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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7KXS

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 **12/12/2019** (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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* 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 :
Shelley Arumba, HFE NE II — 01/21/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas Larson, Enforcement Specialist — 02/10/2020 (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

Electronically delivered
January 6, 2020

Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

RE: CCN: 245266
Cycle Start Date: December 12, 2019

Dear Administrator:

On December 12, 2019, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 12, 2020 (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).

In addition, if substantial compliance with the regulations is not verified by June 12, 2020 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	C 12/12/2019

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
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 12/9/19, through 12/12/19, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 12/9/19, through 12/12/19, a standard survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not to be in compliance with the federal requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be substantiated: H5266074C. Deficiency issued at F610. H5266076C. Deficiency issued at F684. H5266079C. The following complaints were found to be unsubstantiated: H5266075C H5266077C H5266078C 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/16/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	C 12/12/2019

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	Continued From page 1 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584		1/24/20

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 _____	C 12/12/2019

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 584	Continued From page 2 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sanitary, comfortable and homelike environment for 1 of 2 residents (R26) reviewed with environmental concerns. Findings include: R26's diagnosis list printed 12/12/19, identified the following diagnoses: anoxic brain damage, protein-calorie malnutrition, persistent vegetative state, and gastrostomy. On 12/9/19, at 4:02 p.m. R26 came back from shower and was lifted back into bed. Sheets had been changed and the area around the bed had been straightened up. During an observation on 12/9/19, at 4:19 p.m. it was noted that the tubing for R26's g-tube feeding which was hanging from an IV (intravenous) pole, was leaking down the pole. There was fresh as well as dried liquid on the pole, floor, bed frame and some splashed on the wall and base board. On 12/9/19, at 4:27 p.m. registered nurse (RN)-D was observed while providing trach care for R26. There was no leaking fluid observed at this time, however the tube feeding pole and floor were	F 584	It is the policy of Benedictine Health Center Minneapolis to follow all Federal, State, and local guidelines, laws and regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citation. The preparations, submission and implementation of this plan of correction will serve as our credible allegation of compliance. F-584 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R26 IV pole, bed, and floor was cleaned while surveyor were still present on 12/9/2019 B. How will you identify other residents having the potential to be affected by the same deficient practice? " All Nursing and cleaning staff has	

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 _____	C 12/12/2019

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 584	Continued From page 3 dirty. On 12/10/19, at 1:09 p.m. the pole, floor, bed and base board were still dirty. All the liquid was dried. On 12/11/19, at 8:00 a.m. the dried liquid was still present. On 12/11/19, at 8:11 a.m. housekeeper (HSK)-A stated that resident rooms were cleaned daily including the floor and around and under machines. HSK-B was interviewed on 12/11/19, at 8:16 a.m. HSK-B stated she just started her second week of work and just got off of orientation. She was the only housekeeper on the fourth floor. HSK-B stated she had been trained to clean all floors and around furniture and machines. Nursing assistant (NA)-D was interviewed on 12/11/19, at 11:45 a.m. and stated she would notify the nurse if she saw the tubing leaking and would clean up anything on the floor, bed and baseboard. NA-D verified dried liquid in those areas. On 12/11/19, at 11:53 a.m. NA-E verified the dried liquid on the floor, bed, pole and base board. On 12/11/19, at 12:10 p.m. the clinical manager, registered nurse (RN)-E verified the dried liquid. RN-E stated the expectation was that all rooms should be cleaned daily and that staff should have noticed the dried liquid. On 12/11/19, at 12:11 p.m. the director of maintenance (DM) verified that all floors would be	F 584	been provide education to understand the joint responsibility of cleaning and process around cleaning and accountability to ensure cleaning happens.. C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " All staff have been provided education to reiterate cleaning responsibilities and process on January 21, 22, and 23 of 2020. D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented education for all staff to ensure all necessary cleanings to resident equipment in the room occurs on January 21, 22, and 23 of 2020. " A system in a tracking tool for cleaning of resident equipment in the room has been established. " The Nursing Managers, Supply Director and Maintenance personnel will assist to complete weekly quality assurance audits for 8 weeks and monthly for 2 additional months. Additional training may be scheduled based on results of the quality assurance review. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 01/24/2020	

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 _____	C 12/12/2019

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 584	Continued From page 4 expected to be cleaned every day, including around machines and IV poles. DM verified the dried liquid on pole, floor, bed frame and base board. DM stated nursing would clean the actual equipment and housekeeping would clean the rest. The facility policy regarding cleaning and maintenance of equipment dated October 2017, indicated equipment must be maintained and repaired in a manner that would prevent transmission of infection.	F 584		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution	F 585		1/24/20

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 _____	C 12/12/2019

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 585	Continued From page 5	F 585		

of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately

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 _____	C 12/12/2019

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 585	Continued From page 6 reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly respond or resolve grievances expressed by 1 of 1 resident (R23) reviewed for concerns regarding cares with staff. Findings include: Family member (FM)-B was interviewed via telephone on 12/9/19, at 4:57 p.m. and stated	F 585	F-585 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " Grievances expressed by R 23 was entered into the Grievance Tracking system.	

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 _____	C 12/12/2019

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 585	Continued From page 7 R23 and FM-B expressed concerns to clinical manager (CM)-A and the facility administrator regarding call light placement, not assisting R23 with meals timely, and R23's communication computer potentially falling and hitting R23 in the face due to a broken piece and staff not positioning the computer properly. FM-B explained he had expressed multiple concerns during the past six months and had met with the administrator, however FM-B stated he had not received any follow-up and felt as if the concerns were ongoing. FM-B indicated there were concerns with R23 having been mistreated over the summer as well as a "few times" since then by facility staff during cares, however indicated he did not receive follow up. R23 was interviewed on 12/10/19, at 3:29 p.m. and stated staff did not put her call light near her head as they were supposed to. R23 indicated she was able to push her head against her call light when it was placed correctly by staff. R23 indicated her call light was the only way to notify staff when needing assistance due to R23 having been non-verbal. R23 was observed on 12/10/19, at 3:29 p.m. lying on her back resting in her bed eyes open computer near face and call light on the floor not within reach of R23's head. R23's quarterly Minimum Data Set dated 9/17/19, identified R23 had intact cognition and required total assistance of two staff for bed mobility. R23's undated Resident Face Sheet identified R23 had diagnoses which included chronic respiratory failure with hypoxia or hypercapnia, flaccid hemiplegia affecting right dominant side,	F 585	B. How will you identify other residents having the potential to be affected by the same deficient practice? " All staff has been provide education to understand the importance of recording grievances and/or reporting them to member of the management team. C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Review grievance process provided to all staff on January 21, 22, and 23 of 2020 . D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented education for all staff on January 21, 22, and 23 of 2020, to ensure all grievances/concerns are reported and followed up on. " All grievances will be tracked in the concerns Data Base.. " The Social Services Director will assist to complete monthly quality assurance audits for 3months for grievance/concerns. Additional training may be scheduled based on results of the quality assurance review. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 1/24/2020	

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 _____	C 12/12/2019

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 585	Continued From page 8	F 585		

flaccid hemiplegia affecting left non-dominant side and Amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function).

R23's medical record lacked evidence of a written grievance and/or concern form and follow-up.

The administrator was interviewed via telephone on 12/12/19, at 3:40 p.m. and verified he met with FM-B regarding concerns, however indicated there was nothing in writing regarding the concerns and/or follow-up. The administrator stated they would usually sit down and talk to the family regarding concerns, however indicated they did not always document the conversations. The administrator indicated he thought R23 and FM-B's concerns had been "handled."

The Facility Concerns Grievances Policy dated 6/2019, indicated after receiving a concern there was a prompt response by the associates to acknowledge the receipt of the concern, investigate, seek resolution and keep the resident appropriately apprised of progress toward resolution. The resident/ resident representative had a right to receive a written response to their concern or grievance if requested. The policy included when a resident, resident representative, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards the form to the social services department, grievance officer, designees in a confidential container. All written grievance decisions would include the date the grievance was received, summary of the grievance, steps taken to investigate, pertinent findings or conclusions regarding the concern, a statement whether the grievance was confirmed or not

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 _____	C 12/12/2019

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 585	Continued From page 9 confirmed, any corrective action taken or to be taken by the facility as a result of the grievance and the date the written decision was issued.	F 585		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to report timely an	F 609	F-609 SS: D	1/24/20

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 _____	C 12/12/2019

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 609	Continued From page 10 allegation of stolen money to the administrator and state agency (SA) for 1 of 5 residents (R65) reviewed for misappropriation of property. Findings include: R65 was interviewed on 12/9/19, at 1:28 p.m. and stated she had $35.00 stolen from a zippered wallet which was left in her room on her bedside table. R65 recalled she left her room for one to two hours and when she can back the money was stolen. R65 stated she notified the clinical manager (CM)-A two to three months ago regarding the stolen money. R65 stated she felt as if there was not any follow-up and wanted the facility to let her know the outcome of their investigation. R65's quarterly Minimum Data Set dated 11/5/19, identified R65 had moderate cognitive impairment and diagnoses which included depression and anxiety. CM-A was interviewed on 12/10/19, at 3:18 p.m. and stated she was not aware of the stolen money. CM-A indicated she would notify the director of social service (DSS) for further follow-up. R65's Concern Form dated 12/10/19, at 3:32 p.m. indicated R65 told CM-A during the past 90 days R65 had $35.00 missing. R65's medical record lacked evidence of notification to the administrator and/or SA regarding the reported $35.00 stolen on 12/10/19. R65 was observed 12/11/19, at 8:46 a.m. seated in her room in her wheelchair watching television.	F 609	A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R65 had a concern entered into the costumer concerns database on 12/10/2019 B. How will you identify other residents having the potential to be affected by the same deficient practice? " All staff has been provide education to understand the importance of recording concerns and missing items to management. C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " All staff have been provide education to reiterate concerns and missing items on January 21, 22, and 23 of 2020 . D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility educated all staff to ensure all concerns/missing items on January 21, 22, and 23 of 2020 " The Social Services Director will assist to complete monthly quality assurance audits for 3months. Additional training may be scheduled based on results of the quality assurance review. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 1/24/2020	

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 _____	C 12/12/2019

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 609	Continued From page 11 R65 was interviewed on 12/11/19, at 11:40 a.m. and stated DSS came to talk to her "this morning" and indicated R65 told DSS, "I thought it was stolen." DSS was interviewed on 12/12/19, at 10:13 a.m. (three days after concern was reported to facility regarding R65's stolen money) and stated she spoke to R65 whom indicated she had lost $35.00 in her coin purse which was left on her bedside table. DSS indicated she reminded R65 to keep her money locked in her drawer and gave R65 a replacement key as R65's key was lost. DSS explained they only reported missing property if the value was greater than $50.00. During a subsequent interview at 1:48 p.m. DSS indicated R65 "shrugged her arms" when DSS asked if the $35.00 had been stolen, as if R65 was not sure. DSS indicated she completed a concern form for the missing money, however did not notify the SA. The facility Abuse Prevention Plan dated 2017, indicated misappropriation of resident property included the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The policy indicated staff would notify the charge of building immediately of any reports of misappropriation of resident property whom would immediately notify the administrator, director of nursing and DSS. If the even did not result in bodily injury the individual was required to report no later than 24 hours.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		1/24/20

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 _____	C 12/12/2019

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 610	Continued From page 12 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to thoroughly investigate an allegation of mistreatment for 1 of 1 resident (R23) reviewed for employee physical abuse. In addition, the facility failed to thoroughly investigate an allegation of unwanted advances from staff for 1 of 1 resident (R380) reviewed for abuse. Findings include: R23's care plan dated 4/2/19, identified R23 was at risk for skin breakdown and directed staff to move resident with two staff and draw sheet. R23's investigative file dated 7/8/19, indicated R23's daughter reported R23 had received "rough care early AM ...And finger(s) on left hand bent back causing pain." The file indicated it was	F 610	F-610 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R380 was discharged from our facility. R23 is moved/positioned with 2 staff members per care plan B. How will you identify other residents having the potential to be affected by the same deficient practice? " All Nursing staff have been educated around following of care plans and the thorough investigation of allegations. C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?	

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 _____	C 12/12/2019

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 610	Continued From page 13 reported on 7/8/19, by R23's family, however the alleged allegation occurred on 7/6/19, "about" 5:00 a.m. per R23's interview and reported "she was half asleep when blanket was pulled back ...and left hand 2nd finger was bent back." R23 identified the nursing assistant (NA) as a "white lady who is a regular on the unit" The file indicated NA-C, R23 and clinical manager (CM)-A met and NA-C "sincerely apologized" to R23 as NA-C "was working that night." The file identified NA's "were providing care as per care plan and know to gently touch her shoulder during the night." R23's file included NA-C written statement dated 7/8/19, and indicated R23 "takes a lot of time to care for and it is hard to be gentle" due to R23's size. R23's quarterly Minimum Data Set (MDS) dated 9/17/19, identified R23 had intact cognition and required total assistance of two staff for bed mobility. R23's Resident Face Sheet undated, identified R23 had diagnoses which included chronic respiratory failure with hypoxia or hypercapnia, flaccid hemiplegia affecting right dominant side, flaccid hemiplegia affecting left non-dominant side and Amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function). R23's medical record lacked evidence of R23's care plan not having been followed when R23 was turned and repositioned with one staff instead of two. Although other staff were interviewed and one audit was completed, R23's record lacked evidence of NA-C re-educated regarding care plan needed to have been followed regarding repositioning and further	F 610	" All Nursing staff have been provided education on care plans and in thorough investigations. D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has educated nursing staff to ensure understanding of care plan and how to do a thoroughly investigation on January 21, 22, and 23 of 2020. " The DON and Social Services Director will oversee all random audits of care plans and any investigation. Quality assurance audits for care plan compliance and Investigate completeness. On a monthly basis for 3 months. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 1/24/2020	

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 _____	C 12/12/2019

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 610	Continued From page 14	F 610		

audits of NA-C providing resident cares in addition to other resident interviews.

R23 was interviewed with the use of an electronic communication device on 12/9/19, at 1:54 p.m. and stated staff did not take their time when providing cares. R23 explained it was not all staff "just a few" and indicated she "cannot talk during cares to tell them" to slow down. R23 indicated "rough care happens at dark time" and indicated NA's would cause pain and were "degrading I am a person just like them who needs to be treated with respect." R23 stated a few months ago there was one staff who was providing cares during the time R23 reported rough treatment. R23 stated she notified CM-A regarding her concerns with staff.

Family member (FM)-B was interviewed via telephone on 12/9/19, at 4:57 p.m. and stated he felt R23 was "mistreated." FM-B identified R23 told him NA-C was "very rough" when providing cares.

R23 was observed on 12/9/19, at 5:39 p.m. lying in bed and assisted to be repositioned by three NAs whom gently rolled R23 side to side while explaining cares and asked R23 if she was okay. R23 indicated yes by shaking her head. R23 appeared comfortable while the staff assisted her.

NA-C was interviewed on 12/12/19, at 6:37 a.m. and stated "daily we turn and reposition people by ourselves it's the only way to get it done, I am pretty strong." NA-C explained R23 was difficult to understand and "usually" used two people when completing R23's cares. NA-C recalled R23 stated she was "treated roughly with her cares"

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 _____	C 12/12/2019

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 610	Continued From page 15	F 610		

and explained she did not remember "being too rough" with R23. NA-C remembered she worked the night R23 complained of rough treatment and indicated R23's care plan indicated two staff for turning and repositioning, however stated "but we did her as a one ...when I worked." NA-C indicated she "never really asked for help" she had her routine. NA-C explained when turning and repositioning R23 "alone you had to catch her to gently come back." NA-C stated "only a few of us who could do her alone." NA-C further stated "we likely did her alone" the night R23 reported her cares were rough and indicated it was "harder to move alone" due to R23's size and inability to assist. Furthermore, NA-C indicated "but now we use two" staff.

The director of nursing was interviewed on 12/12/19, at 2:08 p.m. and stated it was her expectation for staff to have used two people per R23's care plan.

The facility Abuse Prevention Plan dated 2017, indicated mistreatment was the inappropriate treatment of a resident. The plan indicated supervisors and managers would provide daily supervision of direct care staff to identify inappropriate behaviors, communication quality, physical contact and/ or burn out.

R380 was reviewed as a closed record.

R380's discharge MDS dated 7/30/19, identified R380 had intact cognition and diagnosis which included anxiety.

