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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 629W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00960

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245266**
2.STATE VENDOR OR MEDICAID NO.
(L2) **196677400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/23/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HFE NE II 12/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/19/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5266

Electronically Delivered: December 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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective December 16, 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. 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 feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: December 24, 2014

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

RE: Project Number S5266026

Dear Mr. Brennan:

On November 24, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 6, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 19, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 6, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 6, 2014, effective December 16, 2014 and therefore remedies outlined in our letter to you dated November 24, 2014, will not be imposed.

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

Sincerely,

Anne Kleppe

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245266	A. Building B. Wing	12/23/2014

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **12/16/2014**
ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/16/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/16/2014**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **12/16/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	12/24/2014	31223	12/23/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/6/2014			

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

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	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245266	01 - MAIN BUILDING 01	12/19/2014

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0012	12/16/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/AK	Date: 12/24/2014	Signature of Surveyor: 28120	Date: 12/19/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 11/5/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 629W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00960

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245266**
2.STATE VENDOR OR MEDICAID NO.
(L2) **196677400**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/06/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lou Anne Page, HFE NE II 12/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 24, 2014

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

RE: Project Number S5266026

Dear Mr. Brennan:

On November 6, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

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 actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 16, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 16, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 February 6, 2015 (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 May 6, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	11/06/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 4 residents (R41, R38, R70) observed wearing mitten restraints (cloth hand mittens which completely enclose the hand with a velcro closure strap at the wrist to prevent removal by the resident, and palm padding designed to prevent grasping, pulling or access to the residents' body) were comprehensively assessed to determine indications for use of the restraints and to ensure the restraints were the least restrictive device applied for the least amount of time.	F 221	F221 It is the practice of Benedictine Health Center of Minneapolis to use devices to treat resident medical symptoms. This includes devices such as mitt□s to prevent pulling on or removal of medically necessary equipment such as ventilator tubing, tracheotomy tube, enteral feeding tube etc. A. An assessment related to the use of the mitts has been completed for resident□ R38, R41 and R70. B. Staff education related to restraints and	12/16/14

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

Electronically Signed | 12/04/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	11/06/2014

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

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F 221	Continued From page 1 Findings include: On 11/3/14, at 4:00 p.m. was observed to be asleep in the Broda chair in her room, white cloth mitten restraints, with the velcro straps affixed around both wrists on both hands. On 11/5/14, at 7:30 a.m. R41 was observed to be assisted during morning cares by nursing assistant (NA)-D. R41 was not wearing the mitten restraints. R41's undated Resident Admission Record identified diagnoses to include chronic respiratory failure with mechanical ventilator dependence, anxiety, and altered consciousness. Review of R41's Resident Progress Notes from 10/20/14, through 11/4/14, indicated on 10/20/14, at 6:22 a.m. R41 was seeing and grabbing at imaginary things, a note at 7:32 a.m. indicated R41 had fallen out of bed without injury. At 11:27 p.m. a note indicated, "Hand mits placed on resident at 1900 [4:00 p.m.] after resident found her gt [gastrostomy tube] and began to pul on it to 'remove' it." The note include attmpts by the registered nurse (RN) to distract R41 prior to application of the mitts. - A note written on 10/24/14, at 2:42 p.m. indicated R41 had no respiratory distress or a signs or symptoms of anxiety but "on 5 occasions this morning pulled inline catheter off. Hand mittens in place and attempted to reorient to importance of tubing being connected at all times." A note written at 10:25 p.m. identified R41 continued to attempt to crawl out of bed and pull at various lines while the mitten restraints were in place. The note appropriately indicated R41 tolerated the mitts and cooperated with sliding her	F 221	in particular the use of devices. Review of plan of care for residents presently using a device specific to assessment of need, MD order including reason for use and duration of use. C. Audit of medical records for presence of assessment, orders and presence in care plan over the upcoming OBRA assessment cycle for the quarter. Four out of four residents have been assessed for use of mitts, MD orders present, and plan for use included in the care plan. Director of nursing or designee is responsible. D. Audit results communicated to the Quality Council for input. Compliance date: 12/16/14	

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hands "back into them."
- On 11/1/14, a note written at 1:52 p.m. indicated, "Resident using hand mitts due to tampering with Trach [tracheostomy] and removing inner cannula four times this shift." Although the notes appropriately identified R41 pulled at the tracheostomy and various lines, the notes lacked consistent documented evidence of when the mittens were applied or removed. The notes lacked consistent documentation of application and monitoring of the restraint to ensure they were the least restrictive.

The Physician Order Report dated 10/29/14, directed starting on 10/20/14, "Ok to use hand mittens to prevent pulling on vent tubing PRN [as needed] As Needed."

The 14 day re-admission Minimum Data Set (MDS) dated 10/27/14, identified R41 had severely impaired cognition and decision making skills. Although the MDS identified R41 was totally dependent on staff for all activities of daily living (ADLs), R41 was always incontinent of bowel and bladder and received tube feedings, the MDS did not identify R41 used a restraint.

R41's care plan dated 9/22/14, identified an alteration in safety. A hand written notation dated 10/14/14, which directed, "Ok for Mitts for safety to prevent removal of trach (tracheostomy cannula)/g tube(gastrostomy feeding tube)" and identified, "Resident to have abdominal binder as needed to keep resident from pullling at gastric tube." A hand written notation dated 10/21/14, identified R41 had "Itching severe & all ov body, causing distress." The notation dated 11/5 (no year) directed, "Mitts to prevent skin injury temporary while cuse found." Another hand

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F 221	Continued From page 3 written notation dated 11/5/14, directed, "Ok for Mitts to prevent skin injury/until cause of itching found & treated." Although the care plan identified the use of mitts (mittens), the clinical record lacked evidence the use of the mitts were comprehensively assessed to determine interventions. The care plan lacked appropriate interventions such as but not limited to: when to apply the mittens, when to remove them, monitoring while the restraint was applied, and interventions to attempt to reduce the use of the restraint. On 11/5/14, at 10:00 a.m. RN-G verified R41 had no assessment for the use of hand mitts restraints in the medical record. RN-G stated the hand mitts are not viewed as a restraint and stated "they are a safety device, because they don't prevent access to the body." RN-G verified the intended use was to prevent R41 from grasping and pulling out her tracheotomy and G-tubes. RN-G also verified the physician's order was to prevent the resident from pulling on tubes, and the nursing progress notes indicated the mitts had also been used to prevent R41 from scratching and causing self-injury. Although RN-G stated the mitts were to prevent skin injury, RN-G verified the restratin had not been ordered for scratching. R38 was observed in a Broda chair in her room, ventilated and wearing hand mitten restraints on 11/5/14, at 10:00 a.m. R38's undated Resident Admission Record identified diagnoses to include chronic respiratory failure and mechanical ventilator dependence, anxiety, and legal blindness.	F 221		

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R38's annual MDS dated 5/8/14, identified R38 had severe cognitive impairment, was totally dependent on staff for all ADLs and R38 did not have a physical restraint. R38's Care Area Assessments (CAAs) dated 5/9/14, indicated cognitive loss, able to shake head yes or no to simple questions, attempts to mouth sentences that are not understood by staff; incontinent of bowel and bladder; isolated to room by anxiety and mechanical ventilator dependency. R38 was dependent on tube feedings for nutrition.

