data	num Data Set (MDS) dated Brief Interview of Mental e of 15 (cognitively intact) and hallucinations and behavioral ccur. ted 3/28/14, written by the					
	negative comments  The Medication Ada	ker indicated R40 exhibited sover the past quarter. ministration History dated					
	milligrams (mg) twi	l/14, included Saphris 10 ce daily, Lithium 900 mg at xa 5 mg every evening and 30					
	for R40 indicated a and included diagno	ssion Record dated 4/24/14, n admission date of 6/19/10, oses of paranoid lar disorder, and anxiety.					
	registered nurse (R sheets to monitor to behavior document progress notes or in	on 4/24/14, at 1:24 p.m.  N)-M stated there are no flow arget behaviors and any ation would be done in the the weekly charting. RN-M charting are not specific to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	FR OF MINNEAP 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	each resident and a Nursing assistant (I 4/24/14, at 1:32 p.m of care terminal, stabehavior document  The nurse manager 4/24/14, at 1:55 p.m documented in the summary and specidentified. RN-I stateducation provide behaviors to look for pharmacist recomm when a GDR was not locate a GDR requestinical contraindical. When interviewed a director of nursing (not monitor target be antipsychotic use a used to monitor resultant phate 4/24/14, at 2:58 p.m psychiatrist to monital as they are the expestated she only expif there were behave.  R28's specific behate effects were not being on the consultant phate 4/23/14, at 7:55 his wheelchair (w/c) observed to be calmonitor to the consultant phate 4/23/14, at 7:55 his wheelchair (w/c) observed to be calmonitor to the calmonitor target behate the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the consultant phate 4/24/14, at 2:58 p.m psychiatrist to monital the	are general to all residents.  NA)-G was interviewed on an and after reviewing the point ated there was no required ation for R40.  TRN-I was interviewed on an and stated behavior is progress notes and weekly iffic target behaviors are not ated staff training and clues" as to what target or. RN-I stated the consultant and ations are used to identify eeded and she was unable to est or documentation of a ation for R40.  TON) stated the facility did behaviors daily with and the weekly charting was idents.  Tracist was interviewed on an and stated she expected the tor antipsychotic medications ert. The consultant pharmacist ected antipsychotic monitoring iors.	21530			

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BENEDI	CTINE HEALTH CENT	ER OF MINNEAP	17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21530	On 4/23/14, at 8:38 observed sitting at eating his breakfas conversing to staff -At 9:18 a.m. R28 whimself down the h -At 9:19 a.m. observed the common areaAt 9:20 a.m. observed to back to his room structure back to his room sit the door.  On 4/23/14, at 9:38 sitting at the DR tall therapeutic recreat newspaper as R28 -At 9:48 observed bactivity propelled selevator when asked R28 stated "I like to hang around."  The care plan date diagnosed with deproblems. R28's ar plan dated 4/6/12, medication related striking out at staff,	s a.m. to 9:11 a.m. R28 was the dining room (DR) table to observed to be calm and during the meal. was observed propelling allway to his room eved a staff wheeling R28 to eved R28 wheeling himself ated he was going to the eved the call light in room on sitting on his w/c outside the the hallway. Eved a staff nursing assistant shut the door. Eved NA-C coming out of room observed watching television ting on his w/c calmly facing  a to 9:47 a.m. observed R28 ole area calmly listening as the ion staff was reading the	21530			

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BENEDI	CTINE HEALTH CENT	ER OF MINNEAP	17TH STRE OLIS, MN 5			
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21530	Continued From pa	ige 35	21530			
	quantitatively and o	R28's behaviors and objectively document R28's plan directed to document indicated.				
	7/11/13, identified F depression and Psy and anxiety. The Copresented with symwould be physically at times. In addition required use of meaning the control direct	medication CAA dated R28 had diagnoses of ychosis as well as agitation AA indicated R28 often aptoms of tearfulness and and verbally abusive to staff in, the CAA indicated R28 dication to keep his symptoms ted nursing staff to continue to e side effects of medications.				
	Review dated 8/7/1	ty CP Medication Regimen 3 through 4/15/14, revealed ecific behavior monitoring had as lacking.				