R380's Investigative File dated 7/23/19, indicated

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 _____	C 12/12/2019

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 610	Continued From page 16 R380 expressed to the facility social worker that a staff member made unwanted advances when registered nurse (RN)-G rubbed R380's shoulder close to "my breast" then turned R380's wedding ring and said "where you get this". R380 indicated she said "please don't touch me." R380 indicated she stayed away with her phone due to having been scared and identified the unwanted touching was the worst part. The file indicated the staff member knocked on R380's room to administer medication per orders. However, the file lacked evidence of interviewing additional residents and monitoring interactions between residents and staff. R380 was contacted via telephone on 12/11/19, at 1:08 p.m. however did not return the telephone call. Family member (FM)-C was contacted via telephone on 12/11/19, at 1:09 p.m. however did not return the telephone call. Registered Nurse (RN)-G was interviewed on 12/12/19, at 6:08 a.m. and stated he was attempted to administer R380's medication, however R380 was upset and wanted her narcotic pain medication instead of the Tylenol. RN-G denied touching R380 and stated he knocked on R380's door and only entered when R380 acknowledged him and welcomed his entrance. The director of nursing was interviewed on 12/12/19, at 2:14 p.m. and stated it was her expectation during the investigation to interview additional residents. The facility Abuse Prevention Plan dated 2017,	F 610		

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 _____	C 12/12/2019

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 610	Continued From page 17 indicated abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. The plan indicated all accidents and incidents as well as allegations of abuse would have been investigated.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would	F 623		1/24/20

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 _____	C 12/12/2019

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 623	Continued From page 18 be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental	F 623		

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 _____	C 12/12/2019

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 623	Continued From page 19 disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide written hospital transfer notices to the residents who had a facility-initiated hospital transfer for 2 of 2 residents (R27, R381) reviewed for hospitalizations. Findings include: R27 stated on 12/10/19, at 9:13 a.m. he had recently been hospitalized for too much fluid in his heart and had not had any staff discuss with him regarding a notice of transfer to the hospital and his appeals rights. Review of R27's medical	F 623	F-623 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " All residents moving forward will receive Discharge/Transfer Notice. B. How will you identify other residents having the potential to be affected by the same deficient practice? " The charge nurses will provide the required Transfer and Discharge notice	

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 _____	C 12/12/2019

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 623	Continued From page 20 record (MR) revealed R27 was his own responsible party. R27's Significant Change Minimum Data Set (MDS) dated 9/23/19, indicated R27's cognition was impaired. R27's Discharge Assessment Return Anticipated MDS dated 9/8/19, indicated R27 was discharged to an acute hospital. R27's Entry MDS dated 9/16/19, indicated R27 re-admitted to the facility. R27's Discharge Assessment Return Anticipated MDS dated 9/27/19, indicated R27 was discharged to an acute hospital. R27's Entry MDS dated 10/3/19, indicated R27 re-admitted to the facility. R27's Discharge Assessment Return Anticipated dated 10/21/19, indicated R27 was discharged to an acute hospital. R27's Entry MDS dated 11/5/19, indicated R27 re-admitted to the facility. R27's progress note (PN) dated 9/8/19, indicated R27 was sent to the hospital for shortness of breath (SOB) and decreased oxygen saturations and was admitted to the hospital. PN dated 9/16/19, indicated R27 returned from the hospital and was readmitted to the facility. Review of R27's medical record (MR) revealed no evidence a Notice of Transfer or Discharge was provided to R27. R27's PN dated 9/27/19, indicated R27 was sent to the hospital for SOB and decreased O2 (oxygen) sats (saturation) and was admitted to the hospital. PN dated 10/3/19, indicated R27 returned from the hospital and was readmitted to the facility. Review of R27's MR revealed no	F 623	with the appropriate appeal information as outlined in the regulation in the appropriate instances as indicated by the Discharge and Transfer flow sheet to the patient/representative as the patent is leaving the building when possible. When the notice is unable to be provided in urgent situations, the social worker will provide the required Transfer and Discharge notice with the appropriate appeal information as outlined in the regulation in the appropriate instances as indicated by the Discharge and Transfer flow sheet to the pt./representative by mailing the next business day. C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Transfer/Discharge packets updated to include Notice of Discharge & Bed Hold Agreement " Education was provided to social workers, charge nurses and floor nurses on the discharge and transfer notice policy and procedures on January 21, 22, and 23 of 2020 D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " Transfer/Discharge and Bed Hold agreements included in transfer/discharge packet " Education was provided to social workers, charge nurses and floor nurses on the discharge and transfer notice policy and procedures on January 21, 22, and 23 of 2020	

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 _____	C 12/12/2019

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 623	Continued From page 21 evidence a Notice of Transfer or Discharge was provided to R27. R27's PN dated 10/21/19, indicated R27 was sent to the hospital for SOB and decreased O2 sats and was admitted. PN dated 11/5/19, indicated R27 returned from the hospital and was readmitted to the facility. Review of R27's MR revealed no evidence a Notice of Transfer or Discharge was provided to R27. R27's PN dated 11/29/19, indicated R27 was sent to the hospital for SOB and decreased O2 sats and was admitted. PN dated 12/4/19, indicated R27 returned from the hospital and was readmitted to the facility. Review of R27's MR revealed no evidence a Notice of Transfer or Discharge was provided to R27. Registered Nurse (RN)-A stated on 12/12/19, at 9:26 a.m. nurses did not make residents aware of their appeal rights for transfer or provide the resident with a copy of the Notice of Transfer or Discharge when leaving for the hospital. The Business Office Manager (BOM) stated on 12/11/19, at 3:39 p.m. the facility had not yet implemented giving the residents and/or their representative notices of transfer or discharge when the facility initiated residents' transfers to the hospital. R27's Notices of Voluntary Resident/Patient Transfer or Discharge dated 9/8/19, 9/27/19, 10/21/19, 11/29/19, revealed no evidence of R27's signature, the notice being provided to him, or the reason for the medical transfer.	F 623	" Audits will occur Monthly for three months to ensure that all transfer/Discharge and Bed Hold forms accompanied the patient when appropriate. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 1/24/2020	

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 _____	C 12/12/2019

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 623	Continued From page 22 R381 was reviewed as a closed record and revealed evidence R381 was her own responsible party. R381's Admission MDS dated 5/29/19, indicated R381's cognition was intact. R381's Discharge Assessment Return-Anticipated MDS dated 6/4/19, indicated R381 was transferred to an acute hospital, was unplanned, and R381 was expected to return. R381's PN dated 6/4/19, at 11:36 p.m. indicated R381 was sent to the hospital. R381's PN dated 6/5/19, at 12:51 p.m. indicated R381 was admitted to the hospital and was awaiting spinal fusion surgery. R381's Notice of Voluntary Resident/Patient Transfer or Discharge dated 6/4/19, revealed no evidence of R381's signature, the notice being provided to her, or the reason for the medical transfer. The facility policy regarding Notice of Transfer or Discharge was requested for review, and was not provided.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that	F 625		1/24/20

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 _____	C 12/12/2019

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 625	Continued From page 23 specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents who were hospitalized were given choice to hold their bed for 2 of 2 residents (R27, R381) reviewed for hospitalization. Findings include: R27 stated on 12/10/19, at 9:13 a.m. he had recently been hospitalized for too much fluid in his heart and had not been asked by any staff if he had wanted his bed held while in the hospital. Review of R27's medical record (MR) revealed R27 was his own responsible party. R27's Resident Census sheet dated 12/12/19, indicated R27's payor source was Medicaid (MA).	F 625	F-625 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " All residents moving forward will receive bed holds appropriately. B. How will you identify other residents having the potential to be affected by the same deficient practice? " Bed hold policy was reviewed and beholds will be obtained regardless of payer source C. What measures will be put into place or what systemic changes will you make	

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 _____	C 12/12/2019

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 625	Continued From page 24 R27's Significant Change Minimum Data Set (MDS) dated 9/23/19, indicated R27's cognition was impaired. R27's Discharge Assessment Return Anticipated MDS dated 9/8/19, indicated R27 was discharged to an acute hospital. R27's Entry MDS dated 9/16/19, indicated R27 re-admitted to the facility. R27's Discharge Assessment Return Anticipated MDS dated 9/27/19, indicated R27 was discharged to an acute hospital. R27's Entry MDS dated 10/3/19, indicated R27 re-admitted to the facility. R27's Discharge Assessment Return Anticipated dated 10/21/19, indicated R27 was discharged to an acute hospital. R27's Entry MDS dated 11/5/19, indicated R27 re-admitted to the facility. R27's progress note (PN) dated 9/8/19, indicated R27 was sent to the hospital for shortness of breath (SOB) and decreased oxygen saturations and was admitted. PN dated 9/16/19, indicated R27 returned from the hospital and was readmitted to the facility. R27's PN dated 9/27/19, indicated R27 was sent to the hospital for SOB and decreased O2 (oxygen) sats (saturation) and was admitted. PN dated 10/3/19, indicated R27 returned from the hospital and was readmitted to the facility. R27's PN dated 10/21/19, indicated R27 was sent to the hospital for SOB and decreased O2 sats and was admitted. PN dated 11/5/19, indicated R27 returned from the hospital and was readmitted to the facility.	F 625	to ensure that the deficient practice does not recur? " Facility bed hold policy was reviewed with Education provided to Business Office, HIM, Charge Nurses and floor nurses regarding bed hold policy on January 21, 22, and 23 of 2020. Bed hold to be obtained regardless of payer source. D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " Facility bed hold policy was reviewed. " Education provided to BOM, HIM. Charge Nurses and floor nurses regarding bed hold policy on January 21, 22, and 23 of 2020. Bed hold to be obtained regardless of payer source upon/prior to transfer from facility. In urgent situations, bed hold will be obtained within 24 hours by social worker or designee. " Social worker or designee will complete audit on bed holds for the first 10 days out of the month for 3 months. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 1/24/2020	

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 _____	C 12/12/2019

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 625	Continued From page 25	F 625		

R27's PN dated 11/29/19, indicated R27 was sent to the hospital for SOB and decreased O2 sats and was admitted. PN dated 12/4/19, indicated R27 returned from the hospital and was readmitted to the facility.

R27's record lacked evidence of bedholds provided to R27 upon hospitalizations.

Registered Nurse (RN)-A stated on 12/12/19, at 9:26 a.m. when a resident gets sent to the emergency room (ER) the nurse writes the resident's name on the top copy of the bed hold papers where it says "Resident Signature" and sends the top copy with and leaves the duplicate and triplicate copies at the facility. RN-A confirmed R27's bed holds signature on duplicate and triplicate were not signed by R27 but had been written on the top copy of the form by the sending nurse and transposed to the duplicate and triplicate copy from when the nurse had written R27's name on the Resident Signature line.

Licensed Social Worker (LSW)-A stated on 12/12/19, at 11:52 a.m. residents going to ER were to sign the bed hold forms with nursing if they wanted their bed held during hospitalization. LSW-A stated if the resident was unconscious she would call the resident while in the hospital and document this in the resident's progress note (PN). LSW-A stated she did not get the resident's signature as she did not ask the resident if they wanted their bed held or not, but just informed the resident about the bed hold as the "The bed was held automatically for 18 days for MA residents."

The Business Office Manager (BOM) stated on

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 _____	C 12/12/2019

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 625	Continued From page 26 12/12/19, at 12:01 p.m. she presumed residents on MA wanted their beds held while hospitalized. Health Unit Coordinator (HUC) stated on 12/11/19, at 3:39 p.m. BOM was responsible for family signatures on bed holds. HUC stated the resident received the Bed Hold policy upon admission. BOM stated on 12/12/19, at 12:01 p.m. she got signatures with residents' representative and did not get signatures with residents as they had already agreed to the Bed Hold policy upon admission and residents with MA insurance the beds were "presumed held." BOM stated on 12/11/19, at 3:50 p.m. the top copy of the bed hold form goes out with resident to the hospital and LSW-A calls the hospital and leaves a message regarding the bed hold. BOM stated she mailed out the bed hold to the resident's family if the responsible party was the family. BOM stated she had not gotten R27's signature for bed holds as he was his own responsible party and was unable to sign when being sent out to the hospital. BOM stated R27 was his own responsible party, therefore she had not pursued his signature. BOM stated she did not see the point upon getting R27's signature after readmitting from the hospital. BOM confirmed the signature on the bed holds were not his signature but were written on by staff when sent to the ED. When asked about the signature on the bed hold not being R27's signature BO Director with no explanation stated, "That's our system." R27's Bed Hold Policy Notifications dated 9/8/19, 9/27/19, 10/21/19, and 11/29/19, did not reveal	F 625		

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 _____	C 12/12/2019

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 625	Continued From page 27	F 625		

evidence of R27's signature nor indicated whether R27 wanted his bed held or not. Boxes for I DO or I DO NOT on the notifications forms for R27 were left unchecked.

R381
R381 reviewed as a closed record and revealed evidence R381 was her own responsible party. Review of R381's MR revealed R381 transferred from the facility on 6/4/19, was admitted to the hospital on 6/5/19, and did not return to the facility after hospitalization.

R381's Admission MDS dated 5/29/19, indicated R381's cognition was intact and Medicare (MC) was R381's payor source.

R381's Discharge Assessment Return-Anticipated MDS dated 6/4/19, indicated R381 was transferred to an acute hospital, was unplanned, and R381 was expected to return.

LSW-A stated on 12/12/19, at 11:52 a.m. she did not handle the MC or private pay residents as BOM did.

BOM stated on 12/12/19, at 12:01 p.m. she did not get signatures on bed holds for residents who were their own responsible party as she did not see the point in it. BOM stated she only got signatures for bed holds with families and guardians. BOM stated R381 was on MC insurance and she had not discussed a bed hold with R381.

R381's PN dated 6/4/19, at 11:36 p.m. indicated R381 was sent to the hospital. R381's PNs dated 6/5/19, indicated R381 was admitted to the

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 _____	C 12/12/2019

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 625	Continued From page 28 hospital and was awaiting spinal fusion surgery. R381's Bed Hold Policy Notification dated 6/21/19, did not reveal evidence of R381's signature nor indicated whether R381 wanted her bed held or not. Boxes for I DO or I DO NOT on the notifications form for R381 was left unchecked. Facility Process For Completing Bed Hold Policy Notification Forms undated indicated,"Bed Hold Policy Notification Forms must always be completed at the time the resident is sent to the hospital". The Process indicated there were no need for signatures.	F 625		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns.	F 636		1/31/20

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 _____	C 12/12/2019

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 636	Continued From page 29 (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by:	F 636		

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 _____	C 12/12/2019

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 636	Continued From page 30 Based on interview and document review, the facility failed to ensure the resident Care Area Assessment (CAA) was timely and thoroughly completed for 1 of 1 resident (R3) reviewed. Findings include: R3's most current Minimum Data Set (MDS) had an assessment reference date of 11/20/19, but was not processed and electronically signed until 12/2/19, by RN-E. Section V, CAA indicated seven triggered care areas and care planning decisions with the location and date of CAA documentation notation stated as "see CAA WS [worksheet]". Record review of CAA on 12/12/19, revealed that triggered sections were not completed. RN-E was interviewed on 12/12/19, at 1:16 p.m. and stated she was the person completing both the MDSs and CAAs. RN-E verified there were several sections of the CAA worksheet dated 11/20/19, comprehensive assessment that were incomplete. RN-E stated it had likely not been completed because she was out with an injury. Additionally, RN-E verified the CAA worksheet was important because it drove the care plan. A copy of R3's current CAA was requested and received on 12/12/19. It was noted that care areas # (number)4 communication, #5 activities of daily life, #6 urinary incontinence, #11 falls, #12 nutritional status, #16 pressure ulcers, and #17 psychotropic medication use had all been completed and the document was electronically signed 12/12/19 by RN-E. Corresponding approaches documented in the care plan had not been updated since 5/29/19, or earlier.	F 636	F 636 A. The MDS for resident R3 was closed on 12/2/19 and the CAAS□s were completed on 12/12/19. B. Audit of OBRA comprehensive assessments completed since 12/12/19 for compliance with the regulatory timeframes. C. Review of expectations regarding completion of MDS assessments consistent with the regulatory timeframes with the RAI/IDT members. D. Random audit of two completed MDS per unit for four weeks, then four monthly for compliance with timeframes. Review of audits results with Quality Council for further direction. Compliance Date: 1/31/2020	

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 _____	C 12/12/2019

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 636	Continued From page 31 The Center for Medicare & Medicaid Services Resident Assessment Instrument (RAI) 3.0 (2018) indicated the MDS and the CAA are the basis of development of the individualized resident care plan. The RAI identified several types of assessments, including the Annual Comprehensive Assessment, which is required to be scheduled (called the assessment reference date (ARD)) within 366 days of the previous comprehensive assessment and within 92 days of the ARD of the previous Quarterly Assessment. The MDS and CAA must be completed no later than 14 days after the ARD. The ARD of the previous Quarterly Assessment completed for R65 was dated 8/22/19 and the ARD for the facility Annual Assessment was 11/20/19, 90 days later. The MDS and CAAs were electronically signed RN-E on 12/2/19. However, the CAA was not complete as of 12/12/19, which was verified by RN-E, and 22 days after the ARD. The facility policy for RAI completion was requested for review but was not provided.	F 636		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		1/31/20

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 _____	C 12/12/2019

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 657	Continued From page 32 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the opportunity for 3 of 3 residents (R44, R64, R66) to participate and engage in the development, review, and revision of their care plans and attend care conferences. Findings include: R44's Admission Minimum Data Set (MDS) dated 10/14/19, indicated R44 was cognitively intact, had clear speech, could be understood by others and admitted to facility on 10/8/19. Review of facility's Baseline Care plan dated 10/8/19, indicated R44 was alert and cognitively intact and communicated verbally. Interview with R44 on 12/10/19, at 10:56 a.m.	F 657	F-657 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " All residents moving forward will be invited to attend care conferences and response to request will be documented in the resident□s record and conference will occur within 7 days of MDS closing. B. How will you identify other residents having the potential to be affected by the same deficient practice? " All residents or Guardians response to request to attend care conferences will be documented in the care conference note all care conferenced will occur within 7 day of MDS closing.	