R38's care plan dated 5/15/14, indicated R38 received psychotripic medications, had behaviors and anxiety, and had removed her Trach in the past while anxious. The care plan lacked appropriate interventions such as but not limited to: indications for the use of mitts, when to apply the mittens, when to remove them, monitoring while the physical restraint was applied, and interventions to attempt to reduce the use of the restraint.

The quarterly MDS dated 8/7/14, indicated no changes in R38's cognition or ADL status. Although the use of a the mitt restraint had been ordered, the MDS did not accurately identify R38 used a physical restraint.

R38's Physician Order Report stamped as received on 10/29/14, directed beginning 5/22/13, "Ok to use hand mitts bilaterally PRN [as needed] to prevent inadvertent extubation Q [every] Shift."

The Nursing Progress Notes were reviewed from 9/10/14 going forward and the notes revealed the following:
- On 9/10/14, at 11:16 a.m. describe the resident

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reaching toward the ceiling and bringing non-existent items to her mouth (hallucinations).
- On 9/4/14, at 10:48 p.m. of R38 resisting cares and not allowing staff to suction trach until Ativan given for anxiety.
- On 10/1/14, R38 pulling at blankets, gown, and fingering her trach equipment.
- On 10/3/14, R38 found trying to get out of bed, continued until Ativan was given.
- On 10/11/14, R38 was fidgeting, grabbing at things in the air. The Progress Notes lacked evidence of an assessment for the hand mitts.The medical record lacked evidence that a restraint assessment had been completed for R38, who had hand mitten (restraints) to prevent self extubation, and self-injury.

On 11/6/14, at 12:47 p.m. during the time of survey a Restraints/Adaptive Equipment-Physical Restraint/Adaptive Equipment Consent was completed for R38, and indicated increased feeling of safety and security and protection from other accidents, as reasons for restraint use.

R70 was not comprehensively assessed for a restraint use.

On 11/5/14, at 10.35 a.m. R70 was observed seated on his wheelchair stationed across from the fourth floor television (TV) lounge slightly tilted. R70 was observed to have his whole left arm above his head moving it side to side in a waving manner and his hand had a white mitten on secured at the wrist area with white velcro.

On 11/6/14, at 11:00 a.m. R70 was observed seated on his wheelchair which was stationed by the wall in the TV lounge area with a bag of tube

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feeding hanging from the intravenous (IV) pole next to him. R70 was noted to have a white puffy mitten on his left hand which was secured with a white band of velcro around his wrist.
-At 11:10 a.m. when approached he appeared to be smiling and was reaching out at the surveyor and when spoken to was not able to respond to the questions.
- At 12:52 p.m. R70 room door was observed wide open, R70 was observed lying on his back and his left hand was resting behind his head with a white mitten on his left hand secured with velcro and his eyes were shut.

R70's signed but undated Physician Order Report revealed R70 had an order with start date 12/3/13, which directed "Abdominal binder to reduce risk of pulling out G-tube. May use mitt to Left [L] hand to prevent patient from harming himself and pulling out G-tube Q shift."

During review of R70's annual MDS dated 3/18/14, and all triggered CAAs completed between 3/20/14, to 3/25/14, revealed R70 had not been assessed for using a physical restraint.

R70's diagnoses included hemiplegia, dysphasia cerebrovascular disease and epilepsy obtained from the quarterly MDS dated 9/16/14. In addition, the MDS indicated R70 required total physical assistance with activities of daily living, had functional limitation to both upper and lower extremities, received tube feeding and had both short and long term memory impairment. In addition, quarterly MDS did not identify R70 as using a physical restraint.

When interviewed on 11/6/14, at 12:56 p.m. RN-A stated as far as she knew R70 had the mitten for

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F 221	Continued From page 7 a long time even before she had started working as the nurse manager. When asked if R70 had been assessed for using the mitten as a restraint, RN-A stated she had completed on the previous day 11/5/14, which was after another surveyor had brought it up to the facility attention on a different floor. RN-A then proceeded to show surveyor the Restraint Assessment. When asked when the staff removed the mitten, RN-A stated it was supposed to be removed when R70 was out of his room close to staff supervision such as the TV lounge. When informed R70 had been observed two different times in the TV lounge with the mitten on, RN-A stated she had realized that and had talked to the nurse who had indicated she had forgotten to take it off. - At 2:34 p.m. RN-A verified there had not been a restraint assessment completed for R70 prior to the one she had completed on 11/5/14. RN-A also stated since she became the nurse manager in February she had been doing restraint assessments for residents on the floor annually and would not be able to speak for the other nurse prior to her. RN-A insisted R70 needed to have the mitten due to pulling his gastrostomy tube (G-tube) and did not want him to do that as he was on Coumadin. - At 2:55 p.m. when asked if assessments were being done for the mittens as restraints the director of nursing (DON) stated "To honestly tell you they were not being done consistently." DON further stated the mittens were medically needed to prevent the residents from pulling the tubes and did not understand how mittens were considered restraints for residents who were physically in a vegetative state. Use of Restraints policy revised December 2008, directed "1. "Physical Restraints" are defined as	F 221		

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F 221	Continued From page 8 any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions..." The policy lacked information on who was responsible and oversaw to ensure proper physical restraint assessments were completed to ensure residents were free of restraints.	F 221		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure room furniture was kept in santary condition to prevent pervasive urine odors for 1 of 6 residents (R5). Findings include: On 11/3/14, at 4:58 p.m. R5 was observed in his room lying in bed. A strong pervasive urine odor was noted in the room and got stronger as one approached the chair. The odor did not permeate into the hall. R5 as non-interviewable due to	F 253	F253 It is the practice of Benedictine Health Center of Minneapolis to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior. A. The chair was removed 11/06/14. B. Review of expectations related to housekeeping and maintenance of facility areas with departments most directly involved and with other facility staff related	12/16/14

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F 253	Continued From page 9 cognition level. R5's annual Minimum Data Set (MDS) dated 8/12/14, indicated R5 was severely cognitvely impaired and was always incontinent of urine. On 11/4/14, at 10:00 a.m. R5 was again observed in his room lying in bed and a pervasive urine odor remained. On 11/5/14, at 7:30 a.m. R5 was observed out of his room. The urine odor remained strong in R5's room. An cloth striped chair was observed to have a large yellowish brown ring that almost covered the entire seat on the chair. As the writer got closer to the chair the urine odor became overpowering. On 11/6/14, at 9:55 a.m. the administrator and the director of maintenance (DM)-A verified the straight back arm chair in R5's room where R5 regularly sat showed a large yellowish brown stain on the cloth cushion seat. The administrator and DM-A also verified R5's chair in his room smelled of urine. DM-A stated he would have wanted housekeeping staff to have exchanged out the dirty chair with a clean chair when housekeeping cleaned R5's room. At 10:00 a.m. DM-A radioed maintenance-B to come and get the dirty chair out of R5's room.	F 253	to need to communicate needs to the appropriate departments. C. Bi monthly random audits of facility interior for compliance with expectation of sanitary, orderly and comfortable interior. D. Administrator or designee responsible for monitoring; results of audits and observations communicated to members of Quality Council for input. Compliance date: 12/16/14	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive	F 272		12/16/14

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F 272	Continued From page 10 assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the use of mitt restraints for 1 of 4 residents (R70) in the sample observed to be wearing a physical restraint.	F 272	F272 It is the practice of Benedictine Health Center of Minneapolis to comprehensively assess residents using the RAI process. A. MDS 3.0 for R70 has been modified.	