	(MARs) and Treatm (TARs) dated 4/1/1- no monitoring of be being monitored da	ication Administration Record nent Administration Record 4, through 4/24/14, revealed chavior and side effects were ally for both anti-depressant bic medications R28 was				
	psychosis/agitation encephalopathy da quarterly MDS date indicated R28 recei anti-depressant me behavioral symptom verbal symptoms d hitting and kicking a	cluded dementia, unspecified, anxiety, depression and mage obtained from the ed 4/8/14. In addition, the MDS ived anti-psychotic and edications. R28 exhibited ms which included physical and irected towards other such as among others.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER	FR OF MINNEAP	ADDRESS, CITY, S ST 17TH STRE APOLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21530	once a day for deprantipsychotic medic day with "Special In any agitation occurs"  During further docubehavior charting we Progress Notes datit happened and in using the facility gesheets dated 1/4/14 we checking off the but the sheets lacked specific behaviors a used.  When interviewed continued the stated R28 did not 1 monitored daily but behavior in the progress on 4/23/14, at 8:12 continuously morning observed to be called thanking NA-A and where was and where was and where was and where the state of th	ved Lexapro 10 mg orally ression and Risperdal (an cation) 3 mg oral three times estructions: Please call MD if s."  ment review it was revealed ras being completed in the red 9/5/13, through 4/24/14, a also one to two times weekly nerated "Behavior/Mood" 4, through 4/18/14, which staff behaviors, interventions listered R28's individualized and interventions that were con 4/23/14, at 1:17 p.m. RN-N have specific behaviors to be the nurses would complete gress notes.  Inviors and side effects were do a.m. to 9:11 a.m. during a grange observation R44 was n, pleasant, cooperative, asking NA-A same question en "Mom" was coming.  O a.m. observed R44 sitting a specialized wheelchair) at e area. R44 was observed to ff looking around and was	s f ed			
	potential for alteration	ed 9/17/12, indicated he had on in cognition due to use of ation. The goal for R44 was adverse effects from				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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21530	psychotropic medic staff to administer remonitor medication associated behavior. The CAA dated 7/2 psychotropic medic increased risk for famonitor for side efformation of the CP Mated 9/12/13, throeffects and specific been identified as larecord.  R44's diagnoses in disorder, diabetes record.  R44's diagnoses in disorder, diabetes record.  R44's diagnoses in disorder, diabetes record.  R44's Physician Or indicated from the CI naddition, the MD anti-psychotic and a R44's Physician Or indicated R44 receivantipsychotic medic twice daily, Trazodo for depression and PO once daily for depression and PO once daily for depression indicated to record Family behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behaviors indicated to record Family TAR lacked information associated behavior and the record Family TAR lacked information associated behavior and the record Family TAR lacked information associated behavior and the record Family TAR lacked information associated behavior and the record Family TAR lacked information associated behavior and the record Family TAR lacked information associated	cations." Care plan directed medications as ordered, s administration and any pers of side effects.  9/13, indicated R44 was on cations which did put him at alls and directed staff to ects of medications.  Medication Regimen Review ugh 4/2/14, revealed side is behavior monitoring had not acking in R44's medical  cluded dementia, psychotic mellitus, cerebrovascular miplegia and seizure disorder quarterly MDS dated 1/21/14. S indicated R44 was receiving anti-depressant medications.  der Report dated 3/26/14, ived Seroquel (an cation) 25 mg by mouth (PO) one 25 mg PO every bedtime insomnia and Zoloft 50 mg epression.  timent Administration Record, through 4/24/14, revealed the cated in the TAR were as and meals and staff were R44's food intake percentage. ormation on the side effects esants and anti-psychotropic	21530			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21530	behavior charting we two times weekly us "Behavior/Mood" sh 4/19/14, with staff of interventions listed comments/descript specific behaviors a for R44.  When interviewed of director of social sereceived any anti-pstaff would docume them. Surveyor ask exception the direct "Yes." She further she behavior charting the residents using the charting.  When interviewed of stated "Normally we effects to monitor if effects we would we nurse practitioner keep to salso the nurse protocol is to use we assessment for mo RN-A further stated the staff would be a resident and would happened. RN-A in Abnormal Involunta anti-psychotropic mevery six months of the staff would be a revery six months of the staff would be a resident and would happened. RN-A in Abnormal Involunta anti-psychotropic mevery six months of the staff would be a revery six months of the staff would be a resident and would happened. RN-A in Abnormal Involunta anti-psychotropic mevery six months of the staff would be a reverse were six months of the staff would be a resident and would happened. RN-A in Abnormal Involunta anti-psychotropic mevery six months of the staff would be a reverse were six months of the staff would be a resident and would happened. RN-A in Abnormal Involunta anti-psychotropic mevery six months of the staff would be a reverse were six months of the staff would be a reverse were six months of the staff would be a reverse were six months of the staff would be a reverse were six months of the staff would be a staff would b	ge 38  vas being completed one to sing the facility generated neets dated 11/05/13, through thecking off the behaviors, and wrote additional ions. The sheet lacked R44's and interventions that worked on 4/23/14, at 1:23 p.m. the envices stated residents who sychotropic medication the ent the behaviors as they see ted the director you mean by tor of social service stated there was also weekly nat was completed for facility generic behavior  on 4/23/14, at 2:00 p.m. RN-B endon't have the specific side during the shift we notice side rite a progress note and let the now and then they would give on 4/25/14, at 11:27 a.m. RN-A manager, stated the facility reekly behavior nursing nitoring resident's behaviors. It because the facility is small aware of any change in a chart on it as indicated or as it dicated for the side effects the ary Movement Scale (AIMS) for redications were completed as indicated if otherwise but of side effects and behavior					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 39	21530			
	When interviewed of DON stated current being done weekly, worked closely with of the residents on regularly that monit further stated she had conference sometime when exactly offered Health and had the monitoring was to be long as the staff we concerns and done enough.  When interviewed of consultant pharmack supposed to monitor as they see them in indicated the facility monitoring such as completed every six because of the residue to the sacility psychotic in the sacility psychoti	on 4/25/14, at 12:38 a.m. the thy "Symptom" charting was DON indicated the facility clinical Psychologist for some antipsychotic medications ored residents closely. DON and listened to a phone me last year 2013, not sure to by Minnesota Department of impression "Symptom" be done on a periodic basis as the aware of the resident exact consistently it was sufficient on 4/25/14, at 3:01 p.m. the cist stated the nurses are or and document side effects on the progress note. CP or does other side effects the AIMS which was a months. CP indicated dent population diagnoses at the behavior monitoring in only as a concern or rather				
	behavior episode.					