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 _____	C 12/12/2019

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 657	Continued From page 33 indicated he had not attended a care conference nor had he received any written or verbal invitations to a care conference meeting. When interviewed on 12/10/19, at 3:55 p.m. Clinical Manager (CM) indicated the facility process was to have an initial care conference with residents after admission and then they were setup quarterly thereafter. The Social worker sets up the care conferences and CM usually present ninety percent of the time. Sometimes the care conferences are held in CM's office or in the resident's room. CM indicated could not recall being part of any care conference meeting with R44. Interview with Director of social services (DSS) on 12/11/19, at 3:26 p.m. DSS indicated R44 had not been scheduled for a care conference and his meeting was about three weeks overdue. DSS was planning on maybe doing one the next week and that she usually liked to do it the first 4-6 weeks after admission into facility. Review of undated facility's policy titled, Comprehensive Assessments and Care Planning, indicated residents and resident representatives will be involved in the comprehensive person-centered care planning. If participation of resident and representative in development of plan is not practicable, explanation must be in resident's medical record. Requested documentation of DSS verbal or written invitation given to R44 to attend and participate in care planning and did not get one. R64	F 657	C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " All social worker staff will be educated to this Plan of Correction on January 21, 2020 " It will be documented during care conferences what day the resident was invited and by what means (oral of written) D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " All social worker staff had educated to this Plan of Correction on January 21, 2020. " The facility has implemented a Quality Assurance Program to ensure all residents will be invited to care conferences and that the care notes reflect the invitation and all care conference occur within 7 days of the MDS closing. " The Social Director and staff will complete monthly care conference note audits on current residents for three months. Additional training may be scheduled based on results of the quality assurance review " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 1/31/20	

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 _____	C 12/12/2019

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 657	Continued From page 34	F 657		

R64's Annual MDS dated 11/5/19, indicated R64 was cognitively intact, had clear speech, understands with clear comprehension and made self understood.

During interview with R64 on 12/09/19, at 5:08 p.m. R64 stated he had lived at facility for many years and did not remember attending care conferences. R64 stated, "I don't remember doing that." .

On 12/10/19, at 4:14 p.m. interview with CM revealed care planning scheduling would be completed by DSS. Sometimes resident leaves and goes to out to Starbucks but I cannot say for sure whether he was present during his last care conference meeting.

When interviewed on 12/11/19, at 3:32 p.m. DSS revealed R64's last care conference was 5/24/19. She stated R64 never goes to his care conferences and was usually out of the building most of the time. The last care conference meeting included DSS, dietary, and nursing and R64's code status was reviewed.

Review of undated facility's policy titled, Comprehensive Assessments and Care Planning, indicated residents and resident representatives will be involved in the comprehensive person-centered care planning. If participation of resident and representative in development of plan is not practicable, explanation must be in resident's medical record.

Requested documentation of DSS verbal or written invitation given to R44 to attend and participate in care planning and did not get one.

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 _____	C 12/12/2019

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 657	Continued From page 35	F 657		

R66
During interview with R66 on 12/9/19, at 2:39 p.m. R66 stated she wanted to attend care conferences, had only one care conference since admission to the facility, did not feel included in her care decisions, and was frustrated with staff cares.

R66's Quarterly MDS dated 10/7/19, indicated R66 had admitted to the facility on 7/2/19, cognition was intact, and had diagnoses of GERD (Gastroesophageal Reflux Disease) and anxiety. R66's Quarterly MDS indicated R66 needed extensive staff assistance with activities of daily living and did not reject cares.

R66's Care Area Assessment (CAA) dated 7/9/19, indicated R66 communicated with no problems, needed extensive staff assistance, had a G-tube and had diagnoses including paraplegia, weakness, and poor diet tolerance.

R66's care plan dated 7/23/19, indicated R66 required a tube feeding related to dysphagia but did not indicate when or how often the G-tube needed to be replaced. R66's care plan dated 7/22/19, indicated R66 required staff assistance with ADLs and grooming and personal hygiene and was able to make her needs known clearly to staff.

Family member (FM)-A stated on 12/12/19, at 10:57 a.m. he was concerned about R66's care at the facility and stated some of the staff were curt

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 _____	C 12/12/2019

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 657	Continued From page 36	F 657		

and unpleasant. FM-A stated R66 had had to wait for more than an hour for response from staff for cares.

Registered nurse (RN)-A, who was also nurse manager, stated on 12/12/19, at 9:54 a.m. social services scheduled the resident care conferences and invited the resident and/or representative to the care conference and documented the care conferences. RN-A stated she attended care conferences for residents but had not yet attended one for R66.

R66 stated on 12/12/19, at 2:18 p.m. she thought communication was a big issue at the facility as staff walked out of her room and forgot about following up for R66 and R66 wondered if staff were doing what she had requested. R66 stated she would have liked to known the outcome of her debit card being stolen and had not been informed of who had taken it. R66 stated she had only one care conference held in August and thought it was because Licensed social worker (LSW)-B had been out on leave.

The dietitian confirmed in R66's MR on 12/12/19, at 8:44 a.m. R66 had a care conference held on 8/7/19, which R66 and FM-A had attended. Dietitian stated care conferences were held every three months. Dietitian confirmed no care care conference had been held with R66 and/or FM-A since August.

LSW-A stated on 12/12/19, at 11:13 a.m. she scheduled the newly admitted resident their first care conference four to six weeks after admission, then held a care conference every three months after. LSW-A stated she did not coordinate the care conferences within the 7-day

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 _____	C 12/12/2019

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 657	Continued From page 37 assessment period for the quarterly review and had not ever scheduled them that way. LSW-A stated she would ask corporate if there was a timeline for resident care conferences to be scheduled that she should follow. LSW-A stated care conferences "were behind" schedule since LSW-B had gone out on leave and she was the only SW presently at the facility. Review of R66's MR revealed no evidence of a care conference completed with R66 since 8/7/19. The Director of Nursing stated on 12/12/19, at 2:08 p.m. she expected staff to follow residents' care plans and stated residents were to be included in their plan of care. Facility policy Comprehensive Assessments and Care Planning dated 11/2017, indicated residents and/or representative would be included in the comprehensive person-centered care planning and would incorporate the resident's personal preferences. Facility policy Resident/Family Participation in Care Planning dated 2017, indicated residents had the right to participate in planning care and treatment or changes in care and treatment and actively participate in person-centered care planning.	F 657		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 679		1/20/20

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 _____	C 12/12/2019

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 679	Continued From page 38 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide person-centered, meaningful activities for 2 of 2 residents (R13, R43) reviewed for activities. Findings include: R13 was observed on 12/9/19, at 5:11 p.m. sitting in a chair in his room watching television (TV). R13 was not observed in the group activity held in the dining room on 12/9/19, at 2:00 p.m.. Staff did not know where R13 was at the time. R13's quarterly MDS (Minimum Data Set) dated 9/3/19, indicated R13's cognition was impaired, did not reject cares and was independent with ADLs (activities of daily living). R13's quarterly MDS included diagnoses of dementia, anxiety, depression and traumatic brain disorder. R13's Activity Assessment (AA) dated 12/2/19, indicated R13 was interested in Bingo, Board, Card, Dice games and Dominoes. R13's AA also indicated R13's hobbies were handyman, yard work and handiwork quilt and sew. R13's AA indicated R43 likes exercise, radio, tv, hunting and fishing. music, dine out, fairs, tours, museum, scenic drives, shopping, travel, movies, indoor plants and special events.	F 679	F-679 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " R13/R43□s preferences for activities and attendance will be tracked and reminded of select activities. B. How will you identify other residents having the potential to be affected by the same deficient practice? " Activity staff has been provide in-educated regarding this process used C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " Activity staff has been educated to implemented process by Activity Director on 1/16/2020 to use and record activities attended on a new tracking sheet. " Activity Director will develop process of tracking attendance at these activities. " The facility has implemented training and sheet to help staff identify activities that the resident that need reminding to attend. D. How will you monitor the corrective	

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 _____	C 12/12/2019

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 679	Continued From page 39 R13's Activities care plan dated 12/2/19, indicated staff would help R13 with set up with IPAD/Table to view movies or listen to music independently, be reminded of monthly brunch lunch, would enjoy visits from mentor and go to movies and meals outside of facility. R13's annual MDS dated 12/10/18, indicated it was "Very Important" for R13 to get fresh air outside and attend his favorite activities. The annual MDS indicated it was "Somewhat Important" for R13 to keep up with the news and attend group activities. R13 was observed on 12/11/19, at 8:05 a.m. in dark room laying on his side towards the TV with the TV turned on. Nursing Assistant (NA)-F stated on 12/11/19, at 8:06 a.m. R13 liked to stay in his room a lot and sleep. R13 was observed on 12/11/19, at 11:12 a.m. sitting on a chair in his room, head down, eyes closed with his TV turned on. NA-A stated on 12/11/19, at 1:31 p.m. R13 was pretty mellow, had no behavior issues and was just a little forgetful. NA-A stated R13 was independent with ADLs and R13 liked to stay in his room and watch TV shows. NA-A stated R13 liked current events and loved to read the newspaper. R13 was observed on 12/12/19, at 9:24 a.m. sitting in his room, TV turned on. Licensed practical nurse (LPN)-A stated on	F 679	action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented a Quality Assurance Program to ensure all residents will activity preference and attendance is tracked and lack of attendance tracked " The Activity Director and staff will complete monthly quality assurance audits on current residents . Additional training may be scheduled based on results of the quality assurance review. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 1/20/2020	

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 _____	C 12/12/2019

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 679	Continued From page 40	F 679		

12/12/19, at 9:25 a.m. R13 stayed in his room, ate his meals in his room and came out of his room once and awhile. LPN-A stated she had seen a friend visit R13 but not seen any family visit.

R13 was observed on 12/12/19, at 2:46 p.m. laying on his bed watching TV.

R13 was not observed present at any activity held throughout the duration of the survey week from 12/9/19 through 12/12/19.

The December 2019, Activities Calendar posted indicated Bingo was held on Sunday afternoons, Games were held on 2nd floor and 3rd floor on Monday 12/9/19, at 2:00 p.m. and music was held on Tuesday and Wednesday afternoon at 2:00 p.m. on 12/10/19, and 12/11/19, at the facility.

TR (Therapeutic Recreation) director stated on 12/12/19, at 3:00 p.m. R13 was assessed for activity preference upon admission and thereafter quarterly along with the assessment completed for activity preference with the MDS schedule. TR director stated R13 used to come to Bingo and Pokino and stated R13 used to have a mentor more in the summer. TR director stated R13's family from Chicago had visited R13 in October and stated she thought R13 was feeling down from the news about his sister's illness. TR director stated R13 liked outdoor activities and smoked outside everyday. TR director stated she would like R13 to have 2-3 one-to-one (1 to 1) activities a week provided for R13 from activity staff including the chaplain visits. TR director stated R13 used to come to Bingo independently but had not been coming to Bingo. TR director stated R13 used to be outside more but had not

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 _____	C 12/12/2019

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 679	Continued From page 41	F 679		

now with the weather changed. TR director stated she had tried various things for R13 and R13 needed to be encouraged more and invited to the activities. TR director stated she would now careplan for that. TR director confirmed R13's careplan did not include that and confirmed R13's activity documentation did not include 2-3 a week activity staff 1:1's provided for R13.

R13's Individual Attendance Record (IAR) dated September 2019, indicated R13 had attended Bingo and Special Events one time each and had not been invited to Table games or Music. R13's September IAR indicated R13 had three TR (therapeutic recreation) staff visits (1:1s) provided.
R13's October 2019, IAR indicated R13 attended Pokeno and Cafe/news one time each and had not been invited to Table games or Music. R13's October IAR indicated R13 had four TR staff visits.
R13's November 2019, IAR indicated R13 had attended Table games one time, Social events four times and Special events two times and had not been invited to Music. R13's November IAR indicated R13 had four TR staff visits.
R13's December 2019, IAR indicated R13 had not been invited to or attended Bingo or Music, and had not attended any Table games, Pokeno or cafe/news. R13's December IAR indicated R13 had one TR staff visit provided.

R43 was was not observed present on 12/9/19, at 2:00 p.m. in the group activity held in the dining room. Staff did not know where R43 was.

R43's Annual MDS dated 10/14/19, indicated R43's cognition was impaired, had disorganized

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 _____	C 12/12/2019

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 679	Continued From page 42	F 679		

thinking and delusions. R43's annual MDS indicated R43 needed extensive staff assistance with ADLs and did not reject cares. R43's annual MDS indicated it was "Very Important" for R43 to do her favorite activites and was "Somewhat Important" for R43 with music, animals and group activities.

R43's Activity Assessment (AA) dated 10/15/19, indicated R43 was interested in attending Bingo, Cook/Bake, Handiwork quilt/sew, needlework and paint/draw and also watching TV. R13's AA also indicated R13 was interested in music, reading, clergy visits, radio programs, dining out, fairs/tours/museum trips, plays/movies, scenic drives, shopping, special events, travel, indoor plants and small and large group activities.

R43's care plan dated 10/15/19, indicated R13 would attend 1-2 activities per week, and staff would pain nails with aromatherapy, and chaplain would provide spiritual interaction 1-2 times weekly. R43's Activity car plan dated 10/15/19, did not include R43's interested activities per Activity Assessment completed 10/15/19. R43's care plan dated 12/12/19, edited after survey began, indicated R13 would be invited and needed escort to social and musical programs.

R43 was observed on 12/9/19, at 5:23 p.m. sitting on a chair in her room with her head down, eyes closed and TV turned on.

R43 was observed on 12/10/19, at 9:57 a.m. sitting on a chair in her room with the TV turned on.

RN-A stated on 12/10/19, at 9:58 a.m. R43 does not see her family, talked to herself and stated

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 _____	C 12/12/2019

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 679	Continued From page 43	F 679		

once staff engage R13 in a conversation R13 will talk with you.

NA-B stated on 12/10/19, at 3:20 p.m. R43 could walk alone with her walker but needed staff assistance to stand up. NA-B stated she did not know R43's whereabouts but thought possibly she was downstairs for music.

R43 was observed on 12/11/19, at 8:00 a.m. sitting on a chair in her room. R43 stated she went to some activities and had not went down to the music program yesterday.

R43 was observed on 12/11/19, at 11:13 a.m. sitting in her room head down, eyes closed and TV turned on.

NA-A stated on 12/11/19, at 11:14 a.m. R43 loved to watch TV shows and stated R43 talked to herself. NA-A stated sometimes R43 would talk to staff depending on her mood but mostly talked to herself. NA-A stated she had seen R43 join in a couple of activities and stated R43 liked playing cards and one of her favorites to play was "Whisk and Spades". NA-A stated she had not seen R43's family in the facility.

Occupational therapy (OT) staff stated on 12/11/19, at 11:25 a.m. R43 had two triggered fingers on her right hand in stuck down position and left pinkie finger with not full extension. OT stated R43 and arthritis in her fingers and needed staff assistance with her hands at times.

R43 was observed on 12/12/19, at 9:08 a.m. sitting at a table in dining room looking around.

R43 was observed on 12/12/19, at 9:14 a.m.

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 _____	C 12/12/2019

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 679	Continued From page 44	F 679		

sitting in her room TV turned on.

R43 was not observed present at any activity held throughout the duration of the survey week from 12/9/19 through 12/12/19.