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F 272	Continued From page 11 Findings include: On 11/5/14, at 10.35 a.m. R70 was observed seated on his wheelchair stationed across from the fourth floor television (TV) lounge slightly tilted. R70 was observed to have his whole left arm above his head moving it side to side in a waving manner and his hand had a white mitten on secured at the wrist area with white velcro. On 11/6/14, at 11:00 a.m. R70 was observed seated on his wheelchair which was stationed by the wall in the TV lounge area with a bag of tube feeding hanging from the intravenous (IV) pole next to him. R70 was noted to have a white puffy mitten on his left hand which was secured with a white band of velcro around his wrist. -At 11.10 a.m. when approached he appeared to be smiling and was reaching out at the surveyor and when spoken to was not able to respond to the questions. On 11/6/14, at 12:52 p.m. R70 room door was observed wide open, R70 was observed lying on his back and his left hand was resting behind his head with a white mitten on his left hand secured with velcro and his eyes were shut. On 11/6/14, at 12:56 p.m. registered nurse (RN)-A stated as far as she knew R70 had the mitten for a long time even before she had started working as the nurse manager. When asked if R70 had been assessed for using the mitten as a restraint, RN-A stated she had completed on the previous day 11/5/14, which was after another surveyor had brought it up to the facility attention on a different floor. RN-A then proceeded to show surveyor the Restraint Assessment.	F 272	B. Review of expectations related to coding of section P with members of the IDT. C. Review of coding of OBRA assessments section P for accuracy over next quarter; review by DON or designee. D. Director of nursing responsible for communicating results of review to Quality council for input. Compliance date: 12/16/14	

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F 272	Continued From page 12 On 11/6/14, at 2:34 p.m. RN-A verified there had not been a restraint assessment completed for R70 prior to the one she had completed on 11/5/14. RN-A also stated since she became the nurse manager in February she had been doing restraint assessments for residents on the floor annually and would not be able to speak for the other nurse prior to her. RN-A insisted R70 needed to have the mitten due to pulling his gastrostomy tube (G- tube) and did not want him to do that as he was on Coumadin. On 11/6/14, at 2:55 p.m. when asked if assessments were being done for the mittens as restraints the director of nursing (DON) stated "To honestly tell you they were not being done consistently." DON further stated the mittens were medically needed to prevent the residents from pulling the tubes and did not understand how mittens were considered restraints for residents who were physically in a vegetative state. R70's signed but undated Physician Order Report revealed R70 had an order with start date 12/3/13, which directed "Abdominal binder to reduce risk of pulling out G-tube. May use mitt to Left [L] hand to prevent patient from harming himself and pulling out G-tube Q [every] shift." During review of R70's annual MDS dated 3/18/14, and all triggered Care Area Assessments (CAAs) completed between 3/20/14, to 3/25/14, revealed R70 had not been assessed for use of a physical restraint. In addition quarterly MDS dated 9/16/14, did not identify R70 used a physical restraint.	F 272		

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F 272	Continued From page 13 R70's diagnoses included hemiplegia, dysphasia cerebrovascular disease and epilepsy obtained from the quarterly MDS dated 9/16/14. In addition the MDS indicated R70 required total physical assistance with activities of daily living, had functional limitation to both upper and lower extremities, received tube feeding and had both short and long term memory impairment. Use of Restraints policy revised December 2008, directed "1. "Physical Restraints" are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom and to determine if there are less restrictive interventions..." The policy lacked information on who was responsible and oversaw to ensure proper physical restraint assessments were completed to ensure residents were free of restraints.	F 272		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by:	F 276		12/16/14

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F 276	Continued From page 14 Based on interview and document review, the facility failed to comprehensively assess 1 of 1 resident (R38) for the use of mitten restraints. Findings include: R38 was re-admitted 5/22/13, with admission diagnoses of mechanical ventilator dependence, encephalopathy, anxiety, and agitation. A physicians order dated 5/22/13, "Ok to use hand mitts bilaterally PRN [as needed] to prevent inadvertent extubation every shift". R38's care Area Assessments (CAAs) dated 5/9/14, indicated cognitive loss, able to shake head yes or no to simple questions, attempts to mouth sentences that are not understood by staff; incontinent of bowel and bladder; isolated to room by anxiety and mechanical ventilator dependency. R38 was at risk for falls and experienced delirium. R38 was dependent on tube feedings for nutrition. The CAA lacked a comprehensive assessment for restraint use. R38's care plan dated 5/15/14, indicated R38 received psychotripic medications, had behaviors and anxiety, and had removed her Trach in the past while anxious. The Minimum Data Set (MDS) dated 8/7/14, indicated short-term and long-term memory impairment, severe cognitive impairment. R38 was totally dependent on two care givers for bed mobility, transfers and toilet use. The MDS did not identify restraints were used for R38. The Nursing Progress Notes were reviewed from 9/10/14 going forward and the notes revealed the	F 276	F276 It is the practice of Benedictine Health Center of Minneapolis to assess residents on a quarterly basis. A. MDS 3.0 for R38, section P have been modified. See plan of action noted in F272	

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F 276	Continued From page 15 following: - On 9/10/14, at 11:16 a.m. describe the resident reaching toward the ceiling and bringing non-existent items to her mouth (hallucinations). - On 9/4/14, at 10:48 p.m. of R38 resisting cares and not allowing staff to suction trach until Ativan given for anxiety. - On 10/1/14, R38 pulling at blankets, gown, and fingering her trach equipment. - On 10/3/14, R38 found trying to get out of bed, continued until Ativan was given. - On 10/11/14, R38 was fidgeting, grabbing at things in the air. The Progress Notes lacked evidence of an assessment for the hand mitts.The medical record lacked evidence that a restraint assessment had been completed for R38, who had hand mitten (restraints) to prevent self extubation, and self-injury. The medical record lacked a restraint assessment for R38, who had hand mitten (restraints) to prevent self extubation, and self-injury. On 11/6/14, at 12:47 p.m. during the survey, a Restraints/Adaptive Equipment-Physical Restraint/Adaptive Equipment Consent was completed for R38, and indicated increased feeling of safety and security and protection from other accidents, as reasons for restraint use.	F 276		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate	F 278		12/16/14

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F 278	Continued From page 16 participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 residents (R41, R70) Minimum Data Set (MDS) accurately identified the use of a physical restraint. Findings include: R41 was observed on 11/3/14, at 4:00 p.m. was observed to be asleep in the Broda chair in her room, white cloth mitten restraints, with the velcro straps affixed around both wrists on both hands. The 14 day re-admission Minimum Data Set	F 278	F278 It is the practice of Benedictine Health Center of Minneapolis to complete assessments that accurately reflect the resident□s status. A. MDS 3.0 for R41 and R70, section P have been modified. See plan of action identified in F272 and F276	