	The director of nurs assure that policies and that staff training assure each reside monitored and that unnecessary drugs developed to monit involvement of the pharmacist, to ensure	THOD OF CORRECTION: sing and or designee could and procedures are updated ing has been completed to ent's drug regimen is residents are not taking. An auditing tool could be or compliance, with facility's consultant ure ongoing compliance.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/	24/2014
	PROVIDER OR SUPPLIER	FR OF MINNEAP 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21530	Continued From pa	ge 40	21530			
21540	Subp. 2. Monitoring monitor each reside unnecessary drug thome's policies and pharmacist must reresident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, the change the order, the attending physician does not the attending physician does not the order and if the change the order, the change the order, the attending physician does not the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the order of the order or the order of the order or the o	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the earl director for review if the not the attending physician. If it determines that the attending have adequate justification for attending physician does not the matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter ent is not met as evidenced on, interview and document ailed to ensure resident avior and side effects elemented with antipsychotic ents (R28, R40, R44) reviewed edications. In addition, the ure a gradual dose reduction	21540			6/7/14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	24/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	FR OF MINNEAP	T 17TH STRE POLIS, MN 5			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
21540	(GDR) was attempt contraindication waresidents (R40) who antipsychotic medic Findings include: R40 was not monitor target behaviors for and Saphris (antipsychotic medic for continuous documented.  On 4/23/14, at 7:22 awake and sitting in radio on. At 7:51 a. the day room are an with the staff. At 7: telling the nurse that pill " until after church with the staff. At 7: telling the nurse that pill " until after church documented.  The Medication Rethrough 4/15/14, was clinical indication for antipsychotics was time.  The psychiatrist not 1/16/14, and 4/18/1 why a GDR was con R40 was " at basel Review of the medicidentified target befor R40. Review of from 1/1/14 through the frequency of an The Psychosocial Was and the proposed and the psychosocial Was and the p	red or the clinical s documented for 1 of 5 or received multiple cations.  Fored for resident-specific the use of Lithium, Zyprexally chotic medications) and didempted or the clinical using the medications  a.m. R40 was observed a chair in his room with the m. R40 was observed sitting in a was interacting pleasantly 53 a.m. R40 was observed at he did not want his "water rich.  Igimen Review from 5/1/13 as reviewed and a GDR or or continued use of not recommended during that the dated 7/16/13, 10/15/13, 4, lacked documentation as to intraindicated and indicated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00960			04/2	4/2014
	PROVIDER OR SUPPLIER	FR OF MINNFAP 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21540	behavior of swearin Medication Use CA current medications documentation regard contraindication for The psychotropic danalizations, the relowest effective dos to objectively documentations, the relowest effective dos to objectively documentations, the relowest effective dos to objectively documentations of the medical properties	ag at staff. The Psychotropic A dated 1/3/14, indicated in use and lacked arding a GDR or a clinical one.  Trug use care plan dated 40 was receiving antipsychotic sident will be prescribed the se of medication and directed ment the resident's behavior.  Cal doctor progress note dated practitioner and behavioral e of 15 (cognitively intact) and hallucinations and behavioral ccur.  Sted 3/28/14, written by the ker indicated R40 exhibited a over the past quarter.  In ministration History dated with a find the country of the past quarter.  In ministration History dated with a find the country of the past quarter.  In ministration History dated with a find the country of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter.  In ministration History dated with a find part of the past quarter with a find part of the past quarter.	21540			

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAP	17TH STRE Polis, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	sheets to monitor to behavior document progress notes or inverified the weekly each resident and a Nursing assistant (14/24/14, at 1:32 p.m of care terminal, stabehavior document. The nurse manage 4/24/14, at 1:55 p.m documented in the summary and specidentified. RN-I stateducation provide behaviors to look for pharmacist recommender a GDR was relocate a GDR required clinical contraindical when interviewed director of nursing not monitor target to antipsychotic use a used to monitor residentified. The consultant phate 4/24/14, at 2:58 p.m psychiatrist to monias they are the experiments.	arget behaviors and any tation would be done in the in the weekly charting. RN-M charting are not specific to are general to all residents.  NA)-G was interviewed on in. and after reviewing the point atted there was no required tation for R40.  It, RN-I was interviewed on in. and stated behavior is progress notes and weekly diffic target behaviors are not inted staff training and inclues" as to what target for. RN-I stated the consultant intendations are used to identify intended and she was unable to est or documentation of a action for R40.  In A/24/14, at 2:49 p.m. the (DON) stated the facility did dehaviors daily with and the weekly charting was sidents.  In and stated she expected the itor antipsychotic medications is estered antipsychotic monitoring decreed antipsychotic monitoring				
	Jares, Magdalene R28's specific beha	aviors and potential side				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	4/2014