The December 2019, Activities Calendar posted indicated Bingo was held on Sunday afternoons, Games were held on 2nd floor and 3rd floor on Monday 12/9/19, at 2:00 p.m. and music was held on Tuesday and Wednesday afternoon at 2:00 p.m. on 12/10/19, and 12/11/19, at the facility.

During interview with TR director on 12/12/19, at 3:08 p.m. TR director stated R43 liked music, church, lunch brunch and attending group activities. TR director stated lunch brunch was held monthly. TR director stated R43 should have one to two activity staff 1:1's provided a week including the chaplain visits. TR director stated R43 had no family and liked TV in her room. TR director stated the activity staff knew which activities residents preferred by their care plans and confirmed R43's present careplan did not include R43's favorite activites or preferences. TR director stated she would careplan R43's favorite activites and preferences and replace R43's present careplan. TR director confirmed R43's activity documentation indicated R43 was not being provided one to two activity staff 1:1's a week as she would like.

R43's IAR dated September 2019, indicated R43 had not been invited to Bingo each week or invited to Games and had attended Bingo one time, had not attended Pokeno, had not been invited to or attended music and had no chaplain visits provided. R43's September IAR indicated R43 had five TR staff visits (1:1's) provided for

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 _____	C 12/12/2019

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 679	Continued From page 45 the month. R43's IAR dated October 2019, indicated R43 had not been invited to or attended Bingo or Games, had not attended Pokeno, had not been invited to or attended music and had no chaplain visits provided. R43's October IAR indicated R43 had seven TR staff visits provided for the month. R43's IAR dated November 2019, indicated R43 had not been invited to or attended Bingo, had attended Pokeno one time, had not been invited to or attended music and had no chaplain visits provided. R43's November IAR indicated R43 had two TR staff visits provided for the month. R43's IAR dated December 2019, indicated R43 had not been invited to or attended Bingo or Games, had not attended Pokeno, had not been invited to or attended music, had no chaplain visits, and had not been invited to church services every week. R43's December IAR indicated R43 had two TR staff visits provided. Facility Activities policy was requested for review and , and was not made available.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 684	F 684	1/31/20

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 _____	C 12/12/2019

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 684	Continued From page 46 facility failed to act upon request for medical treatment during a change in condition for 1 of 1 resident (R381) reviewed for hospitalization. Findings include: R381 was reviewed as a closed record. R381 was interviewed via telephone on 12/9/19, at 4:06 p.m. and explained R381 was admitted to the facility 5/2019, due to issues with her spine which resulted in paralysis. R381 indicated on 6/4/19, she had a myelogram (a contrast dye injected and X-rays or computed tomography (CT) to look for problems in the spinal canal) completed at her spinal surgeon's office and returned to the facility during the evening hours and the physician ordered neurological checks every two hours. R381 recalled later in the evening or early night she started having a lack of sensation in her toes. R381 stated she requested a neurological check to have been completed, however felt as if the nurse was unaware how to assess due to the nurse's lack of concern with the loss of sensation in R381's toes. R381 indicated she requested to go to the hospital for further evaluation, however after waiting almost an hour R381 was told by the facility nurse "they were not sending me" and the in house provider "would see me in the morning." R381 indicated the loss of sensation was progressing and decided to call 911 herself from her cell phone. R381 indicated she was admitted to the hospital and placed on bed rest. R381 indicated from the time she first reported the loss of sensation to the time she called 911 herself it was over two hours. R381's Pain Care Plan dated 5/24/19, identified R381 had chronic pain related to significant spine	F 684	A. As noted in 2567, resident did not return to facility and in addition, did not require surgical intervention. B. The licensed nurses for that shift were counseled at the time of this issue and reminded to include resident□s request to go to the hospital in addition to the findings from their focused assessment. C. Review of expectations regarding resident choice and professional standard of practice with a reported or identified change in condition. D. IDT will audit progress notes for presence of indications of change of condition; if present verify follow up occurred. Four record reviews for presence of this follow up, report to Quality Council for further direction. Compliance Date: 1/31/2020	

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 _____	C 12/12/2019

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 684	Continued From page 47	F 684		

history and directed staff to administer medications per orders, cervical collar, thoracic incision care as ordered, encourage out of bed activities, monitor and record any complaints of pain, and pain assessment per protocol.

R381's discharge Minimum Data Set dated 6/4/19, indicated R381 had intact cognition.

R381's Pain Care Area Assessment dated 6/4/19, identified R381 had neuropathic pain and multiple spinal surgeries and indicated R381 would have additional surgery to stabilize her spine.

R381's Provider Telephone Encounter dated 6/4/19, indicated R381 was requesting to go to the hospital due to "not feeling well and report nurse she can not feel any sensation on both legs ...nurse thinks, this might be behavioral and attempt to seek attention. Plan: try to reassure patient, if she insist, ok to send patient to the ED [emergency department]."

R381's Progress note (PN) and Physician Order (PO) were reviewed 6/4/19 through 6/5/19, and revealed the following:
-The PN dated 6/4/19, indicated R381 left for myelogram. A subsequent PN dated 6/4/19, indicated R381 returned from "her appointment around" 6:30 p.m. and order received to check R381 every two hours for 24 hours "There is no new order for resident at this time." An additional PN dated 6/4/19, indicated R381 "has a sensation on her toes" and "stated, I cannot wiggle my toes, I want to call 911." The PN indicated the on call provider returned call and "she does not want to sent resident to hospital" and was directed by provider "if resident want to call by herself, she can." The PN indicated R381 called 911 herself;

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 _____	C 12/12/2019

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 684	Continued From page 48 -The PO dated 6/4/19, indicated check resident every two hours for 24 hours; -The PO dated 6/4/19, indicated the on call was called due to R381 "stated I cannot wiggle my toes. I want to call 911. And resident call 911. On call was called. PO "do not send;" -PN dated 6/5/19, indicated R381 had an x-ray completed which showed "negative results." A subsequent PN dated 6/5/19, indicated the hospital verified R381 was admitted and R381 was awaiting spinal fusion surgery. R381's Diagnoses report dated 6/9/19, indicated R381 had diagnoses which included paraplegia, spinal stenosis cervical and thoracic regions. R381's medical record lacked evidence of facility staff sending R381 to the hospital per PO and/or resident request. The facility investigative file dated 6/11/19, indicated R381 had myelogram on 6/4/19, and returned experiencing no pain with orders to "check on her every two hours for 24 hours" "just before" midnight R381 indicated she wanted to call 911 due to not having been able to wiggle her toes. The facility nurse called on call provider at 11:30 p.m. and handed the phone to another nurse whom could explain the situation "more clearly" and "take orders." The second nurse relayed the order to the resident's assigned nurse "as Do not send (to ED [emergency department])." "Subsequently the order was written just that way and the resident was informed," however documentation from the on-call provider indicated try to reassure R381 and "if she insists Ok to send patient to ED." R381 was noted to call 911 herself.	F 684		

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 _____	C 12/12/2019

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 684	Continued From page 49	F 684		

Licensed practical nurse (LPN)-B was interviewed via telephone on 12/11/19, at 1:12 p.m. and explained he was not assigned to R381 on 6/4/19, however there was "some misunderstanding between the nurse" and on call provider so the other nurse had asked LPN-B to speak to the provider on the telephone. LPN-B stated he informed the provider R381 was in pain and "ready to call 911" per the nurse. LPN-B indicated the provider "told me I can't give permission to send to the hospital but the resident herself can do it." LPN-B indicated he was not sure if R381's neurological status had been assessed as he did not physically see or talk to R381 himself.

R381's Nurse Practitioner was called via telephone on 12/12/19, at 1:26 p.m., however was unavailable and did not return call.

The director of nursing was interviewed on 12/12/19, at 4:04 p.m. and stated it was her expectation if a resident was insisting to go into the hospital the nurse would send them and notify the on call provider.

LPN-C was interviewed via telephone 12/13/19, at 2:19 p.m. and verified she was assigned to R381 on 6/4/19, and recalled she had received an order to "check" on R381 every two hours, however was unaware R381's neurological status needed to be assessed as well. LPN-C stated R381 notified LPN-C at 11:00 p.m. that she did not have sensation in her leg, could not wiggle her toes and asked to go to the hospital. LPN-C explained to assess R381 she touched R381's legs, hands and eyes "to see if she felt anything" and obtained a set of vital signs. LPN-C stated she called the on call provider and recalled she

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 _____	C 12/12/2019

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 684	Continued From page 50 told the provider R381 had a myelogram earlier in the day, however LPN-C stated the provider could not understand her and asked for another nurse to explain. LPN-C indicated the provider asked if R381 had been having behavior issues and gave orders not to send R381 to the hospital for R381 to call 911 herself. The facility Resident Rights and Notification of Resident Rights Policy dated 2017, indicated the facility acted to protect and ensure the rights of residents. The policy included residents had the right to appropriate health care. The facility Neurological Assessment Policy dated 2018, indicated neurological observation and assessment was to have been completed with a change in physical and an acute change of condition. The policy indicated the assessment would include obtaining vital signs, check pupil reaction, motor ability which included the resident moving all extremities, ask resident to squeeze your fingers and plantar and dorsiflex note strength bilaterally and ask resident if he/she had any numbness or tingling in legs/ feet/ toes and document accordingly. The policy indicated to notify the provider of any abnormalities or change in neurological function.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		1/31/20

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 _____	C 12/12/2019

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 688	Continued From page 51 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a range of motion program to maintain or improve range of motion (ROM) for 2 of 2 residents (R43, R66) reviewed for rehabilitation and restorative program. Findings include: R43 was observed on 12/10/19, at 9:57 a.m. sitting on a chair in her room rubbing her knees back and forth. Registered nurse (RN)-F stated on 12/12/19, at 2:26 p.m. R43 had arthritis with pain in her shoulders, back and knees. R43's Annual MDS dated 10/14/19, indicated R43's cognition was impaired, had disorganized thinking, delusions and did not reject cares. R43's Annual MDS did not indicate R43 had limited function for ROM for the upper extremities. R43's Care Area Assessment (CAA) dated 10/14/19, indicated R43 had a contracture of the right hand.	F 688	F 688 A. R43□s finger is at 95% full extension and 100% full flexion. Palm Protector present in resident□s in her location of choice as she uses this when she chooses to. Pain assessment completed on 1/13/2020 essentially unchanged as she decides when she wants to use topical creams. R66 was provided with another copy of the ROM exercise plan she had worked on with therapy in the past and continues to be able to perform these exercises. B. Residents are screened annually and as needed. Restorative and or exercise programs are established and implemented for residents when determined appropriate by the IDT. Residents experiencing a change of condition will be reviewed as part of IDT discussion. C. Review of communication forms for nursing and therapy to use as tools to communicate changes in functional ability or for implementation or change to exercise programs. D. Residents with a restorative or	

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 _____	C 12/12/2019

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 688	Continued From page 52 R43's medical record did not reveal evidence of any ROM being completed or a palm protector to be applied to R43's right hand. R43's care plan dated 7/3/18, indicated R43 was limited in ability to dress/undress self, maintain grooming, and to bathe self related to impaired mobility and fingers 4 and 5 on right hand contracted. R43's care plan did not indicate anything regarding a right hand palm protector to be applied for R43's contracted fingers. R43 stated on 12/11/19, at 8:00 a.m. her arms and legs were sore and stiff the Tylenol pain medication helped. Nursing assistant (NA)-A stated on 12/11/19, at 11:13 a.m. when R43 gets ready to stand up with her walker she would rub her legs and say they are getting tight. NA-A stated R43 was independent. R43 was observed sitting on a chair in her room on 12/11/19, at 11:25 a.m. with fingers on both hands slightly bent down. OT (occupational therapy) confirmed R43's fingers were slightly bent down. OT stated R43 was admitted to the facility with triggered fingers on her right little and middle fingers and were bent down and stated they were stuck down. OT stated therapy had seen R43 and stated R43 was independent with eating and doing her own right hand exercises. OT stated she did not monitor R43's exercises as R43 was independent and could complete on her own. OT stated she had observed R43 four to five months ago and had seen R43 able to complete her exercises. OT stated she did not document this as she did not monitor. OT stated yearly screenings after therapy service ended were	F 688	exercise program will be included in a random audit of four residents for a two week period of time for completion of program and coordination or presence of devices along with presence in plan of care. Review of audit results with Quality Council for further direction. Compliance Date: 1/31/2020	

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 _____	C 12/12/2019

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 688	Continued From page 53	F 688		

completed by therapy to see if resident was at baseline function and maximum functional capacity. OT stated she had not completed a screening for R43 when it was due. Looking at R43's fingers OT stated R43 triggered fingers had not changed but the little pinkie on left hand now had only 95% extension instead of the previous 100% extension when therapy ended. OT instructed R43 now include exercises on her left hand fingers and told R43 to complete exercises on both hands now daily. OT stated R43 had a palm protector she applied herself on her right hand. Nursing staff interviewed stated R43 no longer applied the palm protector.

R43 was observed on 12/12/19, at 9:08 a.m. holding onto her walker ambulating down the hall unassisted.

Physical therapy staff (PT) stated on 12/12/19, at 9:24 a.m. residents who could do their own ROM were not monitored by therapy but therapy completed yearly screenings for those residents whose therapy had ended and needed ROM. PT confirmed R43 had not had a screening completed since ending therapy over a year ago. PT stated since it had been over a year since R43's therapy had stopped and she had not had a screening completed by therapy for over a year. PT indicated she would put in for a screening to be completed by therapy for R43.

R43's Occupational Therapy PN and Discharge Summary dated 6/28/18, indicated R43 had a contracture diagnosis for R43's right hand dated 6/15/18, and indicated R43 had met her therapy goal 6/28/18. R43's OT note indicated R43 was discharged from therapy with a right hand palm protector to wear every night and R43 was to

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 _____	C 12/12/2019

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 688	Continued From page 54	F 688		

perform self passive ROM on her right hand fingers.

R43's OT progress note (PN) dated 10/25/18, indicated therapy had screened R43 and did not need to pick up R43 for therapy services. R43's PN did not indicate review of R43's performance of ROM exercises for her right hand, did not mention whether R43's palm protector was still in use, and did not reveal screening had been performed of R43's left hand for possible contractures.

Review of R43's PNs from 10/26/18, through 12/11/19, did not reveal evidence of any OT screening completed for R43's hands nor any follow up and/or monitoring of R43's ROM exercises.

R66 stated on 12/11/19, at 8:17 a.m. she wondered why therapy services had ended for her and wondered if therapy should be able to help her more.

R66's quarterly MDS dated 10/7/19, indicated R66's cognition was intact and diagnoses included anxiety, depression and paraplegia. R66's quarterly MDS indicated R66 had limited function ROM in bilateral lower extremities, needed extensive staff assistance with bed mobility, total staff dependence with toileting and did not reject cares.

R66's CAA dated 7/9/19, indicated R66 had muscle weakness, was paraplegic, and had impaired ROM bilateral lower extremities with modest rehab goals.

R66's care plan dated 7/22/19, indicated R66

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 _____	C 12/12/2019

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 688	Continued From page 55	F 688		

needed staff assistance with ADLs including positioning and transfers r/t weakness, impaired ROM of lower extremities and restless legs. R66's care plan did not indicate any rehab goals or that ROM exercises should be completed.

R66's physician order dated 7/5/19, indicated R66's rehab potential was good.

PT stated on 12/11/19, at 11:09 a.m. R66 had admitted to the facility with therapy for strengthening and would look in therapy notes to see if restorative program had been planned after R66 discharged from therapy.

RN-A, who was also nurse manager stated on 12/12/19, at 9:54 a.m. R66 had therapy services after admitting to the facility but no longer did. RN-A stated she was not aware of any ROM exercises being provided by staff or by R66.

NA-A stated on 12/11/19, at 1:34 p.m. R66 transferred with an EZ stand with staff and stated R66 had no behavior problems. NA-A stated evening staff completed passive ROM for R66 but not on the day shift which she worked. NA-A stated R66 used to go downstairs for therapy and confirmed on R66's NA care sheet there was no ROM listed for staff to complete for R66 and confirmed no documentation completed for any ROM exercises.