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F 278	Continued From page 17 (MDS) dated 10/27/14, identified R41 had severely impaired cognition and decision making skills. Although the MDS identified R41 was totally dependent on staff for all activities of daily living (ADLs), R41 was always incontinent of bowel and bladder and received tube feedings, the MDS did not identify R41 used a restraint. On 11/5/14, at 10:00 a.m. RN-G verified R41 had no assessment for the use of hand mitts restraints in the medical record. RN-G stated the hand mitts are not viewed as a restraint and stated "they are a safety device, because they don't prevent access to the body." RN-G verified assessments should be accurate. R70's signed but undated Physician Order Report revealed R70 had an order with start date 12/3/13, which directed "Abdominal binder to reduce risk of pulling out G-tube. May use mitt to Left [L] hand to prevent patient from harming himself and pulling out G-tube Q [every] shift." During review of R70's annual MDS dated 3/18/14, and all triggered Care Area Assessments (CAA's) completed between 3/20/14, to 3/25/14, revealed R70 had not been assessed for using a physical restraint. On 11/6/14, at 2:55 p.m. director of nursing (DON) verified assessments should be consistent and accurate.	F 278		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 329		12/16/14

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F 329	Continued From page 18 drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify and continuously monitor behaviors for 2 of 5 residents (R68, R2) who were reviewed for unnecessary medication use. In addition, 1 of 5 residents (R82) did not include a clinical parameters for PRN (as needed) Seroquel (quetapine, an antipsychotic medication) usage. Findings include: R68's Care Area Assessment (CAA) for psychotropic medication use dated 2/5/14, noted	F 329	F329 It is the philosophy of Benedictine Health Center of Minneapolis that the residents medication regimen helps promote or maintain the resident□s highest practicable mental, physical, and psychosocial well-being as identified by the resident and or representatives in collaboration with the interdisciplinary team. A. Monitoring and the clarification for use related to antipsychotic medications for R 82, R 68 and R2 has been implemented.	

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F 329	Continued From page 19 R68 had a history of chronic respiratory failure, depression and anxiety. She received medications of olanzapine (Zyxprea-an antipsychotic), Paxil (an antidepressant) and an PRN Seroquel (anti-psychotic). The resident indicated the Seroquel did work for her and she was not interested in changing it. Care plan dated 10/7/14, indicated R68 had panic attacks, staff was to "be aware requests more suctioning and comes increasingly anxious and demanding when panic attacks occur, wanted cuff deflated, this may decrease oxygen levels and raise anxiety, review past effective coping mechanisms, relaxation tech, involve therapy and psych as needed. Psychotropic medications; attempt and document nonpharmalogical methods used to manage/decrease anxiety or behaviors prior to administration of as needed psychotropic medications, and side effects monitoring. Psychotropic meds, used as needed Seroquel (quetiapine fumarate, an antipsychotic medication. Monitor for behaviors and side effects of dizziness, rash, drowsiness, lethargy, headache, confusion, respiratory depression, etc. Altered mental/emotional conditions with anxiety related to medical conditions, fearful of getting out of bed due to brittle bones, self-isolated to room because R38 would not leave the bed." R68's Physician Order Report dated 10/29/14, revealed R68 received olanzapine (Zyprexa, an antipsychotic medication) 2.5 milligram (mg) which started on 5/29/14, Paxil 20 mg at bedtime and 30 mg during the day which was started on 3/6/14, Ativan 0.5 mg every three hours PRN for muscle spasms, shortness of bresth, and anxiety, In addition, R68 was receiving as needed Seroquel on admission and had since been	F 329	AIMS assessment for resident R68 completed on 11/06/14. B. Staff education related to target behavior monitoring for residents receiving antipsychotic medications. C. Audit of medical records for presence of behavior monitoring for residents receiving antipsychotic medication over the upcoming quarter of OBRA MDS 3.0 assessments. Director of nursing or designee is responsible for monitoring. D. Audit results communicated to the Quality council for input. Compliance date: 12/16/14	

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F 329	Continued From page 20 discontiued. R68's quarterly Minimum Data Set (MDS) dated 10/30/14, indicated R68 was cognitively intact, displayed mood symtoms of hopelessness and was depressed. R68 also felt tired with no energy and felt she was sleeping too much. R68 displayed no behaviors. The MDS also revealed R68 received an anti-psychotic and an anti-depressant medication and saw a licensed mental health professional in the last seven days. R68 was interviewed on 11/3/14, and was able to speak in a harsh/scratchy voice by pressing down on her ventilator tube (allowing air to escape past her vocal cords). R68 stated she became anxious and felt short of breath when talking about the changes in her life, and when she became anxious the nurses would give her Ativan to calm down when she needed it. A review of the medical record revealed the medical record lacked continuous target behavior monitoring for olanzapine and Ativan psychotropic medication use and lacked evidence of adverse side effect monitoring such as abnormal involuntary body movements. It could not be determined when the facility adminsitered the Ativan for anxiety versus shortness of breath, muscle spasms and/or and anxiety. On 11/6/14, at 10:00 a.m. registered nurse (RN)-G stated target behavior monitoring was done in progress notes when behaviors occurred, and continuous target behavior monitoring was not done. On 11/6/14, at 1:22 p.m. the director of nursing	F 329		

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F 329	Continued From page 21 (DON) stated the facility did not have continuous target behavior monitoring every shift. DON stated, "We have started the process working on dementia related behaviors first and then will move on. Unless the resident had a specific diagnosis for schizophrenia, or schizoaffective disorder, they were not priority." DON stated physicians/providers would not always address the consultant pharmacist (CP) recommendations and the facility attempted different ways to get recommendations addressed and were now back to putting them in the physician/provider mailbox. DON discribed if there were time sensitive elements in the CP recommendations, they were hand carried to the nurse manager, and if the nurse manager were not available then they were hand carried to the DON. DON further stated, "Regardless, I get a report of every recommendation before the CP leaves the building." The DON further stated that psychotropic medication monitoring is a quality project they are working on currently. R2's diagnoses as listed in the Electronic Admission Record included schizoaffective disorder, bipolar disorder, antisocial personality disorder, opioid dependence and depressive disorder. The physician's orders dated 11/4/14, indicated R2 was on Abilify (aripiprazole, an anti-psychotic medication) 25 mg by mouth at bedtime for schizoaffective disorder and Zoloft (sertraline HCl, an anti-depressant medication) 50 mg by mouth at bedtime for depression. The Care Area Assessments (CAA) summary dated 1/13/14, indicated R2 was on psychotropic medications for the use of Abilify and Zoloft. The Analysis of Findings section on the CAA indicated R2 had been on psychotropic medications for "many years" related to history of auditory and	F 329		

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F 329	Continued From page 22	F 329		

visual hallucinations, and drug dependence. It was further noted, R2 was verbally aggressive and often challenging towards new staff.

The care plan dated 6/6/14, identified R2 had alteration in condition related to use of psychotropic drugs. The care plan directed staff to know from R2 "if hallucinations were upsetting [R2]" and to monitor if R2 was verbally explosive and highly critical of others. The care plan further directed staff to monitor R2 for depressed mood.