	PROVIDER OR SUPPLIER	FR OF MINNFAP 618 EAST	DRESS, CITY, S 17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	effects were not be On 4/23/14, at 7:55 his wheelchair (w/c) observed to be calr past other residents dining room (DR).  On 4/23/14, at 8:38 observed sitting at eating his breakfast conversing to staff -At 9:18 a.m. R28 w himself down the ha- At 9:19 a.m. obser the common areaAt 9:20 a.m. obser back to his room st bathroomAt 9:22 a.m. obser R28 was observed door looking down to -At 9:23 a.m. obser going to room and se -At 9:26 a.m. obser door and R28 was of (TV) in his room sit the door.  On 4/23/14, at 9:38 sitting at the DR tak therapeutic recreati newspaper as R28 -At 9:48 observed F activity propelled se -At 9:53 a.m. surve elevator when aske	ing monitored.  a.m. R28 observed propelling of down the hallway. R28 in and pleasant as he went is and staff before getting to the stand during room (DR) table to observed to be calm and during the meal. It was observed propelling allway to his room oved a staff wheeling R28 to oved R28 wheeling himself atted he was going to the staff on his w/c outside the the hallway. It was a staff nursing assistant shut the door. It was not staff on his w/c calmly facing to 9:47 a.m. observed R28 ole area calmly listening as the on staff was reading the	21540			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	The care plan dated diagnosed with dep problems. R28's ar plan dated 4/6/12, i medication related striking out at staff, and lack of impulsed directed to monitor quantitatively and obehavior. The care behavior/mood as in R28's psychotropic 7/11/13, identified F depression and Psy and anxiety. The Copresented with symwould be physically at times. In addition required use of me under control direct observe for adversor Review of the facility Review dated 8/7/1 side effects and spot been identified. Review of the Medi (MARs) and Treatm (TARs) dated 4/1/1 no monitoring of being monitored date and anti-psychotropical daily.	d 3/13/12, identified R28 was pression due to multiple atipsychotic medication care indicated R28 received to agitation as evidenced by swearing, verbally abusive a control. The care plan R28's behaviors and objectively document R28's plan directed to document indicated.  medication CAA dated R28 had diagnoses of ychosis as well as agitation AA indicated R28 often aptoms of tearfulness and a rand verbally abusive to staff in, the CAA indicated R28 dication to keep his symptoms ted nursing staff to continue to be side effects of medications.  ty CP Medication Regimen 3 through 4/15/14, revealed ecific behavior monitoring had	21540			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	4/2014
	PROVIDER OR SUPPLIER	FR OF MINNFAP 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21540	indicated R28 recei anti-depressant me behavioral symptoms of hitting and kicking a R28's Physician Or indicated R28 recei once a day for deprantipsychotic medic day with "Special In any agitation occurs. During further docubehavior charting we Progress Notes dat it happened and in using the facility ge sheets dated 1/4/14 we checking off the but the sheets lack specific behaviors a used.  When interviewed of stated R28 did not monitored daily but behavior in the progress on 4/23/14, at 8:12 continuously morning observed to be call thanking NA-A and where was and whe	ved anti-psychotic and dications. R28 exhibited as which included physical and irected towards other such as among others.  der Report dated 4/8/14, ved Lexapro 10 mg orally ression and Risperdal (an cation) 3 mg oral three times a structions: Please call MD if s."  ment review it was revealed as being completed in the red 9/5/13, through 4/24/14, as also one to two times weekly merated "Behavior/Mood" at through 4/18/14, which staff behaviors, interventions listed and interventions that were on 4/23/14, at 1:17 p.m. RN-N have specific behaviors to be the nurses would complete gress notes.	21540			
	on his broad chair (	a specialized wheelchair) at e area. R44 was observed to				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	24/2014	
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	FR OF MINNEAP	DDRESS, CITY, S T 17TH STRE POLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21540	be dosing on and o calm no behavior of R44's care plan dat potential for alterating psychotropic medic R44 "Will not have psychotropic medic staff to administer in monitor medication associated behavior.  The CAA dated 7/2 psychotropic medic increased risk for famonitor for side effect where the CP Mated 9/12/13, through the cord.  R44's diagnoses indisorder, diabetes in accident (CVA), here obtained from the plan addition, the MDS anti-psychotic and a R44's Physician Ornindicated R44 receing antipsychotic medic twice daily, Trazodo for depression and PO once daily for device work the Treat (TAR) dated 4/1/14	ff looking around and was bserved.  ed 9/17/12, indicated he had on in cognition due to use of ation. The goal for R44 was adverse effects from ations." Care plan directed nedications as ordered, and any rest of side effects.  9/13, indicated R44 was on ations which did put him at alls and directed staff to ects of medications.  Medication Regimen Review ugh 4/2/14, revealed side behavior monitoring had not acking in R44's medical  cluded dementia, psychotic mellitus, cerebrovascular miplegia and seizure disorder quarterly MDS dated 1/21/14. Sindicated R44 was receiving anti-depressant medications.  der Report dated 3/26/14, ved Seroquel (an cation) 25 mg by mouth (PO) one 25 mg PO every bedtime insomnia and Zoloft 50 mg	21540				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00960	B. WING		04/2	24/2014
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR OF MINNEAP	DRESS, CITY, S T 17TH STRE POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	refusing medication directed to record F The TAR lacked inf for both anti-depres medications R44 w  During further docubehavior charting with two times weekly us "Behavior/Mood" shad 19/14, with staff comments/descript specific behaviors afor R44.  When interviewed director of social sereceived any anti-pastaff would docume them. Surveyor ask exception the direct "Yes." She further she behavior charting the charting.	as and meals and staff were at 44's food intake percentage. Formation on the side effects sants and anti-psychotropic as taking daily.  In ment review was revealed as being completed one to sing the facility generated neets dated 11/05/13, through thecking off the behaviors, and wrote additional ions. The sheet lacked R44's and interventions that worked on 4/23/14, at 1:23 p.m. the envices stated residents who sychotropic medication the ent the behaviors as they see the director you mean by tor of social service stated there was also weekly nat was completed for facility generic behavior	21540			