R66 stated on 12/12/19, at 2:18 p.m. she had completed therapy in the summer after admitting to the facility. R66 stated she had not received a paper with instructions for exercises for ROM after therapy was completed. R66 stated she thought communication was a problem at the facility. R66 stated therapy staff had come up to

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 _____	C 12/12/2019

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 688	Continued From page 56 her room yesterday looking for a paper for ROM exercises in her room and had not found one and had told her they would get her a paper so she would know what and how often ROM needed to be completed for R66's strengthening exercises. PT Daily Treatment Note dated 8/1/19, indicated R66 was educated on performing exercises and provided written instructions and cues on form for R66 to use; however R66's MR lacked evidence of any follow up and/or monitoring of R66's ROM exercises. The facility Restorative Program policy dated 2017, indicated residents would be comprehensively assessed/reassessed for restorative needs. The policy indicated restorative nursing care promoted resident's highest level of independence in areas including ROM, splints/braces and ADLs.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate causal factors related to falls and comprehensively reassess and implement additional falls interventions for 1 of 2 residents (R38) reviewed	F 689	F689 A. R38, last fall was 12/9/19. Facility honored resident□s choices and her goal of autonomy related to her desire to smoke for as long as possible in the	1/31/20

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 _____	C 12/12/2019

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 689	Continued From page 57 for falls. Findings include: R38's Fall Risk Observation dated 10/2/19, identified R38 was not at risk for falls and directed staff to continue current plan of care. R38's admission MDS dated 10/7/19, identified R38 with moderate cognitive impairment and diagnoses which included cancer, anemia and schizophrenia. The MDS indicated R38 was independent with activities of daily living (ADLs) and had no falls for six months prior to admission. R38's Falls Care Plan edited on 12/11/19, after survey began, identified R38 was at risk for falls related to history, chronic pain, unsteadiness, weakness, impaired safety and judgment decision making due to cancer and functional decline and directed staff to check R38 hourly to see if she needs assistance, R38 can independently adjust bed height as desires, two staff assist with transfers, high back w/c with footrests attached for mobility, call light and personal items within reach, comprehensive medication review by pharmacist, ensure proper footwear, when transferring encourage R38 to assume a standing position slowly. R38's ADL Care Plan dated 12/6/19, identified R38 needed assistance with transfers for toileting and directed staff to provide assist with cares following toileting as R38 requests and remind not to transfer without assistance. R38's Resident Incident Form (RIF), Incident Follow-up and Progress Notes (PN) were reviewed from 10/29/19, through 12/12/19, and revealed the following:	F 689	course of her terminal disease. B. Review of expectations post fall including RCA process with IDT, RN□s and LPNs. C. Review of RCA and subsequent changes or implementation of modifications to plan of care for current residents with falls since 1/1/2020. Case examples from recent resident falls included in this education. D. Audit of RCA and plan of care changes for three residents post fall for one month. Review of audit results with Quality Council for further direction. Director of Nursing or designee. Compliance Date: 1/31/2020	

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 _____	C 12/12/2019

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 689	Continued From page 58 -The RIF dated 10/29/19, indicated R38 fell in her room when attempting to get out of bed R38 reported she felt lightheaded and fell onto the carpet by her bedside. The follow-up dated 10/29/19, indicated incident was related to underlying illness/ condition pain current interventions call light in plan used to request assist as needed assume standing position slowly. Analysis of intervention effectiveness indicated R38 desired to remain independent as possible and chose not to seek assist from staff. New interventions implemented were none at this time; -The PN dated 11/1/19, indicated hospice ordered a w/c for R38 per R38's request instead of a walker; -The RIF dated 11/8/19, indicated R38 fell when attempting to go to the bathroom and fell on the carpet by her bedside. The follow-up dated 11/8/19, indicated incident related to was left blank and current interventions call light in place requested to use when needed assistance, assume standing position slowly, remind R38 to use call light, discuss falls with interdisciplinary (IDT) and fall committee. Analysis of intervention effectiveness was left blank. New interventions implemented indicated "not at this time;" -The PN dated 11/8/19, indicated R38 fell down when trying to get out of bed on her way to the bathroom; -The PN dated 11/11/19, indicated R38 was using w/c intermittently encouraged R38 to use w/c for safety R38 got agitated when reminded; -The RIF dated 11/20/19, indicated R38 tried to get up and fell next to her bed. The follow-up dated 11/20/19, indicated incident related to was left blank and current interventions call light in place and used for needed assistance, assume standing position slowly, w/c for mobility, remind	F 689		

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 _____	C 12/12/2019

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 689	Continued From page 59 to use call light, assist with transfers to w/c. Analysis of intervention effectiveness indicated R38 was independent and chose not to seek staff assistance. New intervention implemented "not at this time;" -The PN dated 11/21/19, at 4:48 p.m. indicated R38 reported to staff she "often feels weak" and was currently using w/c intermittently educated R38 on benefits of a walker as a step between walking without a device and using a w/c, however R38 insisted on trying walker reviewed fall risks such as floor rugs and how to prevent falls; -The RIF dated 11/21/19, at 9:10 p.m. indicated R38 fell when she tried to get up from rocking chair then tripped on the carpet. The follow-up dated 11/21/19, indicated incident was related to R38's impaired mobility and judgment/ safety awareness deficit current interventions call light in place remind R38 to use when needing assistance with transfers, assume standing position slowly, w/c for mobility, non-ambulatory, encourage w/c used. Analysis of intervention effectiveness indicated R38 used w/c intermittently when encouraged to use w/c R38 would ask when would she stop using and R38 choose to use w/c as desired. New interventions implemented "not at this time;" -The PN dated 11/22/19, indicated R38 was heard yelling and found standing "clinging to her room doorway R38 was assisted to sit in w/c and said she could not breathe R38 appeared to have been experiencing anxiety, and "writer" reminded R38 to use call light when needing assistance; -The RIF dated 11/22/19, indicated R38 fell in her room while walking looking at the bulletin board. The follow-up dated 11/22/19, indicated incident related to was left blank and current interventions w/c for mobility, call light remind R38 to use w/c,	F 689		

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 _____	C 12/12/2019

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 689	Continued From page 60 staff assist with transfers, assume standing position slowly. Analysis of intervention effectiveness R38 chose to use w/c intermittently and not call for assist. New interventions implemented "not at this time;" -The RIF dated 11/23/19, at 2:20 a.m. indicated R38 fell onto the floor in front of her bed onto the carpet when R38 attempted to get up and go to the bathroom. R38 reported she lost balance when she sat on the edge of the bed. The follow-up dated 11/23/19, indicated incident related to was left blank and current interventions assume standing position slowly, staff assist transfers, w/c for mobility, call light in place remind to use call light and w/c. Analysis of intervention effectiveness was left blank. New interventions implemented were not at this time. A subsequent RIF dated 11/23/19, at 12:15 p.m. indicated R38 was trying to get her pop then lost her balance and was found on the floor by her bed on the carpet. The follow-up dated 11/23/19, indicated current interventions "see early report for same day" analysis of intervention effectiveness was left blank and new interventions implemented "not at this time;" -The PN dated 11/24/19, indicated R38 had a "tab alarm" and would look for a phone to answer, "despite she was educated about tab alarm for her safety and agreed;" -The PN dated 11/25/19, at 9:49 a.m. indicated R38's carpet was rolled up and placed in corner of R38's room for guardian to pick up. A subsequent PN dated 11/25/19, at 2:52 p.m. indicated R38 appeared to be weak and was encouraged to use call light for assistance and had been monitored throughout the shift, however R38 was noted to attempt to self-transfer two times during the shift; -The RIF dated 11/25/19, at 3:40 p.m. indicated	F 689		

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 _____	C 12/12/2019

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 689	Continued From page 61 R38 attempted to grab the bed control and fell. The follow-up dated 11/25/19, indicated the incident was related to impaired balance and judgment/ safety awareness deficit current interventions staff assist with transfers, assume standing position slowly, call light in place, remind to use w/c for mobility and not self-transfer and to use call light. Analysis of intervention effectiveness R38 was not using call light for assist and w/c intermittently as desired. New interventions implemented "not at this time continue current plan of care;" -The RIF dated 11/28/19, indicated R38 was found on the floor next to her bed and was unable to recall how and/ or what she was attempting to do prior to the fall. The follow-up dated 11/28/19, indicated incident was related to "hospice-cancer (throat)," impaired mobility, impaired cognition and judgment/ safety awareness deficit. Current interventions R38 to use call light for assist, call light and frequently used items close to R38, staff assist with transfers, w/c for all mobility, assume standing position slowly, remind to use call light and w/c. Analysis of intervention effectiveness was left blank. New interventions implemented "not at this time continue current plan of care;" -The PN dated 11/28/19, indicated R38 was found sitting on the floor and seemed lethargic and had difficulty sitting up in w/c; -The RIF dated 11/29/19, indicated R38 was found on the floor next to her bed and was unsure what she was doing. The follow-up dated 11/29/19, indicated incident was related to hospice-cancer, impaired mobility, impaired cognition and judgment/ safety awareness deficit. Current interventions check R38 every hour, call light in place, w/c for mobility, staff assist with transfers, remind not to self-transfer and use w/c, and assume standing position slowly. Analysis of	F 689		

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 _____	C 12/12/2019

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 689	Continued From page 62	F 689		

intervention effectiveness R38 chose to use w/c intermittently and did not use call light. New interventions implemented "not at this time;"
-The RIF dated 11/30/19, at 4:00 a.m. indicated R38 was found lying by door and was unable to recall what she was attempting to do. The follow-up dated 11/30/19, indicated incident was related to hospice, cancer throat, impaired mobility, impaired cognition and judgment/ safety awareness deficit. Current interventions hourly checks, staff assist to bathroom and transfers, w/c for mobility, call light in place, frequently used items near, remind not to self-transfer, use call light and w/c, and assume standing slowly. Analysis of intervention effectiveness R38 continued not to use w/c or call light. New interventions implemented "not at this time;"
-The PN dated 11/30/19, at 11:21 p.m. indicated R38 had been restless asked staff to take her to smoke. Administered Ativan (anti-anxiety) once and was somewhat effective. R38 seemed lethargic "noted when trying to transfer self out bed." R38 had been on continuous supervision;
-The RIF dated 12/5/19, indicated R38 was found sitting on the floor next to her bed due to attempting to go to the bathroom. The follow-up dated 12/5/19, indicated incident was related to hospice, cancer of throat, impaired mobility, balance, impaired cognition and judgement/ safety awareness deficit. Current interventions staff assist to bathroom and with transfers, w/c for mobility, call light in place, assume standing position slowly and hourly checks. Analysis if intervention effectiveness R38 chose not call for assist and used w/c intermittently continued reminders which R38 "does not welcome." New interventions implemented R38 would accept to carry w/c leg/ foot rests on back of w/c in a bag however would not allow on chair at all times;

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 _____	C 12/12/2019

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 689	Continued From page 63 -The RIF dated 12/8/19, indicated R38 was found on the floor due to attempting to use the bathroom. The follow-up dated 12/8/19, indicated incident related to was left blank and current interventions hourly checks, staff assist with transfers and bathroom, call light and frequently used items within reach, w/c for mobility, assume standing position slowly, remind to use call light, w/c and not to self-transfer, meet and discuss falls in facility. Analysis of intervention effectiveness was left blank. New interventions implemented "not at this time continue plan of care;" -The RIF dated 12/9/19, indicated R38 slid down to the floor when she attempted to go to the bathroom, intervention R38 was assisted to her bed per care plan. West 4th Floor Nursing Care Work Sheet dated 12/11/19, identified R38 needed staff assist for toileting and directed staff to assist R38 to the toileting requests R38 was able to make needs known and to check R38 hourly. R38's medical record lacked evidence of root cause analysis, monitoring for effectiveness of interventions and implementation of additional fall interventions. R38 was interviewed on 12/10/19, at 3:56 p.m. and refused to answer any questions. R38 was observed on 12/10/19, at 3:56 p.m. seated in high back w/c self-propelling w/c with feet around room. R38 had shoes on and was noted to lean to her left side of the w/c. Nursing assistant (NA)-E was interviewed on 12/12/19, at 11:53 a.m. and explained staff were	F 689		

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 _____	C 12/12/2019

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 689	Continued From page 64 to check R38 hourly due to R38 wanting to go outside to smoke. NA-E stated staff would assist R38 to the bathroom when R38 would request and was not aware of a toileting schedule for R38. RN-E was interviewed on 12/12/19, at 11:34 a.m. and verified R38's Fall Care Plan was updated yesterday and explained the last intervention developed was hourly checks. RN-E indicated the IDT and fall committee had discussed R38's falls, however stated it had been "challenging" to help R38 not fall due to R38's desire to remain independent. RN-E indicated staff should offer R38 assistance to the bathroom when they did hourly checks. DON was interviewed on 12/12/19, at 1:58 p.m. and stated due to R38's "rapid" decline was "probably" not reflected in the care plan which placed R38 at increased risk for falls. DON indicated R38 was offered a bedside commode and declined and had the furniture in the room moved around as well. DON indicated she met with R38 and "told" R38 she was unsafe and "really" needed to consider using a device. The facility Integrated Fall Management Policy dated 2013, indicated residents with risk for falling would have an individualized resident centered care plan developed. Care plan interventions were based on the finding of the fall risk assessment. When a resident fell the environment of the fall would be evaluated for possible contributing factors and addressed. The IDT reviewed the fall and care plan changes and if needed implemented additional interventions.	F 689		
F 756	Drug Regimen Review, Report Irregular, Act On	F 756		1/31/20

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 _____	C 12/12/2019

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 756 SS=D	Continued From page 65 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

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 _____	C 12/12/2019

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 756	Continued From page 66 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility consulting pharmacist (PharmD) failed to identify and report staff failures to notify the provider of weight gain of greater than two pounds while taking a diuretic medication for 1 of 5 residents (R65) reviewed for unnecessary medication use. Findings include: R65's physician order summary dated 11/20/19, identified diagnoses including chronic respiratory failure with hypoxia, dependence on respirator, chronic obstructive pulmonary disease, tracheostomy, polyneuropathy, and venous insufficiency. On 6/12/18, R65's Lasix order, a medication used to manage edema (swelling), was decreased from 40 milligrams (mg) orally (o) to 20 mgs (o). Special instructions included with this order were to do weekly weights on R65 and notify the certified nurse practitioner (CNP) if R65 gained more than two pounds (lbs). Record review revealed several weekly weight gains of greater or equal to two pounds: - 7/18/19 - 7/25/19 = 10.8 lbs - 8/29/19 - 9/5/19 = 9.8 lbs - 9/26/19 - 10/3/19 = 9.0 lbs - 10/17/19 - 10/24/19 = 6.1 lbs - 10/31/19 - 11/7/19 = 3.2 lbs - 12/5/19 - 12/12/19 = 7.8 lbs Record review revealed a lack of evidence that these weight gains had been communicated with	F 756	F 756 A. EHR for R65 was reviewed specific to order noted in 2567. The reporting parameters portion was discontinued as resident□s weight range is stable at present. B. Audit of diuretic orders for 6 residents specific to possible presence of reporting parameters such as this and nursing follow through if present. C. Reviewed with RN□s, LPN□s and HUC□s specific to use of order linking in a situation such as this so the reporting direction remains present and readily visible. D. Random audit of linked orders with reporting parameters specific to compliance with reporting for 30 days. Review of audit results with Quality Council for further direction. Director of Nursing or designee responsible. E. Compliance Date: 1/31/2020	

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 _____	C 12/12/2019

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 756	Continued From page 67 the CNP with the exception of a telephone order found in the paper chart dated 10/3/19, indicating a 9 lb weight gain. The provider responded to continue to monitor. R65's MRRs dated 1/2/19, 2/26/19, 3/6/19, 4/17/19, 5/14/19, 5/2/19, 6/11/19, 7/16/19, 8/13/19, 9/16/19, 10/15/19, and 11/13/19, were all reviewed. No weight changes or notifications to the CNP were addressed in the MRRs. During an interview on 12/12/19, at 12:49 p.m. the PharmD stated he had not been aware of the order to contact CNP with a two pound weight gain, and noted that order would usually be tied directly to the medication order. The PharmD verified the weight gain assessment would have been part of the MRR. The facility's medication regimen review policy was requested for review and none was provided.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		1/31/20

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 _____	C 12/12/2019

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 757	Continued From page 68 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the provider of weight gain of greater than two pounds while taking a diuretic medication for 1 of 5 residents (R65) reviewed for unnecessary medication use. Findings include: R65's physician order summary dated 11/20/19, identified diagnoses including chronic respiratory failure with hypoxia, dependence on respirator, chronic obstructive pulmonary disease, tracheostomy, polyneuropathy, and venous insufficiency. On 6/12/18, R65's Lasix order, a medication used to manage edema (swelling), was decreased from 40 milligrams (mg) orally (o) to 20 mgs (o). Special instructions included as an additional order dated 6/19/18, stated "NOTE: patients lasix decreased from 40 to 20 mg. If patient gains more than 2 lbs update NP during clinic hours". Record review of R65's weekly weights in the vital signs section of Matrix, the electronic health record, from June through December 12, 2019, revealed several weekly weight gains of greater or equal to two pounds: - 7/18/19 - 7/25/19 = 10.8 lbs	F 757	F 757 Refer to plan of action for 756.	