On 11/05/14, at 7:35 a.m. R2 stated they did not understand why the nurses kept giving the "psych medication" despite R2 having complained to staff about "shaking so bad that could not even hold a cup, and drooling all over." When surveyor asked about R2's hallucinations, R2 replied, "I did not have any hallucinations in months and months and months."
-At 1:01 p.m. nursing assistant (NA)-C denied observing signs of hallucinations being manifested by R2, NA-C added R2 had the behavior of getting upset when needs were unmet in relation to Oxygen use. NA-C stated she was not monitoring R2 for any specific behavior.
-At 1:35 p.m. NA-B stated R2 never showed signs of hallucinations or depression during the times she worked with R2. NA-B was not aware of any specific behavior monitoring for R2.
-At 1:41 p.m. RN-E stated she took care of R2 for a "long time" and further verbalized knowledge that R2 was on the anti-psychotic medicine "ever since." RN-E admitted resident specific target behavior monitoring was not being done for R2, but would be written in progress notes if behaviors occurred.
-At 2:35 p.m. RN-F stated R2's target behaviors were "some hallucinations one to two times a

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F 329	Continued From page 23 month and had some periods of paranoia." RN-F verified there was no system for monitoring the occurrence of resident specific target behaviors. RN-F admitted nurses do not chart about behaviors in progress notes, but nurses wrote notes on referral sheets and sent with R2 during visits with specialists such as a psychiatrist and/or psychologist "every three months." R82's admission MDS, dated 8/19/14, included diagnoses schizophrenia, schizoaffective disorder, anxiety disorder and depression. The MDS indicated R82 had moderately impaired cognition. The MDS also indicated R82 was on an antipsychotic medication and exhibited behaviors not directed toward others. On 11/05/14, at 7:12 a.m. R82 was observed lying in bed, covered up, eyes closed with the head of the bed (HOB) up approximately 30-40 degrees. - At 8:51 a.m. R82 was observed lying in bed, HOB elevated, and stated he was not feeling okay and had his call light on for staff assistance. - At 10:18 a.m. R82 was observed lying in bed, covered up, eyes closed, television on, with the HOB elevated.	F 329		

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F 329	Continued From page 24 - At 2:20 p.m. R82 was observed lying in bed, covered up, HOB elevated, reading a book with the television on. R82 stated he was still not feeling well. On 11/5/14, at 9:04 a.m. licensed practical nurse (LPN)-A stated R82 was not feeling well with a little nausea and anxiety, but usually R82 got up for meals. LPN-A stated R82 was anxious every morning but was pleasant and usually in a good mood, but it did not take much to get R82 anxious. - At 10:59 a.m. LPN-A and RN-A verified the November 2014 electronic Medication Administration Record (eMAR) for R82 did not include a clinical indication for when R82's PRN quetiapine should be given. RN-A also stated she had transcribed the original PRN quetiapine order. RN-A verified she had not transcribed the word agitation from the original paper order to the computer for the e-mar. - At 2:09 p.m. when asked how the nurse would know when to give R82 a PRN quetiapine when there was no clinical indication on the e-MAR for the PRN quetiapine, LPN-A stated she would give R82 a PRN quetiapine if R82 requested one, if R82 was crying, yelling, hollering or throwing things on the floor. R82's care plan dated 8/13/14, indicated R82 had an alteration in general condition due to use of psychotropic medication. R82 will not have adverse effects from psychotropics, administer meds per medical doctor (MD) orders, attempt a gradual dose reduction if ordered by MD and not contraindicated, attempt and document methods used to manage/decrease anxiety or behaviors	F 329		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 prior to administration of prn psychotropic medications, pharmacy consultant to review meds monthly and prn, and recommendation follow up to be done by nursing/nurse practitioner (NP)/MD. Psychotropic medications document if any signs or symptoms observed. Physician orders dated 10/29/14, included: quetiapine tablet; 25mg; amt: 25mg; gastric tube Special Instructions: DX: (diagnosis) AGITATION Every 4 hours - PRN which was started upon R82's admission of 8/13/14. The order lacked parameters for usage. The Consultant Pharmacist monthly Medication Regimen Review dated 9/15/14, directed, "See report for any noted irregularities and/or recommendations." The Pharmacy Consultant Report dated 9/15/14, included no clinical indication for usage of R82's PRN quetiapine. On 11/6/14, at 3:05 p.m. the consulting pharmacist stated she gave the clinical indicator for R82's PRN quetiapine usage in her September 2014 report. The Antipsychotic Medication Use policy dated May 2015 directed, "Residents receive antipsychotic medications only when medically necessary. Every effort is made to ensure that residents who are prescribed antipsychotic medications receive the intended benefit of the medication and to minimize the unwanted effects of the antipsychotic medication."	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		12/16/14

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	245266	A. BUILDING _____ B. WING _____	11/06/2014

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F 428	Continued From page 26 reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the consultant pharmacist (CP) failed to identify lack of continuous behavior monitoring for 2 of 5 residents (R68, R2) who were reviewed for psychotropic medication use. In addition, the CP did not recommend a clinical indication for a PRN (as needed) antipsychotic medication for 1 of 5 residents (R82). Findings include: R68's Care Area Assessment (CAA) dated 2/12/14, identified the resident had diagnoses to include a history of depression and anxiety, R68 received olanzapine (Seroquel, an antipsychotic medication) 10 milligrams (mg) at bedtime (HS). The CAA indicated R68 was able to ask for the PRN Seroquel. R68's care plan dated 2/18/14, identified the resident had a diagnosis of depression due to multiple medical problems. the care plan directed, "Document residents [sic] behavior/mood as indicated." R68's care plan identified use of an "antipsychotic medication" and directed to administer the medication as ordered. The care	F 428	F428 It is the practice of Benedictine Health Center of Minneapolis to have the consultant pharmacist report irregularities as part of the review of the drug regimen. These reports are provided to the attending physician and the director of nursing. A. MD orders of 11/5/14 for R82 relate to the Pharmacist□s recommendation from September. Refer to plan of action noted in F329	

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F 428	Continued From page 27 plan directed, "Monitor medication administration and any associated beahviors of [sic] side effects." R68 physician medication orders dated 10/29/14, for olanzapine (anti-psychotic medication that can produce tardive dyskinesia (abnormal involuntary movements). In addition, R68 was receiving as needed Seroquel (an antipsychotic medication) on admission. R68's quarterly Minimum Data Set (MDS) dated 10/30/14, indicated R68 was cognitively intact, displayed mood symtoms of hopelessness and was depressed. R68 also felt tired with no energy and felt they were sleeping too much. R68 displayed no behaviors. The MDS also revealed R68 received an anti-psycotic and an anti-depressant medication and saw a licensed mental health professional in the last seven days. A review of the medical record revealed the record lacked continuous target behavior monitoring for psychotropic medication use, and lacked direction for what "anxiety" behaviors were exhibited for the resident to indicate a need for the as needed lorazepam dosing. On 11/6/14, at 1:22 p.m. the director of nursing (DON) stated they did not have continuous target behavior monitoring every shift. We have started the process working on dementia related behaviors first and then will move on. Unless the resident had a specific diagnosis for schizophrenia, or schizoaffective disorder, they were not priority. Physicians/providers do not always address the consultant pharmacist (CP) recommendations, and the facility attempted different ways to get recommendations	F 428		

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F 428	Continued From page 28	F 428		

addressed and were now back to putting them in the physician/provider mailbox. The DON further stated if there were time sensitive elements in the CP recommendations, there were hand carried to the nurse manager (NM), and if NM are not available then they are hand carried to me and regardless I get a report of every recommendation before the CP leaves the building.