	stated "Normally we effects to monitor if effects we would w	on 4/23/14, at 2:00 p.m. RN-Be don't have the specific side during the shift we notice side rite a progress note and let the now and then they would give				
	was also the nurse protocol is to use w assessment for mo RN-A further stated	on 4/25/14, at 11:27 a.m. RN-A manager, stated the facility eekly behavior nursing nitoring resident's behaviors. because the facility is small laware of any change in a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00960	B. WING		04/2	24/2014
	PROVIDER OR SUPPLIER	FR OF MINNEAP 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21540	resident and would happened. RN-A ind Abnormal Involunta anti-psychotropic mevery six months or no daily monitoring was being documen.  When interviewed of DON stated current being done weekly, worked closely with of the residents on regularly that monit further stated she had conference sometimed when exactly offered Health and had the monitoring was to blong as the staff we concerns and done enough.  When interviewed of consultant pharmace supposed to monitoring as they see them in indicated the facility monitoring such as completed every six because of the resist the facility psychotic done when there we behavior episode.  SUGGESTED MET The director of nurse and that staff training and the staff training and that staff training and that staff training and that staff training and the staff training and that staff training and the staff training and trai	chart on it as indicated or as it dicated for the side effects the ry Movement Scale (AIMS) for redications were completed as indicated if otherwise but of side effects and behavior need only as it happened.  On 4/25/14, at 12:38 a.m. the rely "Symptom" charting was DON indicated the facility clinical Psychologist for some antipsychotic medications ored residents closely. DON red listened to a phone relast year 2013, not sure done on a periodic basis as the aware of the resident exact consistently it was sufficient on 4/25/14, at 3:01 p.m. the resist stated the nurses are for and document side effects the AIMS which was a months. CP indicated dent population diagnoses at the behavior monitoring in only as a concern or rather.  THOD OF CORRECTION: Sing and or designee could and procedures are updated to the form of the regimen is	21540			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED	
		00960	B. WING		04/2	24/2014
	PROVIDER OR SUPPLIER	FR OF MINNFAP 618 EAST	DRESS, CITY, S 17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21540	monitored and that unnecessary drugs developed to monit	residents are not taking . An auditing tool could be	21540			
21610	and Preparation Are Subpart 1. Storage must store all drugs under proper tempe only authorized nur- access to the keys.  This MN Requireme by: Based on observati review, the facility fi were stored at the p (1st floor) medication R13 and R57 medic Findings include:  On 4/24/14, at 11:2 medication refrigeratemperature of 50 of included two unope (used to treat diabet Compro suppositor verified the findings what the safe storat was.  R13's Minimum Dat	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have  ent is not met as evidenced on, interview and document ailed to ensure medications proper temperature in 1 of 4 on refrigerators which affected cations.  O a.m. the first floor ator was observed to have a degrees. The refrigerator ned vials of Novolog insulinates) for R13 and R57 had ies (used for nausea). LPN-B and stated she was not sure ge temperature for insulinate Set (MDS) dated 3/5/14, a diagnosis of diabetes and	21610			6/7/14

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Review of the Insul dated 9/30/13; rever good until the expir between 36 and 46 for 28 days when sibetween 59 and 86  When interviewed of director of nursing medications to be rexpired and stated logs for the first flood DON stated a new purchased to replace The consultant phate 4/24/14, at 3:12 p.n. would be above ref Novolog insulin wor at that temperature The facility Storage April, 2007, directed discontinued, outdate biologicals. All such dispensing pharma The package insert Physicians Total Caread "Vials: After intemperatures below days, but should not heat or sunlight. Operefrigerated."  The package insert from JHP Pharmace 2013, informed use 30 days should be as the storage of the package insert from JHP Pharmace 2013, informed use 30 days should be as the storage of the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP Pharmace 2013, informed use 30 days should be as the package insert from JHP	in Storage Recommendations caled unopened Novolog was ation date when stored degrees and was only good tored at room temperature degrees.  On 4/24/14, at 2:49 p.m. the (DON) stated she expected emoved and discarded when there were no temperature or medication refrigerator. The refrigerator had been been centered the one on first floor.  In and stated 50 degrees rigerator temperature and all only be good for thirty days of Medications policy dated do "the facility shall not use ated, or deteriorated drugs or a drugs shall be returned to the cy or destroyed."  If for Aspart insulin from are, Inc. last revised 1/12/12, initial use a vial may be kept at v 30°C (86°F) for up to 28 of the exposed to excessive	21610			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING: COMP			SURVEY PLETED	
			A. BOILDING.	7.1. 50.125.11.10.		
		00960	B. WING		04/2	24/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAP	17TH STRE Polis, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	age 52	21610			
	potency."					