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 _____	C 12/12/2019

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 757	Continued From page 69 - 8/29/19 - 9/5/19 = 9.8 lbs - 9/26/19 - 10/3/19 = 9.0 lbs - 10/17/19 - 10/24/19 = 6.1 lbs - 10/31/19 - 11/7/19 = 3.2 lbs - 12/5/19 - 12/12/19 = 7.8 lbs Record review revealed a lack of evidence that these weight gains had been communicated with the CNP with the exception of a telephone order found in the paper chart dated 10/3/19, indicating a 9 lb weight gain. The provider responded to continue to monitor. RN-D was interviewed on 12/12/19, at 11:10 a.m. and stated he did not know there was an order to call the CNP with a weight increase of two pounds or more. RN-D verified the order and reviewed several weeks that indicated a weight of two pounds or greater, including the weight dated 10/31/19, which was two pounds higher than the weight dated 10/24/19. RN-D stated the nursing assistants weighed the residents and notified the nurse if there had been a weight gain. RN-D stated typically the nurse would leave a voice mail message for the CNP and the message would be documented in the progress notes. RN-D also verified there was no documentation notifying the CNP of the two pound weight gain. RN-D found a telephone order (TO) message left in R65's paper chart for R65's provider after a 9 pound weight gain. A physician directed staff to continue to observe R65. RN-D was unable to find any other documentation regarding notification of weight gain in either the electronic progress notes or in the TO's in the paper chart. RN-D stated the weight gain would be important likely because of R65's congestive heart failure. During an interview on 12/12/19, at 11:30 a.m.,	F 757		

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 _____	C 12/12/2019

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 757	Continued From page 70 the director of nutrition services (RD) stated that she was responsible for assessing R65's nutritional status in the minimum data set (MDS) and care area assessments (CAA). The RD also created the goal and approaches for R65's care plan. Additionally, the RD reviewed R65's record monthly including an assessment of R65's weekly weights and addressed R65's weight in the progress notes. The RD did not specifically evaluate R65's weight changes week to week and stated she did not know whether or not the provider was notified of weight gains of two pounds or more. The pharmacist (PharmD) was interviewed on 12/12/19, at 12:18 p.m. and verified that a chart review including vital signs would be done with every monthly medication regimen review (MRR) completed. PharmD stated that typically an order for specific weight gain monitoring would be tied directly to a medication order. PharmD verified none of the two pound weight gains were noted in the MRRs completed for the past year. The facility medication administration and monitoring policy was requested and none provided.	F 757		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State	F 808		1/31/20

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 _____	C 12/12/2019

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 808	Continued From page 71 law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure prescribed diets per physician orders were received for 1 of 1 resident (R23) reviewed during dining assistance in room. Findings include: R23 was observed on 12/9/19, at 6:08 p.m. in her room lying on her back in bed with the head of bed elevated connected to a ventilator. R23 was unable to independently move her arms and/or feed herself without assistance. Nursing assistant (NA)-B began to assist R23 to eat vegetables in sauce, pears in juice, tuna sandwich, Jello and potato chips from a canister in room. NA-B gave R23 three bites of a dry potato chip then a drink of regular water from a cup with a straw then a bite of tuna sandwich followed by another drink of regular water. NA-B gave R23 two more bites of tuna sandwich then a drink of nectar thick cranberry juice. At 6:20 p.m. clinical manager (CM)-A entered and dropped off plastic spoons and exited. At 6:29 p.m. CM-A returned with extra nectar thick cranberry juice and exited the room. NA-B fed R23 a bite of the sandwich and another dry potato chip then a drink of nectar thick cranberry juice. R23 did not cough during bites of potato chips and/or thin water. NA-B was interviewed on 12/9/19, at 6:30 p.m. and verified R23 was able to drink thin (regular consistency) water, however required nectar thick juice and milk. NA-B stated "she drinks regular water" as NA-B turned to R23 and NA-B asked R23 "right" R23 shook head yes in response.	F 808	F 808 A. Nursing assistant received counseling regarding following plan of care, assignment sheet and to obtain assistance from the licensed staff with any questions he/she may have. B. Observation of random morning and evening shift meals on the unit involved for four meals. C. Review of expectations related to following plan of care including diet orders and if issues arise to seek clarification from licensed staff. D. Random audit of meal assistance on other units for 30 days, then report to Quality Council for further direction. Director of Nursing or designee responsible. Compliance Date: 1/31/2020	

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 _____	C 12/12/2019

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 808	Continued From page 72	F 808		

NA-B stated R23's family purchased R23 snacks and confirmed the potato chips from the canister were allowed per R23's diet orders.

R23's Nutritional Status Care Plan dated 4/17/19, identified R23 was at risk for compromised nutrition related to diagnosis of dysphagia secondary to Amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function), dependence on ventilator with tracheostomy and directed staff to follow diet and liquid texture per physician orders.

R23's Speech Therapy Progress and Updated Plan of Care dated 5/1/19, indicated R23 safely tolerated nectar thickened liquids, mechanical soft solid cut up into nickel size pieces, using small bites with plastic spoons, liquid wash every three to four bites and slow rate. The plan indicated "Husband found to provide thin liquids" and was educated to continue nectar thickened liquids for safe swallowing.

R23's quarterly Minimum Data Set dated 9/17/19, identified R23 had intact cognition and required total assistance of one staff with eating.

R23's Resident Face Sheet undated, identified R23 had diagnoses which included chronic respiratory failure with hypoxia or hypercapnia, flaccid hemiplegia affecting right dominant side, flaccid hemiplegia affecting left non-dominant side and Amyotrophic lateral sclerosis.

R23's Physician Order Report dated 12/12/19, included diet order dated 4/17/19, which indicated nectar thickened liquids and mechanical soft solids that must be cut into nickel size pieces sitting upright at 90 degrees use small plastic

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 _____	C 12/12/2019

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 808	Continued From page 73 spoons food must have been moist or add moisture alternate solids and liquids every three bites. R23 was interviewed on 12/11/19, at 9:42 a.m. and shook head "yes" when asked if she was able to drink thin water and eat potato chips. Speech language pathologist (SLP) was interviewed on 12/12/19, at 9:48 a.m. and verified R23 was to have received nectar thickened liquids and mechanical soft solids. SLP explained R23 was at risk for aspiration as R23 had no cough reflex and was unable to clear "things' out well. SLP indicated potato chips were not mechanical soft and stated R23 should not eat them. SLP confirmed she was not aware staff were "feeding" R23 food family brought into the facility. The director of nursing was interviewed on 12/12/19, at 2:08 p.m. and stated it was her expectation for therapeutic diet orders to be followed. The facility policy regarding therapeutic diets was requested, but not provided.	F 808		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State	F 812		1/20/20

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 _____	C 12/12/2019

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 812	Continued From page 74 and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store and maintain cooking utensils under sanitary conditions for 2 of 2 utensil storage drawers which had the potential to affect 57 residents. Furthermore, the facility failed to clean 4 of 4 dusty shelves and 4 of 4 white cabinets noted with reddish, brownish stains, dark matter, and paint chipped doors near kitchen cabinet handles. Findings include: During initial kitchen tour on 12/9/19, at 12:05 p.m. observed two utensil storage drawers with dust and brownish debris, four shelves below two countertops dusty, and four white kitchen cabinets with scattered reddish, brownish and dark matter with paint chipped areas near kitchen cabinet handles. During interview 12/9/19, at 12: 15 p.m. Dietary Director (DD) indicated that the dirt and debris in utensil drawer, and dust on shelving appeared to have not been cleaned by staff for more than a week. DD further verified utensil drawers, shelves and kitchen cabinets should have been cleaned	F 812	F812 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " Moving forward all utensils will be stored using sanitary practices B. How will you identify other residents having the potential to be affected by the same deficient practice? " All residents have the potential to be affected under inappropriate sanitary conditions of storage C. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? " All dietary staff will receive education focusing on cleaning practices, schedules, and assignments on January 13 or January 17th 2020. " Dietary Manager will develop process of tracking cleaning and assignments, with audits	

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 _____	C 12/12/2019

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 812	Continued From page 75 weekly per schedule and currently did not appear those areas had been cleaned for more than a week. When interviewed on 12/12/19, at 11:24 a.m. DD stated she would place request with maintenance to get cabinets painted and stated staff had gone through the drawers and cleaned out the debris and also cleaned the shelves. Review of the undated Facility Cleaning and Sanitizing Policy indicated all food service departments must have an effective cleaning program that includes a cleaning schedule. Procedure includes: identify the cleaning jobs in each area in the kitchen. Review of the facility AM-PM staff weekly cleaning duties dated 12/2/19-12/8/2019, indicated staff to scrub down all shelves on clean side of dish room on Sunday. There was no signature for Sunday to show that cleaning was done. There was no noted specific duties assigned to clean utensil drawers, or cupboards.	F 812	D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " The facility has implemented education for dietary staff on January 13 or January 17th 2020. " A weekly spot check tools for sanitary storage of utensils will be used. " The Dietary Manager will assist to complete monthly quality assurance audits for 3 months, based on weekly spot checks Additional training may be scheduled based on results of the quality assurance review. " The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in QAPI for need of ongoing monitoring or until substantial compliance is maintained. COMPLETION DATE: 01/20/2020	
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		1/31/20

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 _____	C 12/12/2019

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 880	Continued From page 76	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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 _____	C 12/12/2019

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 880	Continued From page 77 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to analyze monthly surveillance data for trends and patterns to reduce the spread of illness and infections. This had the potential to affect all 82 residents residing in the facility. Findings include: The facility's infection control logs were reviewed from September 2019, through November, 2019. The logs identified tracking records of residents with infections, symptoms, cultures and treatment. The type of infections were tracked by rooms and floor for each month. There were 20 infections meeting criteria including 10 urinary tract infections (UTI), six respiratory infections, two soft tissue infections, one gastrointestinal infection, and one fever of unknown origin. There were four "suspected" UTIs on the second floor between 9/18/19, and 10/29/19. These infections were documented on the floor plan by month, but it did not appear to have been investigated to	F 880	F880 SS: D A. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? " Infection prevention plan was reviewed and remains appropriate. Any potential infection identified is monitored by IP and IDT via progress notes, changes in orders, internal infection tracking tool and through verbal report B. How will you identify other residents having the potential to be affected by the same deficient practice? " Staff reviewed infection plan and accompanying tools at staff meeting by January 31, 2020. All staff receive infection prevention education as part of onboarding, skills fairs, annually and periodically throughout any given year. C. What measures will be put into place or what systemic changes will you make	

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 _____	C 12/12/2019

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 880	Continued From page 78 determine if there were common staff providing care or other potential reasons that would explain the infections. Additionally, the data were not evaluated longitudinally as an entire quarter of data. A quarterly report for July through September was submitted to the Quality Council for the October meeting. There were 13 infections meeting criteria including seven urinary tract infections (UTI), three respiratory infections, and three soft tissue infections. The report was a list of infections and indicated most infections appeared to occur in the tracheostomy or ventilated residents; however, there was no evidence of further analysis for the cause of the patterns identified. During interview on 12/12/19, at 1:45 p.m. the infection preventionist, registered nurse (RN)-F, stated she was new in her role and still learning the tracking system. RN-F indicated there was no monthly written analysis regarding possible causes of the infections, so the facility could implement interventions to prevent infections. RN-F stated she was not aware that further analysis was needed. Further, RN-F stated infections were tracked by unit and displayed on maps. RN-F indicated that location of residents with infections was not evaluated or compared. There were no criteria to determine if there was an outbreak and each infection was evaluated individually. There was also no comparison month to month to determine any pattern. In addition, there were no specific plans developed to address identified infections. The facility Infection Prevention and Control Program policy dated November 16, 2016	F 880	to ensure that the deficient practice does not recur? " All infections, including potential and actual, with rates and patterns are reviewed by IP, IDT, and QA. Preventive measures such as review of peri care procedures or visual observational audits of cares are conducted if potential infections are identified. If an outbreak or pattern were identified on a particular unit additional steps would be taken such as review of staffing patterns, procedural review by unit or individual 1:1 review. D. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? " Infection tracking reports with analysis will continue to go to QA for review. Any individual confirmed infection will be audited for potential root cause identification as noted in internal electronic tracking tool daily for weeks and then at least one random infection if identified, weekly for 4 weeks Then note your desired number of audits and of course the QA piece. COMPLETION DATE: 1/31/2020	

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 _____	C 12/12/2019

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 880	Continued From page 79 identified that the infection prevention and control program existed to assure a safe, sanitary and comfortable environment for residents and personnel and was designed to help prevent the development and transmission of disease and infection.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2019**

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
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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/12/2019. At the time of this survey, Benedictine Health Center of Minneapolis was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/20/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2019**

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
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A 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. Benedictine Health Center of Minneapolis is a 5-story building with a full basement that was built in 1969 was determined to be of Type II(222) construction. Each floor of this facility that provides care and sleeping-rooms, is divided into smoke compartments. The facility is fully protected throughout by an automatic fire sprinkler system and 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 81 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2019**

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
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility did not use power cords and extension cords in a manner that exercises general precautions per NFPA 99 (2012), Health Care Facilities Code, sections 10.2.3.6, 10.2.4, 10.5.2.2 and NFPA 70 (2011), National Electrical Code, sections 400.8, 590.3(D), and TIA 12-5.	K 920	K- Tag 920 SS=D 1) What Corrective Action (s) will be accomplished for those fire safety requirements found to have been deficient.	12/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/12/2019**

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
K 920	Continued From page 3 This deficient practice could affect all residents within the affected room. Findings include: On a facility tour between the hours of 11:00 AM and 3:00 PM on 12/12/2019, it was revealed that Room 222 had a resident on a life support ventilator, there was patient-care-related electrical equipment plugged into a power-strip that was not UL 1363A listed.	K 920	" New Power strips have been deployed and mounted to medical Carts for all ventilator rooms with only URL approved patient care items plugged in. 2) How will you identify related fire safety features having the potential to be affected by the same deficient practices and what corrective action will be taken. " New Power strips have been deployed and mounted to medical Carts for all ventilator rooms 3) What measure will be put into place or what systemic changes you will make to ensure that the deficiency does not recur. " Power strips (1363A Hospital Grade) will be installed in vent rooms and plugin ends will be marked with colored tape to make them easily identifiable. 4) How the corrective action (s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place including time frames and person (s) responsible. " The facility has implemented a Quality Assurance Program to ensure all vent rooms have 1363 Hospital Grade Power Strips and will audit them weekly for 2 month. " The facility administrator and/or designee will report finding of the audit to QAPI. COMPLETION DATE: 12/17/2019	

Electronically delivered
January 6, 2020

Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders
Event ID: 7KXS11

Dear Administrator:

The above facility was surveyed on December 9, 2019 through December 12, 2019 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Eva Loch, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: eva.loch@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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