R2's diagnoses as listed in the Electronic Admission Record dated 9/2/14, included schizoaffective disorder, bipolar disorder, antisocial personality disorder, opioid dependence and depressive disorder.

The Psychotropic CAA summary dated 1/13/14, indicated R2 was on psychotropic medications for the use of Abilify and Zoloft. The Analysis of Findings section on the CAA indicated R2 had been on psychotropic medications for "many years" related to history of auditory and visual hallucinations, and drug dependence. It was further noted, R2 was verbally aggressive and often challenging towards new staff.

The care plan dated 6/6/14, identified R2 had alteration in condition related to use of psychotropic drugs. The care plan directed staff to know from R2 "if hallucinations were upsetting [R2]" and to monitor if R2 was verbally explosive and highly critical of others. The care plan further directed staff to monitor R2 for depressed mood.

The Physician's Order Report dated 11/4/14, indicated R2 was on Abilify (aripiprazole, an anti-psychotic medication) 25 mg by mouth at bedtime for schizoaffective disorder and Zoloft (sertraline HCl, an anti-depressant medication) 50

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F 428	Continued From page 29 mg by mouth at bedtime for depression. On 11/05/14, at 7:35 a.m. R2 stated they did not understand why the nurses kept giving the "psych medication" despite R2 having complained to staff about "shaking so bad that could not even hold a cup, and drooling all over." When surveyor asked about R2's hallucinations, R2 replied, "I did not have any hallucinations in months and months and months." -At 1:01 p.m. nursing assistant (NA)-C denied observing signs of hallucinations being manifested by R2, NA-C added R2 had the behavior of getting upset when needs were unmet in relation to Oxygen use. NA-C stated she was not monitoring R2 for any specific behavior. -At 1:35 p.m. NA-B stated R2 never showed signs of hallucinations or depression during the times she worked with R2. NA-B was not aware of any specific behavior monitoring for R2. -At 1:41 p.m. registered nurse (RN)-E stated she took care of R2 for a "long time" and further verbalized knowledge that R2 was on the anti-psychotic medicine "ever since." RN-E admitted resident specific target behavior monitoring was not being done for R2, but would be written in progress notes if behaviors occurred. -At 2:35 p.m. RN-F stated R2's target behaviors were "some hallucinations one to two times a month and had some periods of paranoia." RN-F verified there was no system for monitoring the occurrence of resident specific target behaviors. RN-F admitted nurses do not chart about behaviors in progress notes, but nurses wrote notes on referral sheets and sent with R2 during visits with specialists such as a psychiatrist and/or psychologist "every three months."	F 428		

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F 428	Continued From page 30	F 428		

On 11/06/14, at 3:05 p.m. CP stated she expected resident specific behavior monitoring for the use of psychotropic medications. The records lacked evidence to show R2's specific target behaviors were being monitored.

R82's admission MDS, dated 8/19/14, included diagnoses schizophrenia, schizoaffective disorder, anxiety disorder and depression. The MDS indicated R82 had moderately impaired cognition. The MDS also indicated R82 was on an antipsychotic medication and exhibited behaviors not directed toward others.

On 11/05/14, at 7:12 a.m. R82 was observed lying in bed, covered up, eyes closed with the head of the bed (HOB) up approximately 30-40 degrees.
- At 8:51 a.m. R82 was observed lying in bed, HOB elevated, and stated he was not feeling okay and had his call light on for staff assistance.
- At 10:18 a.m. R82 was observed lying in bed, covered up, eyes closed, television on, with the HOB elevated.
- At 2:20 p.m. R82 was observed lying in bed, covered up, HOB elevated, reading a book with the television on. R82 stated he was still not feeling well.

On 11/5/14, at 9:04 a.m. licensed practical nurse (LPN)-A stated R82 was not feeling well with a little nausea and anxiety, but usually R82 got up for meals. LPN-A stated R82 was anxious every morning but was pleasant and usually in a good mood, but it did not take much to get R82 anxious.

- At 2:42 p.m. RN-A stated the consulting

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F 428	Continued From page 31 pharmacist's recommendations for R82 were given to her from the DON. On 11/6/14, at 10:25 a.m. RN-A stated either herself or the floor nurses would complete the follow up from the consulting pharmacist's recommendations. - At 10:59 a.m. LPN-A and RN-A verified the November 2014 e-mar (electronic medication administration record) for R82 did not include a clinical indication when R82's PRN quetiapine should be given. RN-A also stated she had transcribed the original PRN quetiapine order. RN-A verified she had not transcribed the word agitation from the original paper order to the computer for the e-mar when R82 was admitted from the hospital in August 2014. - At 2:09 p.m. when asked how the nurse would know when to give R82 a PRN quetiapine when there was no clinical indication on the e-mar for the PRN quetiapine, LPN-A stated she would give R82 a PRN quetiapine if R82 requested one, if R82 was crying, yelling, hollering or throwing things on the floor. R82's care plan dated 8/13/14, indicated R82 had an alteration in general condition due to use of psychotropic medication. R82 will not have adverse effects from psychotropics, administer meds per medical doctor (MD) orders, attempt a gradual dose reduction if ordered by MD and not contraindicated, attempt and document methods used to manage/decrease anxiety or behaviors prior to administration of prn psychotropic medications, pharmacy consultant to review meds monthly and prn, and recommendation follow up to be done by nursing/nurse practitioner (NP)/MD. Psychotropic medications document if any signs or symptoms observed.	F 428		

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F 428	Continued From page 32 The Physician's Order dated 10/29/14, read: "quetiapine tablet; 25mg; amt [amount]: 25mg; gastric tube Special Instructions: DX: (diagnosis) AGITATION Every 4 hours - PRN" which was started upon R82's admission of 8/13/14. The Consultant Pharmacist monthly Medication Regimen Review dated 10/13/14, read "no irregularities or recommendations." The Consultant Pharmacist monthly Medication Regimen Review dated 9/15/14, read "See report for any noted irregularities and/or recommendations." The Pharmacy Consultant Report dated 9/15/14, included no clinical indication for usage of R82's PRN quetiapine. On 11/6/14, at 3:05 p.m. the consulting pharmacist stated she gave the clinical indicator for R82's PRN quetiapine usage in her September 2014 report. The facility's policy for the use of anti-psychotic medications dated 5/2014, directed the consultant pharmacist to do a monthly medication review and provide appropriate recommendations for usage of the medications. Under policy Antipsychotic Medication Use dated May 2014 noted: 'Residents receive antipsychotic medications only when medically necessary. Every effort is made to ensure that residents who are prescribed antipsychotic medications receive the intended benefit of the medication and to minimize the unwanted effects of the antipsychotic medication." Auditing: "1. The	F 428		

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F 428	Continued From page 33 Pharmacist Consultant will perform monthly drug reviews including psychotherapeutic medications and provide recommendations regarding these medications as appropriate."	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		12/16/14