	suppositories from	t information for the Compro PD-Rx Pharmaceuticals, Inc. 10, read, "Store at 20° to 25°C				
	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 FOI (21) days.	R CORRECTION: Twenty-one				
21630	MN Rule 4658.135 Medications; Destr	0 Subp. 2 A.B. Disposition of uction	21630			6/7/14
	remaining in the nu discharge of a resid prescribed, or any discontinued perma manner recommen or the consultant pl pharmacist must fu instructions and for kept on file in the n B. Unused por drugs remaining in death or discharge were prescribed or discontinued perma	tions of controlled substances ursing home after death or dent for whom they were controlled substance anently must be destroyed in a ded by the Board of Pharmacy harmacist. The board or the urnish the necessary rms, a copy of which must be tursing home for two years. tions of other prescription the nursing home after the of the resident for whom they				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00960	B. WING	B. WING		4/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	FR OF MINNFAP 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21630	be returned to the person destruction listing the medication, prescriperson destroying the witness to the destruction listing the clinical record.  This MN Requirements by: Based on observation were reflected, R53, R57, R8.  Findings include:  During observation medication cart on tablets of Prochlorp milligrams (mg) for 11/19/13, were four verified the findings expired."  R62's Minimum Daindicated R82 had smaking skills and horse the findings of the findings expired."  R62's Minimum Daindicated R82 had smaking skills and horse the findings expired. The third floor med 4/24/14, at 10:44 at noted; a multi-use with diabetes for R53 with 3/4/14, and a multi-for tuberculosis of days after opening the findings of	charmacy according to part to 2. A notation of the ne date, quantity, name of ption number, signature of the he drugs, and signature of the ruction must be recorded on the recorded on the is not met as evidenced to 1. Interview and document ailed to ensure expired emoved for 5 of 5 residents	21630			

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00960	B. WING		04/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	FR OF MINNFΔP	T 17TH STRE POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21630	Continued From pa	ge 54	21630			
	(used to treat Asthndate of November 2 practical nurse (LPI R57's MDS dated 2 cognitively intact and During observation room and East med 11:26 a.m. the following in the following Metoprolol (uspressure for R89 will 4/17/14, and Glucate for R98 dated as expenses of the second secon	s observed. A Xopenex inhaler na) for R57 with an expiration 2013 was found. Licensed N)-B verified the findings.  2/5/14, indicated R57 was ad had a diagnosis of asthma.  of the second floor medication dication cart on 4/24/14, at wing was observed; a bottle of sed to treat high blood ith an expiration date of gen (used for low blood sugar) (pired 3/2014, with the led in black. LPN-C and RN-J				
		2/27/14, indicated R89 was ly impaired and had a c dysthymia.				
		/7/14, indicated R98 was impaired and had a diagnosis				
	The director of nurs development and in procedures to remo director of nursing of	THOD OF CORRECTION: sing or her designee could implement policies and experience medications. The property has been been property of the staff for adherence to the lures.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00960		B. WING		04/	24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAP	618 EAST	DRESS, CITY, S 17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21695	Continued From pa	ige 55		21695			
21695	Subp. 4. Houseke provide housekeep necessary to maint comfortable interior ceilings, registers, f and furnishings.  This MN Requirements: Based on observation review, the facility for the same content of th	eration, & Maintenance eping. A nursing home ing and maintenance sain a clean, orderly, and including walls, floor extremely in the property of the property o	e must services ad s, hting, enced ument ous	21695	-		6/7/14
	Findings include:						
	checked for noxiou residents R82, R45 R82's Minimum Da indicated R82 was cognitively intact. R45's MDS dated 3 continent of bladde catheterized, and w R37's MDS dated 3 always incontinent cognitively intact. R8's MDS dated 3/continent of bladde R13's MDS dated 3 continent of bladde The director of envithe pervasive noxio	5, 116, 118, and 301 whose odors which affected is, R37, R8 and R13. It a Set (MDS) dated 3/6 continent of bladder are 3/12/14, indicated R45 ir, was intermittently was cognitively intact. 3/28/14, indicated R37 of bowel and bladder are 12/14, indicated R8 war and was cognitively in a rand was cognitively ir ironmental services copus odors in the rooms and 118 were confirmed by the director of	6/14, nd was was was and was as antact. vas antact. nfirmed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	24/2014
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAP	17TH STRE OLIS, MN 5	<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21695	environmental servi aware of the urine of eliminate the odors.  SUGGESTED MET The administrator of review, and/or revise ensure resident roof clean and free of ur or designee could effect the policies and profit The administrator of monitoring systems compliance.	ices stating housekeeping was odor and was working to try to the try to try to the try to try	21695			
