Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

October 30, 2024

Administrator
Benedictine Home Health
615 NORTH FIRST STREET
COLD SPRING, MN 56320

Re: Event ID: 64232-H1

Dear Administrator:

A partial extended survey was completed at your agency on October 16, 2024, for the purpose of assessing compliance with Federal certification.
At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division, noted one or more deficiencies. Electronically attached is a copy of the Statement of Deficiencies (CMS-2567).

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

The plan of correction should be directed to:

Nikki Harvey, Regional Operations Supervisor
St. Cloud A District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557
Email: nikki.harvey@state.mn.us
Office: (320) 223-7318 Mobile: (320) 216-5631

Please make a copy of your plan of correction for your records.

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Home Health	**615 NORTH FIRST STREET , COLD SPRING, Minnesota, 56320**

(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
E0000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 10/14/24-10/16/24 during a recertification survey. The facility was in compliance with the Appendix Z Emergency Preparedness Requirements.	E0000		
G0000	INITIAL COMMENTS On 10/14/24-10/16/24 a recertification survey was conducted. This resulted in a partial extended survey at Benedictine Home Care. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies. The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care. Unduplicated census previous 12 months: 12 Total home visits conducted: 0- no skilled nursing or unskilled visits were scheduled during time of survey. Location visited: Cold Spring: 615 North First Street Cold Spring, MN 56320 No branch locations. List Hours of Operation: 8:00 a.m. to 4:30 p.m. List total number of records reviewed: 5	G0000		
G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs	G0514		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Home Health	615 NORTH FIRST STREET , COLD SPRING, Minnesota, 56320

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G0514	Continued from page 1 of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure each patient had an initial assessment visit within 48 hours of their referral date for 1 of 5 residents, (P5), skilled clients reviewed. Findings include: P5 had been referred to the home care agency by his physician on 5/17/24 for skilled nurse visits. P5's Home Health Certification and Plan of Care dated 5/20/24 through 7/18/24, indicated P5 did not start home health services until 5/20/24, three days after the physician's referral date to the agency. The plan of care identified resident preferred care on Mondays-Wednesdays-Fridays (M-W-F), however, orders were not obtained to reflect desired delayed start of care. During interview with the agencies director of nursing (DON) on 10/15/24, at 3:43 p.m. stated the initial assessment was to be completed within 48 hours of the initial referral unless orders were obtained to delay the date of the start of care. DON stated although there had been information as to potentially changed date of SOC for P3, or preference with P5, there had not been orders to delay the SOC. DON stated the provider was to be updated with any potential for change start of care. On 10/16/24, at 9:00 a.m., the executive director (ED) stated the initial visit for admission was to be completed within 48 hours of the referral from the admitting provided unless a delay in start of care date authorization is received from the admitting provider. The facility policy, Comprehensive Patient Assessment, revised 1/2024, identified the client would receive an accurate and comprehensive assessment consistent with the patient's immediate needs. The initial assessment must be conducted by a registered nurse (RN) of referral and/or with 48 hours of the patient's return home, unless a physician specifies a specific time to conduct the assessment.	G0514		
G0808	Onsite supervisory visit every 14 days	G0808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248110	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0808	Continued from page 2 CFR(s): 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services— (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. This ELEMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide supervision of home health aides for 2 of 2 residents (R2, R4) reviewed for home health aide services. R2's Home Health Certification and Plan of Care certification period 10/2/24 to 11/30/24, included home health aide visits two times weekly and skilled nurse visits every other week. R2's Aide Care Plan with start date 2/25/20, included R2 would receive one whirlpool bath and one shower per week, skin care and grooming. R2 had skilled nurse visits on 10/9/24, 9/25/24, 8/28/24, 8/14/24, 7/31/24, 7/17/24, 7/3/24, 6/29/24, 6/5/24, 5/22/24, 5/8/24, 4/24/24, and 4/10/24 and recertification visits on 10/1/24, 7/29/24, and 6/4/24. The last documented supervision visit was 4/22/24. During interview on 10/14/24 at 3:25 p.m., R2's family member (FM)-B stated the home health aides were doing a good job and there were no concerns regarding care. FM-B stated the nurses do not ask at every visit how the home health aides are preforming but usually had	G0808		

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G0808	Continued from page 3 during recertification visits. During interview on 10/15/24 at 12:15 p.m., director of nursing (DON) stated home health aide supervision should have been completed every 14 days. DON stated she typically completed the supervision on Mondays when R2 had a whirlpool bath but had not documented the supervision. DON confirmed it was important to document home health aide visit supervision to show R2's needs were being met and that staff are treating him well. DON confirmed she had not documented a supervision visit since April 2024. R4's Home Health Certification and Plan of Care certification period 1/17/24 to 3/16/24, included home health aide (HHA) visits two times weekly and skilled nurse visits every other week. R4's Aide Care Plan with start date 7/24/23, indicated R4 would receive a tub bath with shampoo of hair twice weekly. The narrative notes within the plan of care identified the aide was to receive a whirlpool or shower, as determined by client preference. The aide was to assist R4 to wash [body] and shampoo hair. The plan of care directed the aide to assist to dry after shower and get dressed. The plan also directed the staff to assist the client to shave, brush teeth, if needed and comb hair. The plan of care also directed the staff to assist to select clothes, assist with dressing, brush/comb hair, and shave. The plan of care also directed staff to assist to brush teeth. The plan of care was signed by director of nursing (DON) on 7/25/23. Upon review of the medical record, it was noted R4 had received skilled nurse visits by licensed practical nurse (LPN)-A on the following dates during the certification period of 1/17/24 to 3/16/24; 1/24/24, 2/7/24, 2/21/24, and 3/6/24. Although the skilled nurse documentation form had an area to complete when a supervisory visit was done for home health aide visits provided, this was not completed as the skilled visits were completed by a LPN, and supervisory visits were to be completed by a registered nurse. During interview on 10/15/24, at 3:51 p.m. DON stated a supervisory visit for the HHA would not be done when the skilled visit was completed by an LPN. DON stated this needed to be completed by a registered nurse (RN) and should have been placed on the calendar for completion. DON stated the medical record lacked indication the supervisory visits were completed, and identified "it's not on here."	G0808		

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G0808	Continued from page 4 On 10/16/24, at 9:00 a.m. the executive director (ED) stated in person supervisory visits are to be completed every 14 days when the client was receiving HHA visits. ED stated if the skilled visit was completed by a LPN, the supervisory visit needed to be completed every 14 days in person by a RN. A facility policy, titled Home Health Aide Services, revised January 2024, included supervisory visits would be made at least every 2 weeks for patients receiving skilled care.	G0808		

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October 30, 2024

Administrator
Benedictine Home Health
615 NORTH FIRST STREET
COLD SPRING, MN 56320

Re: Event ID:64232-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on October 16, 2024, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **26118**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/16/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Home Health	**615 NORTH FIRST STREET , COLD SPRING, Minnesota, 56320**

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00000	Initial Comments On 10/14/24 through 10/16/24 a recertification survey was conducted. No licensing orders were issued during this survey.	00000		

Office of Primary Care and Health Systems Management

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