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F 431	Continued From page 34 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 medication carts containing various resident medications was locked on 4th floor. This had the potential to affect 6 of 6 residents (R59, R67, R75, R9, R19, R5) on the 4th floor who physically were able to access the unsecured medication cart and R79's Nitrostat (medication used to treat chest pain) was not dated when opened on the third floor. In addition, the facility failed to ensure Fentanyl patches (a topical narcotic patch used for pain control) were destroyed in a manner to prevent potential diversion for 2 of 2 residents (R81, R82). Findings include: Unlocked medication cart: On 11/4/14, at 3:17 p.m. during a random observation on 4th floor the second drawer of the medication cart, stationed to the front left of the nursing station, was observed open approximately one foot and unattended. The knob of the medication cart was observed fully extended in the unlocked position. During observation, R19 propelled self in her wheelchair and was observed going past the medication cart to the water fountain with the medication cart drawer still open. Registered nurse (RN)-C and licensed practical nurse (LPN)-B were to the left of the medication cart by the nursing station receiving and giving report at the time of the observation. The medication cart was out of their line of sight.	F 431	F431 It is the practice of Benedictine Health Center of Minneapolis to store drugs and biologicals under proper controls and to remove or dispose of expired meds on a timely basis. A. Licensed staff member responsible for medication cart identified in 2567 immediately accepted responsibility for the failure to close and lock the medication cart; RN Clinical Manager reviewed practice expectations with nurse involved. Re: Fentanyl patches-two licensed staff signatures present in medical record with Fentanyl disposal. Re: Nitrostat-bottle present in the medication cart for R79, it is in the original bag as dispensed by pharmacy, unopened with the dispense date of 1/24/14. B. Reviewed with licensed nursing staff the expectations related to dating, removal and disposal of Fentanyl patches and expired meds. C. Random bi-monthly audit of med carts for presence of expired or discontinued meds and for presence of two signatures with disposal of used Fentanyl patches. Director of nursing or designee responsible. D. Audit results reported to Quality Council for input. Compliance date: 12/16/14	

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F 431	Continued From page 35 - At 3:18 p.m. RN-C and LPN-B walked away from the medication cart area. The drawer remained open, unattended and unlocked. Both nurses were observed going from room to room giving report on the West Wing. - At 3:19 p.m. the nurse manager (RN)-A was observed walking in front and past the medication cart with the drawer still open. RN-A went to the East Wing and was observed speaking briefly to one of the nursing assistants. RN-A did not close, lock and RN-A was looking away. -At 3:20 p.m. RN-D was observed to walk in front of the medication cart and went behind the nursing station. RN-D did not close and lock the medication cart. - At 3:20 p.m. LPN-B was observed walking in front of the medication cart and made a quick turn and walked in the nursing station and sat down. LPN-B did not close and lock the medication cart. - At 3:21 p.m. RN-D walked again in front of the medication cart, went to the water fountain, obtained a glass of water, walked back in front of the cart and came back from the right side of the nursing station, sat down. The medication cart was still open and unattended. - At 3:22 p.m. the medication cart knob was still extended outward with second drawer remaining open exposing multiple cards of medications. - At 3:22 p.m. three nursing assistants (NAs) walked past the open unattended medication cart with a linen cart to the East Wing and were observed passing linen from room to room. During observation six residents were observed seated in the dining room and television lounge areas of which two had walkers and the rest were on wheelchairs. The residents were seated three to four feet from the opened medication cart. - At 3:24 p.m. RN-C walked towards the cart pushed the drawer back inward and pushed the	F 431		

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F 431	Continued From page 36 extended knob inward to lock the cart. - At 3:24 p.m. when interviewed RN-C stated the facility expected the medication cart to be locked and the nurse to have the keys. - At 3:25 p.m. when asked about the open medication cart, LPN-B stated, "I didn't see it." and indicated he had handed over the keys to RN-C. LPN-B stated the facility expected him to ensure the medication cart was locked at all times when not attended to. - At 3:26 p.m. RN-D stated, "It should be closed at all times." RN-D acknowledged she had walked past the medication cart but did not see it open. R59's Minimum Data Set (MDS) dated 11/4/14, indicated R59 was moderately cognitively impaired. Displayed no mood symptoms or behaviors and was able to ambulate but needed supervision, cueing and encouragement. R67's MDS dated 9/23/14, indicated R67 was cognitively intact. Displayed behaviors of pacing, hitting, scratching self and had verbal vocalizations of screaming, had no mood symptoms of depression and was independent with ambulation. R75's MDS dated 10/2/14, indicated R75 was severely cognitively impaired. Displayed no behaviors, had mood symptoms of depression and was able to ambulate but needed supervision, cueing and encouragement. R9's MDS dated 10/14/14, indicated R9 was cognitively intact. Displayed no behaviors and had mood symptoms of feeling hopeless and was independent with ambulation.	F 431		

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R19's MDS dated 9/30/14, indicated R19 was cognitively intact. Displayed no mood symptoms or behaviors and was able to maneuver the wheelchair independently.

R5's MDS dated 8/12/14, indicated R5 was severely cognitively impaired. Displayed no behaviors and had mood symptoms of feeling hopeless and was independent with ambulation.

On 11/4/14, at 3:36 p.m. RN-A acknowledged she had walked past the medication cart, but stated she was facing the other direction and never saw it open. RN-A stated she expected the medication cart to be locked when not in use or unattended and "it should be a habit."

On 11/6/14, at 1:42 p.m. the director of nursing (DON) stated nurses should lock the medication cart when out of sight, "I don't look at the carts every time I walk past them, I don't necessarily look at them."

On 11/6/14, at 2:34 p.m. when asked how many residents were physically capable of accessing the unlocked medication cart RN-A stated only six residents on the unit.

On 11/6/14, at 3:16 p.m. the facility consultant pharmacist (CP) stated if the nurse was not at the medication cart, it should be locked.

The Storage and Expiration of Medications, Biologicals, Syringes and Needles policy revised 1/1/13, directed, "1. Facility should ensure that only authorized Facility staff, as defined by Facility, should have possession of the keys, access cards, electronic codes, or combinations which open medication storage areas...3.3

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	245266	A. BUILDING _____ B. WING _____	11/06/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 38 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors." Third floor: On 11/5/14, at approximately 2:13 p.m. a tour of the medication cart was completed with RN-E. During the tour a bottle of Nitrostat for R79 was observed stored inside a clear small plastic bag on the top drawer of the medication cart with the seal broken. The Nitro bottle lacked a label indicating date when medication had been opened. On the plastic bag was a dispense date of 8/22/13. - At 2:15 p.m. when interviewed regarding the expired medication RN-E stated as far as she knew, the facility policy directed the Nitrostat was supposed to be dated when it was opened, stored in a dark area and was to be disposed of thirty days after being opened. She further stated expired medications were not to be stored in the medication carts. On 11/6/14, at 8:18 a.m. the nurse manager (RN)-F stated expired medications should not be stored in the medication cart and multiple use medications needed to be dated upon being opened. - At 11:15 a.m. during a telephone interview with a pharmacy technician it was revealed R79's Nitrostat had last been dispensed on 8/22/13. - At 2:41 p.m. RN-F approached surveyor and stated R79 was the only resident in the unit that received Nitrostat. She further stated, "After opening, we think it should be dated but if not it's the dispensed date." - At 3:16 p.m. during a telephone interview the	F 431		

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F 431	Continued From page 39	F 431		

consultant pharmacist (CP) stated she expected and hoped expired medications to be pulled from the medication carts and put in an area to be disposed of. When asked if the staff were supposed to date Nitrostat when first opened, CP stated, "I have to look that up, it used to be six months so may be good until it doesn't tingle any longer, may have to look it up for correct information." CP further stated she would send DON additional information about Nitrostat, but that when she became a pharmacist the rule of thumb was Nitrostat should be disposed of within six months and the Nitrostat should have been dated when opened.