21710	Subp. 7. Hot water supplied to sinks ar maintained within a degrees Fahrenheit the fixtures.  This MN Requirement by: Based on observation review the facility fatemperatures for 4 R68, R28) who had had the potential to Findings include:  On 4/21/14, at 3:30	temperature. Hot water and bathing fixtures must be temperature range of 105 to 115 degrees Fahrenheit at the sent is not met as evidenced on, interview and document alled to ensure safe water of 4 residents (R40, R122, concerns of hot water. This affect all 83 residents.  p.m. R40 stated he was hands under the hot water.	21710			6/7/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	FR OF MINNEAP 618 EAST	ORESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21710	because of the high used the bathroom water gets so hot "in p.m. the water at the 127.5 degrees.  The quarterly Minim dated 3/24/14, inclued Mental Status (BIM intact), indicated Ratoileting and was inset-up.  On 4/21/14, at 3:32 room 318 was 125.  On 4/21/14, at 3:50 room water at show and at the sink in state 129.2 degrees.  On 4/21/14, at 3:56 room water at show and at the sink in state 125.9 degrees.  On 4/21/14, at 4:00 room water at the state 125.9 degrees.  On 4/21/14, at 4:00 room water at the state 125.9 degrees.  On 4/21/14, at 4:06 room 220 was 127.  On 4/21/14, at 4:13 room water at the state 125.9 degrees.	n temperature. R40 stated he multiple times per day and the t burns your skin." At 3:47 e sink in R40's room was num Data Set (MDS) for R40 ided a Brief Interview of S) score of 15 (cognitively 40 was independent with dependent with bathing after p.m. the water at the sink in 9 degrees.  p.m. the third floor shower wer head was 120.2 degrees hower room the water was p.m. the fourth floor shower wer head was 114.8 degrees hower room the water was p.m. the second floor shower hower head was 121.8 sink the water at the faucet in p.m. the water at the faucet in	21710			
	On 4/21/14, at 4:16	p.m. the administrator stated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00960	B. WING		04/2	4/2014
	PROVIDER OR SUPPLIER	FR OF MINNFAP 618 EAST	DRESS, CITY, S 17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21710	mixing valve and it hour.  On 4/21/14, at 4:30 the women's bathrodegrees.  The admission MDS indicated a BIMS so On 4/23/14, at 8:43 ambulating indepen	an had a call out to get a new should be here within the p.m. the water at the sink in som on fifth floor was 121.2  S dated 4/11/14, for R122 core of 14 (cognitively intact). a.m. R122 was observed	21710			
	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 floorAt 3:29 p.m. maintenance director came up to the floor went to R68's room with surveyor and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00960	B. WING		04/2	4/2014
	PROVIDER OR SUPPLIER  CTINE HEALTH CENT	FR OF MINNEAR 618 EAST	DRESS, CITY, S 17TH STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21710	temperature reading Maintenance directs the hot water temperature. On 4/21/14, at 3:31 R28's bathroom sing noted to be hot approximate the water temperature. It was with the maintenance of F-At 3:32 p.m. mainth would go adjust the downstairs. He furth the concern at time this would cause the R28's MDS dated 3 extensive assist from severely cognitively. On 4/21/14, at 3:36 returned to the floor valve and had made to come out to check and had made to come out to check stated "It's not safe will check later to make the maintenance of the make gone down as the mixing valve and the mixing valve	g was 127 Fahrenheit (°F). or stated he was not aware of s.  p.m. during room observation k water temperature was roximately ten seconds after During observation surveyor enance director who checked ure which was recording 123 enance director stated he temperature valve her stated, "I was not aware of s the valve would be filled and e temperature to go up."  6/31/14, revealed R28 received m staff for cares and was impaired.  p.m. maintenance director r stated he had adjusted the e a call out to have someone ok the concern. He further when it creeps up like that. I hake sure the temperatures it took time."  p.m. Hot water temps 127 to renheit were noted on the 4th he director of maintenance lowered the temperature at d called the mechanical the valve that afternoon. On the mechanical engineer	21710			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00960	B. WING		04/24/2014		
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 04/2	4/2014	
	618 FAST	17TH STRE				
BENEDICTINE HEALTH CENTE	MINNEAP MINNEAP	OLIS, MN 5	5404			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
sampling at the reside temperatures were in acceptable range at the water temperature 4/18/14, indicated 77 that spanned 126 day of popped safety religible three days a notation documented. It was water temperatures record Fahrenheit. On 4/21/2 the maintenance log revealed water temperature hot enough and October of water temperature hot enough and October of water temperatures degrees Fahrenheit. Was completed 3/14/2 degrees Fahrenheit. Was completed 3/14/2 degrees Fahrenheit. The incident and acception of water temperatures to the serious water temperatures water temperat	d of water temperature dent rooms to verify water maintained within the the patient room. A review of re log from 12/13/14 to 7 entries were made in a log ays. On four days a notation it valves was document; on n of flame failure was noted that dometic / hot had recorded of 120 to 134, and Boiler/supply had water ded of 176 to 204 degrees /14, at 5:00 p.m. a review of as for water temperatures beratures were recorded at ween 124 and 130 degrees by to keep the water ough at the patient rooms.  Iterly safety checks in April, 2013, indicated all room were recorded at < 120. Last quarterly safety check /14, indicated 108 to 115.  Cidents reports were reviewed the from 4/21/14, and no 1. It could not be determined if ported the hot water facility.  If the facility was conducted a maintenance director and aperatures were recorded in grees Fahrenheit, room 202 renheit, and room 121 at 108	21710				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00960	B. WING		04/24/2014	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0412	.4/2014
BENEDIO	CTINE HEALTH CENT	ER OE MINNEAP⊨	17TH STRE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21710	SUGGESTED MET facility maintenance and/or a designee of procedures related temperatures for remaintenance employed mew policies and prosystem could be imple the facility's quality committee to ensure safe water temperature.  TIME PERIOD FOR days.	HOD OF CORRECTION: The e supervisor, administrator could develop policies and to management of safe water sident accessible fixtures. Expenses could be educated on occedures. A monitoring plemented and reviewed by assessment and assurance e ongoing compliance with tures.  R CORRECTION: Seven (7)	21710			6/7/14