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

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health

Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/9/19, through 12/12/19, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Complaints were also investigated and found to be substantiated: H5266074C and State Order issued at St 2000.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 H5266076C and state order issued at St 0830. H5266079C. The following complaints were found to be unsubstantiated H5266075C, H5266077C, H5266078C. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential;	2 540		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 3 K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident Care Area Assessment (CAA) was timely and thoroughly completed for 1 of 1 resident (R3) reviewed. Findings include: R3's most current Minimum Data Set (MDS) had an assessment reference date of 11/20/19, but was not processed and electronically signed until 12/2/19, by RN-E. Section V, CAA indicated seven triggered care areas and care planning decisions with the location and date of CAA documentation notation stated as "see CAA WS [worksheet]". Record review of CAA on 12/12/19, revealed that triggered sections were not completed. RN-E was interviewed on 12/12/19, at 1:16 p.m. and stated she was the person completing both the MDSs and CAAs. RN-E verified there were several sections of the CAA worksheet dated 11/20/19, comprehensive assessment that were incomplete. RN-E stated it had likely not been completed because she was out with an injury. Additionally, RN-E verified the CAA worksheet was important because it drove the care plan. A copy of R3's current CAA was requested and received on 12/12/19. It was noted that care areas # (number)4 communication, #5 activities of daily life, #6 urinary incontinence, #11 falls, #12	2 540	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 4 nutritional status, #16 pressure ulcers, and #17 psychotropic medication use had all been completed and the document was electronically signed 12/12/19 by RN-E. Corresponding approaches documented in the care plan had not been updated since 5/29/19, or earlier. The Center for Medicare & Medicaid Services Resident Assessment Instrument (RAI) 3.0 (2018) indicated the MDS and the CAA are the basis of development of the individualized resident care plan. The RAI identified several types of assessments, including the Annual Comprehensive Assessment, which is required to be scheduled (called the assessment reference date (ARD)) within 366 days of the previous comprehensive assessment and within 92 days of the ARD of the previous Quarterly Assessment. The MDS and CAA must be completed no later than 14 days after the ARD. The ARD of the previous Quarterly Assessment completed for R65 was dated 8/22/19 and the ARD for the facility Annual Assessment was 11/20/19, 90 days later. The MDS and CAAs were electronically signed RN-E on 12/2/19. However, the CAA was not complete as of 12/12/19, which was verified by RN-E, and 22 days after the ARD. The facility policy for RAI completion was requested for review but was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, or designee could review applicable procedures and policies to ensure the timely and accurate capture of resident information pertaining to the Minimum Data Set (MDS), Care Area Assessments (CAA), and care plans. The administrator, director of	2 540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 540	Continued From page 5 nursing, or designee could educate staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the opportunity for 3 of 3 residents (R44, R64, R66) to participate and engage in the development, review, and revision of their care plans and attend care conferences. Findings include: R44's Admission Minimum Data Set (MDS) dated 10/14/19, indicated R44 was cognitively intact, had clear speech, could be understood by others and admitted to facility on 10/8/19.	2 570	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 Review of facility's Baseline Care plan dated 10/8/19, indicated R44 was alert and cognitively intact and communicated verbally. Interview with R44 on 12/10/19, at 10:56 a.m. indicated he had not attended a care conference nor had he received any written or verbal invitations to a care conference meeting. When interviewed on 12/10/19, at 3:55 p.m. Clinical Manager (CM) indicated the facility process was to have an initial care conference with residents after admission and then they were setup quarterly thereafter. The Social worker (SW) sets up the care conferences and CM usually present ninety percent of the time. Sometimes the care conferences are held in CM's office or in the resident's room. CM indicated could not recall being part of any care conference meeting with R44. Interview with Director of social services (DSS) on 12/11/19, at 3:26 p.m. DSS indicated R44 had not been scheduled for a care conference and his meeting was about 3 weeks overdue. DSS was planning on maybe doing one the next week and that she usually likes to do it the first 4-6 weeks after admission into facility. Review of undated facility's policy titled, Comprehensive Assessments and Care Planning, indicated residents and resident representatives will be involved in the comprehensive person-centered care planning. If participation of resident and representative in development of plan is not practicable, explanation must be in resident's medical record. Requested documentation of DSS verbal or	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 7 written invitation given to R44 to attend and participate in care planning and did not get one. R64 R64's Annual MDS dated 11/5/19, indicated R64 was cognitively intact, had clear speech, understands with clear comprehension and made self understood. During interview with R64 on 12/09/19, at 5:08 p.m. R64 stated he had lived at facility for many years and did not remember attending care conferences. R64 stated, "I don't remember doing that." . On 12/10/19, at 4:14 p.m. interview with CM revealed care planning scheduling would be completed by DSS. Sometimes resident leaves and goes to out to Starbucks but I cannot say for sure whether he was present during his last care conference meeting. When interviewed on 12/11/19, at 3:32 p.m. DSS revealed R64's last care conference was 5/24/19. She stated R64 never goes to his care conferences and was usually out of the building most of the time. The last care conference meeting included the DSS, dietary, and nursing and R64's code status was reviewed. Review of undated facility's policy titled, Comprehensive Assessments and Care Planning, indicated residents and resident representatives will be involved in the comprehensive person-centered care planning. I participation of resident and representative in development of plan is not practicable, explanation must be in resident's medical record.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 8 Requested documentation of DSS verbal or written invitation given to R44 to attend and participate in care planning and did not get one. R66 During interview with R66 on 12/9/19, at 2:39 p.m. R66 stated she wanted to attend care conferences, had only one care conference since admission to the facility, did not feel included in her care decisions, and was frustrated with staff cares. R66's Quarterly MDS dated 10/7/19, indicated R66 had admitted to the facility on 7/2/19, cognition was intact, and had diagnoses of GERD (Gastroesophageal Reflux Disease) and anxiety. R66's Quarterly MDS indicated R66 needed extensive staff assistance with activities of daily living and did not reject cares. R66's Care Area Assessment (CAA) dated 7/9/19, indicated R66 communicated with no problems, needed extensive staff assistance, had a G-tube and had diagnoses including paraplegia, weakness, and poor diet tolerance. R66's care plan dated 7/23/19, indicated R66 required a tube feeding related to dysphagia but did not indicate when or how often the G-tube needed to be replaced. R66's care plan dated 7/22/19, indicated R66 required staff assistance with ADLs and grooming and personal hygiene and was able to make her needs known clearly to staff. Family member (FM)-A stated on 12/12/19, at 10:57 a.m. he was concerned about R66's care at the facility and stated some of the staff were curt and unpleasant. FM-A stated R66 had had to wait	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 9 for more than an hour for response from staff for cares. Registered nurse (RN)-A, who was also nurse manager, stated on 12/12/19, at 9:54 a.m. social services scheduled the resident care conferences and invited the resident and/or representative to the care conference and documented the care conferences. RN-A stated she attended care conferences for residents but had not yet attended one for R66. R66 stated on 12/12/19, at 2:18 p.m. she thought communication was a big issue at the facility as staff walked out of her room and forgot about following up for R66 and R66 wondered if staff were doing what she had requested. R66 stated she would have liked to known the outcome of her debit card being stolen and had not been informed of who had taken it. R66 stated she had only one care conference held in August and thought it was because Licensed social worker (LSW)-B had been out on leave. The dietitian confirmed in R66's MR on 12/12/19, at 8:44 a.m. R66 had a care conference held on 8/7/19, which R66 and FM-A had attended. Dietitian stated care conferences were held every three months. Dietitian confirmed no care care conference had been held with R66 and/or FM-A since August. LSW-A stated on 12/12/19, at 11:13 a.m. she scheduled the newly admitted resident their first care conference four to six weeks after admission, then held a care conference every three months after. LSW-A stated she did not coordinate the care conferences within the 7-day assessment period for the quarterly review and had not ever scheduled them that way. LSW-A	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 10 stated she would ask corporate if there was a timeline for resident care conferences to be scheduled that she should follow. LSW-A stated care conferences "were behind" schedule since LSW-B had gone out on leave and she was the only SW presently at the facility. Review of R66's MR revealed no evidence of a care conference completed with R66 since 8/7/19. The Director of Nursing stated on 12/12/19, at 2:08 p.m. she expected staff to follow residents' care plans and stated residents were to be included in their plan of care. Facility policy Comprehensive Assessments and Care Planning dated 11/2017, indicated residents and/or representative would be included in the comprehensive person-centered care planning and would incorporate the resident's personal preferences. Facility policy Resident/Family Participation in Care Planning dated 2017, indicated residents had the right to participate in planning care and treatment or changes in care and treatment and actively participate in person-centered care planning. SUGGESTED METHOD OF CORRECTION: The social worker or designee could review and revise procedure with care conference scheduling and participation of residents and/or representative in planning of care. The social worker/designee could coordinate with interdisciplinary team and resident and monitor to ensure compliance.	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate causal factors related to falls and comprehensively reassess and implement additional falls interventions for 1 of 2 residents (R38) reviewed for falls. In addition the facility failed to act upon request for medical treatment during a change in condition for 1 of 1 resident (R381) reviewed for hospitalization. Findings include: R38's Fall Risk Observation dated 10/2/19, identified R38 was not at risk for falls and directed staff to continue current plan of care.	2 830	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 R38's admission MDS dated 10/7/19, identified R38 with moderate cognitive impairment and diagnoses which included cancer, anemia and schizophrenia. The MDS indicated R38 was independent with activities of daily living (ADLs) and had no falls for six months prior to admission. R38's Falls Care Plan edited on 12/11/19, after survey began, identified R38 was at risk for falls related to history, chronic pain, unsteadiness, weakness, impaired safety and judgment decision making due to cancer and functional decline and directed staff to check R38 hourly to see if she needs assistance, R38 can independently adjust bed height as desires, two staff assist with transfers, high back w/c with footrests attached for mobility, call light and personal items within reach, comprehensive medication review by pharmacist, ensure proper footwear, when transferring encourage R38 to assume a standing position slowly. R38's ADL Care Plan dated 12/6/19, identified R38 needed assistance with transfers for toileting and directed staff to provide assist with cares following toileting as R38 requests and remind not to transfer without assistance. R38's Resident Incident Form (RIF), Incident Follow-up and Progress Notes (PN) were reviewed from 10/29/19, through 12/12/19, and revealed the following: -The RIF dated 10/29/19, indicated R38 fell in her room when attempting to get out of bed R38 reported she felt lightheaded and fell onto the carpet by her bedside. The follow-up dated 10/29/19, indicated incident was related to underlying illness/ condition pain current interventions call light in plan used to request assist as needed assume standing position	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 13 slowly. Analysis of intervention effectiveness indicated R38 desired to remain independent as possible and chose not to seek assist from staff. New interventions implemented were none at this time; -The PN dated 11/1/19, indicated hospice ordered a w/c for R38 per R38's request instead of a walker; -The RIF dated 11/8/19, indicated R38 fell when attempting to go to the bathroom and fell on the carpet by her bedside. The follow-up dated 11/8/19, indicated incident related to was left blank and current interventions call light in place requested to use when needed assistance, assume standing position slowly, remind R38 to use call light, discuss falls with interdisciplinary (IDT) and fall committee. Analysis of intervention effectiveness was left blank. New interventions implemented indicated "not at this time;" -The PN dated 11/8/19, indicated R38 fell down when trying to get out of bed on her way to the bathroom; -The PN dated 11/11/19, indicated R38 was using w/c intermittently encouraged R38 to use w/c for safety R38 got agitated when reminded; -The RIF dated 11/20/19, indicated R38 tried to get up and fell next to her bed. The follow-up dated 11/20/19, indicated incident related to was left blank and current interventions call light in place and used for needed assistance, assume standing position slowly, w/c for mobility, remind to use call light, assist with transfers to w/c. Analysis of intervention effectiveness indicated R38 was independent and chose not to seek staff assistance. New intervention implemented "not at this time;" -The PN dated 11/21/19, at 4:48 p.m. indicated R38 reported to staff she "often feels weak" and was currently using w/c intermittently educated R38 on benefits of a walker as a step between	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 14 walking without a device and using a w/c, however R38 insisted on trying walker reviewed fall risks such as floor rugs and how to prevent falls; -The RIF dated 11/21/19, at 9:10 p.m. indicated R38 fell when she tried to get up from rocking chair then tripped on the carpet. The follow-up dated 11/21/19, indicated incident was related to R38's impaired mobility and judgment/ safety awareness deficit current interventions call light in place remind R38 to use when needing assistance with transfers, assume standing position slowly, w/c for mobility, non-ambulatory, encourage w/c used. Analysis of intervention effectiveness indicated R38 used w/c intermittently when encouraged to use w/c R38 would ask when would she stop using and R38 choose to use w/c as desired. New interventions implemented "not at this time;" -The PN dated 11/22/19, indicated R38 was heard yelling and found standing "clinging to her room doorway R38 was assisted to sit in w/c and said she could not breathe R38 appeared to have been experiencing anxiety, and "writer" reminded R38 to use call light when needing assistance; -The RIF dated 11/22/19, indicated R38 fell in her room while walking looking at the bulletin board. The follow-up dated 11/22/19, indicated incident related to was left blank and current interventions w/c for mobility, call light remind R38 to use w/c, staff assist with transfers, assume standing position slowly. Analysis of intervention effectiveness R38 chose to use w/c intermittently and not call for assist. New interventions implemented "not at this time;" -The RIF dated 11/23/19, at 2:20 a.m. indicated R38 fell onto the floor in front of her bed onto the carpet when R38 attempted to get up and go to the bathroom. R38 reported she lost balance when she sat on the edge of the bed. The	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 15 follow-up dated 11/23/19, indicated incident related to was left blank and current interventions assume standing position slowly, staff assist transfers, w/c for mobility, call light in place remind to use call light and w/c. Analysis of intervention effectiveness was left blank. New interventions implemented were not at this time. A subsequent RIF dated 11/23/19, at 12:15 p.m. indicated R38 was trying to get her pop then lost her balance and was found on the floor by her bed on the carpet. The follow-up dated 11/23/19, indicated current interventions "see early report for same day" analysis of intervention effectiveness was left blank and new interventions implemented "not at this time;" -The PN dated 11/24/19, indicated R38 had a "tab alarm" and would look for a phone to answer, "despite she was educated about tab alarm for her safety and agreed;" -The PN dated 11/25/19, at 9:49 a.m. indicated R38's carpet was rolled up and placed in corner of R38's room for guardian to pick up. A subsequent PN dated 11/25/19, at 2:52 p.m. indicated R38 appeared to be weak and was encouraged to use call light for assistance and had been monitored throughout the shift, however R38 was noted to attempt to self-transfer two times during the shift; -The RIF dated 11/25/19, at 3:40 p.m. indicated R38 attempted to grab the bed control and fell. The follow-up dated 11/25/19, indicated the incident was related to impaired balance and judgment/ safety awareness deficit current interventions staff assist with transfers, assume standing position slowly, call light in place, remind to use w/c for mobility and not self-transfer and to use call light. Analysis of intervention effectiveness R38 was not using call light for assist and w/c intermittently as desired. New interventions implemented "not at this time	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 16 continue current plan of care;" -The RIF dated 11/28/19, indicated R38 was found on the floor next to her bed and was unable to recall how and/ or what she was attempting to do prior to the fall. The follow-up dated 11/28/19, indicated incident was related to "hospice-cancer (throat)," impaired mobility, impaired cognition and judgment/ safety awareness deficit. Current interventions R38 to use call light for assist, call light and frequently used items close to R38, staff assist with transfers, w/c for all mobility, assume standing position slowly, remind to use call light and w/c. Analysis of intervention effectiveness was left blank. New interventions implemented "not at this time continue current plan of care;" -The PN dated 11/28/19, indicated R38 was found sitting on the floor and seemed lethargic and had difficulty sitting up in w/c; -The RIF dated 11/29/19, indicated R38 was found on the floor next to her bed and was unsure what she was doing. The follow-up dated 11/29/19, indicated incident was related to hospice-cancer, impaired mobility, impaired cognition and judgment/ safety awareness deficit. Current interventions check R38 every hour, call light in place, w/c for mobility, staff assist with transfers, remind not to self-transfer and use w/c, and assume standing position slowly. Analysis of intervention effectiveness R38 chose to use w/c intermittently and did not use call light. New interventions implemented "not at this time;" -The RIF dated 11/30/19, at 4:00 a.m. indicated R38 was found lying by door and was unable to recall what she was attempting to do. The follow-up dated 11/30/19, indicated incident was related to hospice, cancer throat, impaired mobility, impaired cognition and judgment/ safety awareness deficit. Current interventions hourly checks, staff assist to bathroom and transfers, w/c for mobility, call light in place, frequently used	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 17 items near, remind not to self-transfer, use call light and w/c, and assume standing slowly. Analysis of intervention effectiveness R38 continued not to use w/c or call light. New interventions implemented "not at this time;" -The PN dated 11/30/19, at 11:21 p.m. indicated R38 had been restless asked staff to take her to smoke. Administered Ativan (anti-anxiety) once and was somewhat effective. R38 seemed lethargic "noted when trying to transfer self out bed." R38 had been on continuous supervision; -The RIF dated 12/5/19, indicated R38 was found sitting on the floor next to her bed due to attempting to go to the bathroom. The follow-up dated 12/5/19, indicated incident was related to hospice, cancer of throat, impaired mobility, balance, impaired cognition and judgement/ safety awareness