The quarterly Minimum Data Set (MDS) dated 7/28/14, indicated R79's diagnoses included heart failure and hypertension.

R79's signed but not dated Physician Order Report indicated R79 had an order for Nitrostat 0.4 milligrams (mg) 1 tablet sublingual with special instructions: "every 5 minutes for chest pain. Dissolve under tongue as needed [PRN]."

The Storage and Expiration of Medications, Biologicals, Syringes and Needles policy dated as revised on 1/1/13, directed, "5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened."

Fentanyl patches disposal on Third and Fourth Floors:
On 11/5/14, at approximately 1:42 p.m. a tour of

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F 431	Continued From page 40	F 431		

the medication cart was completed with LPN-A. During the tour inside the narcotic box to the back was observed an opened box of Fentanyl patches with one patch inside for R81. When interviewed LPN-A stated the facility policy and procedure on disposing used Fentanyl patches was with two nurses observing the patch being flushed down the toilet. LPN-A stated the patch disposal was to be documented in the electronic Medication Administration Record (EMAR). LPN-A then opened R81's EMAR for the last fourteen days and verified only one nurse had signed off after disposing the Fentanyl patch. She further stated only one nurse was able to do that in the EMAR and the other nurse did not document witnessing anywhere else.

On 11/6/14, at 10:14 a.m. the Fentanyl Patch disposal policy was requested from DON.
- At 11:35 a.m. DON was approached for the policy and stated it was being typed at that time.
- At 12:45 p.m. DON provided the undated policy.

On 11/6/14, at 1:06 p.m. when re-approached LPN-A was asked if a second nurse signed off on the Fentanyl patch or puts a note in the EMAR, she stated, "No. Only one nurse can sign off." and pointed to the computer.

On 11/6/14, at 1:42 p.m. DON stated, "We had entered that direction to have two nurses, we don't have a separate place for second nurse to initial." DON stated per the pharmacy, there were two residents in the facility who used Fentanyl Patches.

On 11/6/14, at 3:16 p.m. when interviewed via telephone CP stated DON had identified it was a challenge with the Matrix EMAR for two nurses to

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F 431	Continued From page 41 document Fentanyl patch destruction and she had asked Matrix to see if there would be a way for the second nurse to document after witnessing. R81's Physician's Orders indicated R81 had an order for the Fentanyl patch (used for pain) as of 6/10/14. R81's diagnoses included malignant neoplasm of prostate and second malignant neoplasm of bone and bone marrow obtained from quarterly MDS dated 9/15/14. During review of R81's EMAR dated 11/1/14 through 11/6/14, it was revealed R81 had the Fentanyl patch removed and disposed of twice with only one nurse signing off. It could not be determined if there were two nurses or one nurse signing off for the removal and destruction of the Fentanyl patch. R82's diagnoses included spinal stenosis in cervical region obtained from MDS admission assessment dated 8/19/14. The Physician's Orders indicated R82 had an order for the Fentanyl patch as of 8/24/14. During review of R82's EMAR dated 11/1/14 through 11/6/14, it was revealed R82 had the Fentanyl patch removed and disposed of twice with only one nurse signing off. It could not be determined if there were two nurses or one nurse signing off for the removal and destruction of the Fentanyl patch. The Undated Administration and Disposal of Fentanyl Patches policy directed, "9. Regardless of disposal method, two nurses should witness	F 431		

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F 431	Continued From page 42 the disposal of used patches and unused patches. The standard form for destruction of unused Class II drugs should be completed for documentation per state regulations. 10. Document drug administration and removal per Class II drug policy and procedure." Although the facility policy indicated two nurses were to witness the disposal of the used and unused patches the policy did not address both nurses had to actually document the disposal but rather only one of the nurse's was able to do so which increased the risk of diversion.	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents (R9) reviewed for accidents had a call light that functioned properly. Findings include: On 11/4/14, at 8:58 a.m. R9's bathroom call light was observed not functioning. R9's annual Minimum Data Set (MDS) identified R9 as being at risk for falls. R9's quarterly MDS dated 10/14/14, indicated R9 was cognitively intact. The MDS included active diagnoses of hypertension, diabetes mellitus, depression and	F 463	F463 Benedictine Health Center of Minneapolis nurses stations are equipped to receive resident calls through a communication system from resident rooms, bathrooms and bathing areas. A. Call light in room 424 was repaired on 11/4/14. B. Reviewed expectation of immediate communication of any call light repairs needed to maintenance. C. Monthly call light checks of all call lights by maintenance staff. D. Random audit of resident call light	12/16/14

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F 463	Continued From page 43 schizophrenia. The MDS read R9 needed staff assistance with personal hygiene and staff supervision with bathing. On 11/4/14, at 8:59 a.m. nursing assistant (NA)-A verified the red light above R9's door did not appear after the call light cord was pulled in R9's bathroom. NA-A stated the red light was supposed to show on top of residents' doors in the hall when residents needed assistance in their bathrooms. NA-A also stated she would tell her supervisor about the call light in R9's bathroom not working. NA-A further stated R9 was able to use her call light. --At 9:05 a.m. registered nurse (RN)-B stated, "I will call maintenance, it's an old building." RN-B also stated when call lights do not work we call maintenance, and if need be while waiting for maintenance we give the resident a bell to use." --At 9:08 a.m. maintenance-A verified R9's bathroom call light was not working and stated, "I will fix it." At 9:11 a.m. maintenance-A stated he had addressed the call light function. Maintenance also stated staff let him know when call lights are not working. On 11/6/14, at 10:05 a.m. during environmental tour maintenance-A stated he had repaired R9's call light and he did monthly audits on call lights to make sure call lights are working properly. The Administrator verified R9's call light should be in working order. The maintenance request book was observed at the nurse's desk. The book did not have a request for R9's bathroom call light to be repaired. The facility's Call Light Policy dated 5/2012,	F 463	system as part of safety survey. Reviewed for trends, communicated to Quality Council for input. Compliance date: 12/16/14	

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F 463	Continued From page 44 indicated, "Call lights are checked on a monthly basis by the maintenance department. An audit report is kept for records in the maintenance department. If another staff member finds a broken, non-working or missing call light, they should contact maintenance with location of the problem call light immediately."	F 463		

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	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/05/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Heatlh Center of Mpls was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/04/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 5-story building was determined to be of Type II(000) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 79 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirement for construction	K 012	Correction not needed. Benedictine Health Center of Minneapolis has	12/16/14

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K 012	Continued From page 2 type and height. This deficient practice could affect all residents. Findings include: On facility tour between 9:00 AM and 11:30 AM on 11/05/2014, observation revealed that this 5-story, non-combustible facility of Type II(000) construction does not meet the minimum construction requirements for a building of this height. The roof of the facility does not have a fire rating. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012	achieved a passing FSES score.	