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						

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  (X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00960	B. WING		04/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	FR OF MINNEAP	17TH STRE Polis, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	the written stateme to patients, residen chosen representat to the administrator person, consistent Practices Act, and s vulnerable adults.	ties, and further explanation of ent of rights shall be available ats, their guardians or their tives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to	21800			
	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.			-		
	currently resided at Medicare Provider skilled services wor facility provided the Advanced Beneficia 3/28/14, which was	to the facility on 3/24/14, and the facility. A Notice of Non-Coverage indicated R37's uld end effective 3/29/14. The e Skilled Nursing Facility ary Notice (SNFABN) on a less than forty eight hours killed services would be				
	note: resident record on-going Medicare receive last dose of Condition has been	ed 3/28/14, indicated "Medicare rd reviewed to determine coverage. Resident will f abx [antibiotic] on 3-29-2014. In stable since hospital return. Stice will be issued with last day 3-29-14."				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00960	B. WING		04/2	24/2014
	PROVIDER OR SUPPLIER	ER OF MINNEAR 618 EAST	DRESS, CITY, S 17TH STRE OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21800	On 4/22/14, at 2:54 registered nurse acheen given a 48 horegulation and furth can do a notification compliance."  On 4/23/14, at 10:3 stated the facility diprovided a facility gof Medicare/Medica which indicated if the ligibility criteria had issue a denial notice on the time frame the provided  When interviewed director of nursing a should have been gof or the denial notice.  SUGGESTED MET administrator or destine process of provinces of provinces and the process of province	p.m. the Medicare/admission knowledged R37 had not urs notification per the er indicated "I will see if we in for reinstatement to maintain 6 a.m. business office staff d not have an actual policy but enerated handout titled Notice and Benefit dated 05/2013, he facility did not feel the did been met, the facility would be in the form lack information the denial notice would be on 4/25/14, at 12:44 p.m. the acknowledged the resident given 48 hours per regulation	21800			
21810	(21) days.  MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810			6/7/14
	residents shall have medical and persor needs. Appropriate	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED						
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
BENEDICTINE HEALTH CENTER OF MINNEAP  618 EAST 17TH STREET  MINNEAPOLIS, MN 55404												
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE						
21810	highest level of phy This right is limited reimbursable by put This MN Requirem by: Based on observat review, the facility fin reach for 2 of 40 sample.  Findings include: R24: On 4/21/14, at 2:49 setting in w/c on the light was observed side of the bed. The not reach the call litto wait for someone her. A nursing assis call light being out R24's Minimum Daindicated R24 need with activities of da eating and wheelch independent with e ambulate. R24's Br (BIMS- a test to de which depicted model.)	rige 64 rsical and mental functioning. where the service is not ablic or private resources.  ent is not met as evidenced ion, interview, and document ailed to ensure call lights were residents (R24, R12) in the  o p.m. R24 was observed e right side of the bed. The call around the side rail on the left e resident confirmed she could ght and stated she would have e to come by and check on stant (NA) was notified of the of reach for the resident.  Ita Set (MDS) dated 4/7/14, ded extensive to total assist ily living with the exception of nair mobility. R24 was ating and R24 did not rief Interview for Mental Status termine cognition) was 7/15 derate cognition impairment.	21810	-								
1	A tour of the facility	was conducted on 4/24/14, at										

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
BENEDICTINE HEALTH CENTER OF MINNEAP  618 EAST 17TH STREET  MINNEAPOLIS, MN 55404												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE						
21810	10:05 a.m. with the the director of envir in his room in his w other side of his be across the bed. Why questioned about the turned around in towards the bed stalight.  R12's MDS dated 1 extensive to total as living with the excembility. R12 was in R12 did not ambulation 15/15 which depicted.  Both of the director tour of the facility arresidents should have all times.  SUGGESTED MET The director of nursidevelop, review, an procedures to ensure resident reach. The educate all appropring procedures. The Domonitoring systems compliance.	director of maintenance and conmental services. R12 was theelchair watching TV on the droom. The call light was lying nen the resident was ne ability to reach his call light in his wheel chair and went ating he could reach the call along the could reach the call along price at the call are sist with activities of daily prion of eating and wheelchair independent with eating and ate. R12's BIMS score was ad no cognition impairment. It is were interviewed during the number of the average their call lights available at a single policies and are call lights are kept within a DON or designee could direct staff on the policies and ON or designee could develop	21810									

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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 <u>only a suggestion</u> 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 <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. 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

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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

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