deficit. Current interventions staff assist to bathroom and with transfers, w/c for mobility, call light in place, assume standing position slowly and hourly checks. Analysis if intervention effectiveness R38 chose not call for assist and used w/c intermittently continued reminders which R38 "does not welcome." New interventions implemented R38 would accept to carry w/c leg/ foot rests on back of w/c in a bag however would not allow on chair at all times; -The RIF dated 12/8/19, indicated R38 was found on the floor due to attempting to use the bathroom. The follow-up dated 12/8/19, indicated incident related to was left blank and current interventions hourly checks, staff assist with transfers and bathroom, call light and frequently used items within reach, w/c for mobility, assume standing position slowly, remind to use call light, w/c and not to self-transfer, meet and discuss falls in facility. Analysis of intervention effectiveness was left blank. New interventions implemented "not at this time continue plan of care;"	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 18 -The RIF dated 12/9/19, indicated R38 slid down to the floor when she attempted to go to the bathroom, intervention R38 was assisted to her bed per care plan. West 4th Floor Nursing Care Work Sheet dated 12/11/19, identified R38 needed staff assist for toileting and directed staff to assist R38 to the toileting requests R38 was able to make needs known and to check R38 hourly. R38's medical record lacked evidence of root cause analysis, monitoring for effectiveness of interventions and implementation of additional fall interventions. R38 was interviewed on 12/10/19, at 3:56 p.m. and refused to answer any questions. R38 was observed on 12/10/19, at 3:56 p.m. seated in high back w/c self-propelling w/c with feet around room. R38 had shoes on and was noted to lean to her left side of the w/c. Nursing assistant (NA)-E was interviewed on 12/12/19, at 11:53 a.m. and explained staff were to check R38 hourly due to R38 wanting to go outside to smoke. NA-E stated staff would assist R38 to the bathroom when R38 would request and was not aware of a toileting schedule for R38. RN-E was interviewed on 12/12/19, at 11:34 a.m. and verified R38's Fall Care Plan was updated yesterday and explained the last intervention developed was hourly checks. RN-E indicated the IDT and fall committee had discussed R38's falls, however stated it had been "challenging" to help R38 not fall due to R38's desire to remain independent. RN-E indicated staff should offer	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 R38 assistance to the bathroom when they did hourly checks. DON was interviewed on 12/12/19, at 1:58 p.m. and stated due to R38's "rapid" decline was "probably" not reflected in the care plan which placed R38 at increased risk for falls. DON indicated R38 was offered a bedside commode and declined and had the furniture in the room moved around as well. DON indicated she met with R38 and "told" R38 she was unsafe and "really" needed to consider using a device. The facility Integrated Fall Management Policy dated 2013, indicated residents with risk for falling would have an individualized resident centered care plan developed. Care plan interventions were based on the finding of the fall risk assessment. When a resident fell the environment of the fall would be evaluated for possible contributing factors and addressed. The IDT reviewed the fall and care plan changes and if needed implemented additional interventions. R381 was reviewed as a closed record. R381 was interviewed via telephone on 12/9/19, at 4:06 p.m. and explained R381 was admitted to the facility 5/2019, due to issues with her spine which resulted in paralysis. R381 indicated on 6/4/19, she had a myelogram (a contrast dye injected and X-rays or computed tomography (CT) to look for problems in the spinal canal) completed at her spinal surgeon's office and returned to the facility during the evening hours and the physician ordered neurological checks every two hours. R381 recalled later in the evening or early night she started having a lack of sensation in her toes. R381 stated she requested	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 20 a neurological check to have been completed, however felt as if the nurse was unaware how to assess due to the nurse's lack of concern with the loss of sensation in R381's toes. R381 indicated she requested to go to the hospital for further evaluation, however after waiting almost an hour R381 was told by the facility nurse "they were not sending me" and the in house provider "would see me in the morning." R381 indicated the loss of sensation was progressing and decided to call 911 herself from her cell phone. R381 indicated she was admitted to the hospital and placed on bed rest. R381 indicated from the time she first reported the loss of sensation to the time she called 911 herself it was over two hours. R381's Pain Care Plan dated 5/24/19, identified R381 had chronic pain related to significant spine history and directed staff to administer medications per orders, cervical collar, thoracic incision care as ordered, encourage out of bed activities, monitor and record any complaints of pain, and pain assessment per protocol. R381's discharge Minimum Data Set dated 6/4/19, indicated R381 had intact cognition. R381's Pain Care Area Assessment dated 6/4/19, identified R381 had neuropathic pain and multiple spinal surgeries and indicated R381 would have additional surgery to stabilize her spine. R381's Provider Telephone Encounter dated 6/4/19, indicated R381 was requesting to go to the hospital due to "not feeling well and report nurse she can not feel any sensation on both legs ...nurse thinks, this might be behavioral and attempt to seek attention. Plan: try to reassure patient, if she insist, ok to send patient to the ED [emergency department]."	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 21 R381's Progress note (PN) and Physician Order (PO) were reviewed 6/4/19 through 6/5/19, and revealed the following: -The PN dated 6/4/19, indicated R381 left for myelogram. A subsequent PN dated 6/4/19, indicated R381 returned from "her appointment around" 6:30 p.m. and order received to check R381 every two hours for 24 hours "There is no new order for resident at this time." An additional PN dated 6/4/19, indicated R381 "has a sensation on her toes" and "stated, I cannot wiggle my toes, I want to call 911." The PN indicated the on call provider returned call and "she does not want to sent resident to hospital" and was directed by provider "if resident want to call by herself, she can." The PN indicated R381 called 911 herself; -The PO dated 6/4/19, indicated check resident every two hours for 24 hours; -The PO dated 6/4/19, indicated the on call was called due to R381 "stated I cannot wiggle my toes. I want to call 911. And resident call 911. On call was called. PO "do not send;" -PN dated 6/5/19, indicated R381 had an x-ray completed which showed "negative results." A subsequent PN dated 6/5/19, indicated the hospital verified R381 was admitted and R381 was awaiting spinal fusion surgery. R381's Diagnoses report dated 6/9/19, indicated R381 had diagnoses which included paraplegia, spinal stenosis cervical and thoracic regions. R381's medical record lacked evidence of facility staff sending R381 to the hospital per PO and/or resident request. The facility investigative file dated 6/11/19, indicated R381 had myelogram on 6/4/19, and returned experiencing no pain with orders to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 22 "check on her every two hours for 24 hours" "just before" midnight R381 indicated she wanted to call 911 due to not having been able to wiggle her toes. The facility nurse called on call provider at 11:30 p.m. and handed the phone to another nurse whom could explain the situation "more clearly" and "take orders." The second nurse relayed the order to the resident's assigned nurse "as Do not send (to ED [emergency department])." "Subsequently the order was written just that way and the resident was informed," however documentation from the on-call provider indicated try to reassure R381 and "if she insists Ok to send patient to ED." R381 was noted to call 911 herself. Licensed practical nurse (LPN)-B was interviewed via telephone on 12/11/19, at 1:12 p.m. and explained he was not assigned to R381 on 6/4/19, however there was "some misunderstanding between the nurse" and on call provider so the other nurse had asked LPN-B to speak to the provider on the telephone. LPN-B stated he informed the provider R381 was in pain and "ready to call 911" per the nurse. LPN-B indicated the provider "told me I can't give permission to send to the hospital but the resident herself can do it." LPN-B indicated he was not sure if R381's neurological status had been assessed as he did not physically see or talk to R381 himself. R381's Nurse Practitioner was called via telephone on 12/12/19, at 1:26 p.m., however was unavailable and did not return call. The director of nursing was interviewed on 12/12/19, at 4:04 p.m. and stated it was her expectation if a resident was insisting to go into the hospital the nurse would send them and notify	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 23 the on call provider. LPN-C was interviewed via telephone 12/13/19, at 2:19 p.m. and verified she was assigned to R381 on 6/4/19, and recalled she had received an order to "check" on R381 every two hours, however was unaware R381's neurological status needed to be assessed as well. LPN-C stated R381 notified LPN-C at 11:00 p.m. that she did not have sensation in her leg, could not wiggle her toes and asked to go to the hospital. LPN-C explained to assess R381 she touched R381's legs, hands and eyes "to see if she felt anything" and obtained a set of vital signs. LPN-C stated she called the on call provider and recalled she told the provider R381 had a myelogram earlier in the day, however LPN-C stated the provider could not understand her and asked for another nurse to explain. LPN-C indicated the provider asked if R381 had been having behavior issues and gave orders not to send R381 to the hospital for R381 to call 911 herself. The facility Resident Rights and Notification of Resident Rights Policy dated 2017, indicated the facility acted to protect and ensure the rights of residents. The policy included residents had the right to appropriate health care. The facility Neurological Assessment Policy dated 2018, indicated neurological observation and assessment was to have been completed with a change in physical and an acute change of condition. The policy indicated the assessment would include obtaining vital signs, check pupil reaction, motor ability which included the resident moving all extremities, ask resident to squeeze your fingers and plantar and dorsiflex note strength bilaterally and ask resident if he/she had any numbness or tingling in legs/ feet/ toes and document accordingly. The policy indicated to	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 24 notify the provider of any abnormalities or change in neurological function. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review, revise policies and procedures regarding comprehensive assessment and interventions related to change in condition, comprehensive assessment and interventions related to falls. Facility staff could be educated on these policies and procedures. The administrator, DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by:	2 890		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 25 Based on observation, interview and document review, the facility failed to implement a range of motion program to maintain or improve range of motion (ROM) for 2 of 2 residents (R43, R66) reviewed for rehabilitation and restorative program. Findings include: R43 was observed on 12/10/19, at 9:57 a.m. sitting on a chair in her room rubbing her knees back and forth. Registered nurse (RN)-F stated on 12/12/19, at 2:26 p.m. R43 had arthritis with pain in her shoulders, back and knees. R43's Annual MDS dated 10/14/19, indicated R43's cognition was impaired, had disorganized thinking, delusions and did not reject cares. R43's Annual MDS did not indicate R43 had limited function for ROM for the upper extremities. R43's Care Area Assessment (CAA) dated 10/14/19, indicated R43 had a contracture of the right hand. R43's medical record did not reveal evidence of any ROM being completed or a palm protector to be applied to R43's right hand. R43's care plan dated 7/3/18, indicated R43 was limited in ability to dress/undress self, maintain grooming, and to bathe self related to impaired mobility and fingers 4 and 5 on right hand contracted. R43's care plan did not indicate anything regarding a right hand palm protector to be applied for R43's contracted fingers. R43 stated on 12/11/19, at 8:00 a.m. her arms	2 890	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 26 and legs were sore and stiff the Tylenol pain medication helped. Nursing assistant (NA)-A stated on 12/11/19, at 11:13 a.m. when R43 gets ready to stand up with her walker she would rub her legs and say they are getting tight. NA-A stated R43 was independent. R43 was observed sitting on a chair in her room on 12/11/19, at 11:25 a.m. with fingers on both hands slightly bent down. OT (occupational therapy) confirmed R43's fingers were slightly bent down. OT stated R43 was admitted to the facility with triggered fingers on her right little and middle fingers and were bent down and stated they were stuck down. OT stated therapy had seen R43 and stated R43 was independent with eating and doing her own right hand exercises. OT stated she did not monitor R43's exercises as R43 was independent and could complete on her own. OT stated she had observed R43 four to five months ago and had seen R43 able to complete her exercises. OT stated she did not document this as she did not monitor. OT stated yearly screenings after therapy service ended were completed by therapy to see if resident was at baseline function and maximum functional capacity. OT stated she had not completed a screening for R43 when it was due. Looking at R43's fingers OT stated R43 triggered fingers had not changed but the little pinkie on left hand now had only 95% extension instead of the previous 100% extension when therapy ended. OT instructed R43 now include exercises on her left hand fingers and told R43 to complete exercises on both hands now daily. OT stated R43 had a palm protector she applied herself on her right hand. Nursing staff interviewed stated R43 no longer applied the palm protector.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 27 R43 was observed on 12/12/19, at 9:08 a.m. holding onto her walker ambulating down the hall unassisted. Physical therapy staff (PT) stated on 12/12/19, at 9:24 a.m. residents who could do their own ROM were not monitored by therapy but therapy completed yearly screenings for those residents whose therapy had ended and needed ROM. PT confirmed R43 had not had a screening completed since ending therapy over a year ago. PT stated since it had been over a year since R43's therapy had stopped and she had not had a screening completed by therapy for over a year. PT indicated she would put in for a screening to be completed by therapy for R43. R43's Occupational Therapy PN and Discharge Summary dated 6/28/18, indicated R43 had a contracture diagnosis for R43's right hand dated 6/15/18, and indicated R43 had met her therapy goal 6/28/18. R43's OT note indicated R43 was discharged from therapy with a right hand palm protector to wear every night and R43 was to perform self passive ROM on her right hand fingers. R43's OT progress note (PN) dated 10/25/18, indicated therapy had screened R43 and did not need to pick up R43 for therapy services. R43's PN did not indicate review of R43's performance of ROM exercises for her right hand, did not mention whether R43's palm protector was still in use, and did not reveal screening had been performed of R43's left hand for possible contractures. Review of R43's PNs from 10/26/18, through 12/11/19, did not reveal evidence of any OT	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 28 screening completed for R43's hands nor any follow up and/or monitoring of R43's ROM exercises. R66 stated on 12/11/19, at 8:17 a.m. she wondered why therapy services had ended for her and wondered if therapy should be able to help her more. R66's quarterly MDS dated 10/7/19, indicated R66's cognition was intact and diagnoses included anxiety, depression and paraplegia. R66's quarterly MDS indicated R66 had limited function ROM in bilateral lower extremities, needed extensive staff assistance with bed mobility, total staff dependence with toileting and did not reject cares. R66's CAA dated 7/9/19, indicated R66 had muscle weakness, was paraplegic, and had impaired ROM bilateral lower extremities with modest rehab goals. R66's care plan dated 7/22/19, indicated R66 needed staff assistance with ADLs including positioning and transfers r/t weakness, impaired ROM of lower extremities and restless legs. R66's care plan did not indicate any rehab goals or that ROM exercises should be completed. R66's physician order dated 7/5/19, indicated R66's rehab potential was good. PT stated on 12/11/19, at 11:09 a.m. R66 had admitted to the facility with therapy for strengthening and would look in therapy notes to see if restorative program had been planned after R66 discharged from therapy.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 29 RN-A, who was also nurse manager stated on 12/12/19, at 9:54 a.m. R66 had therapy services after admitting to the facility but no longer did. RN-A stated she was not aware of any ROM exercises being provided by staff or by R66. NA-A stated on 12/11/19, at 1:34 p.m. R66 transferred with an EZ stand with staff and stated R66 had no behavior problems. NA-A stated evening staff completed passive ROM for R66 but not on the day shift which she worked. NA-A stated R66 used to go downstairs for therapy and confirmed on R66's NA care sheet there was no ROM listed for staff to complete for R66 and confirmed no documentation completed for any ROM exercises. R66 stated on 12/12/19, at 2:18 p.m. she had completed therapy in the summer after admitting to the facility. R66 stated she had not received a paper with instructions for exercises for ROM after therapy was completed. R66 stated she thought communication was a problem at the facility. R66 stated therapy staff had come up to her room yesterday looking for a paper for ROM exercises in her room and had not found one and had told her they would get her a paper so she would know what and how often ROM needed to be completed for R66's strengthening exercises. PT Daily Treatment Note dated 8/1/19, indicated R66 was educated on performing exercises and provided written instructions and cues on form for R66 to use; however R66's MR lacked evidence of any follow up and/or monitoring of R66's ROM exercises. The facility Restorative Program policy dated 2017, indicated residents would be	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 30 comprehensively assessed/reassessed for restorative needs. The policy indicated restorative nursing care promoted resident's highest level of independence in areas including ROM, splints/braces and ADLs. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review and/or revise policies and procedures to ensure all residents received a therapy screening evaluation for residents with limited range of motion. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician.	2 945		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 945	Continued From page 31 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure prescribed diets per physician orders were received for 1 of 1 resident (R23) reviewed during dining assistance in room. Findings include: R23 was observed on 12/9/19, at 6:08 p.m. in her room lying on her back in bed with the head of bed elevated connected to a ventilator. R23 was unable to independently move her arms and/or feed herself without assistance. Nursing assistant (NA)-B began to assist R23 to eat vegetables in sauce, pears in juice, tuna sandwich, Jello and potato chips from a canister in room. NA-B gave R23 three bites of a dry potato chip then a drink of regular water from a cup with a straw then a bite of tuna sandwich followed by another drink of regular water. NA-B gave R23 two more bites of tuna sandwich then a drink of nectar thick cranberry juice. At 6:20 p.m. clinical manager (CM)-A entered and dropped off plastic spoons and exited. At 6:29 p.m. CM-A returned with extra nectar thick cranberry juice and exited the room. NA-B fed R23 a bite of the sandwich and another dry potato chip then a drink of nectar thick cranberry juice. R23 did not cough during bites of potato chips and/or thin water. NA-B was interviewed on 12/9/19, at 6:30 p.m. and verified R23 was able to drink thin (regular consistency) water, however required nectar thick	2 945	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 945	Continued From page 32 juice and milk. NA-B stated "she drinks regular water" as NA-B turned to R23 and NA-B asked R23 "right" R23 shook head yes in response. NA-B stated R23's family purchased R23 snacks and confirmed the potato chips from the canister were allowed per R23's diet orders. R23's Nutritional Status Care Plan dated 4/17/19, identified R23 was at risk for compromised nutrition related to diagnosis of dysphagia secondary to Amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function), dependence on ventilator with tracheostomy and directed staff to follow diet and liquid texture per physician orders. R23's Speech Therapy Progress and Updated Plan of Care dated 5/1/19, indicated R23 safely tolerated nectar thickened liquids, mechanical soft solid cut up into nickel size pieces, using small bites with plastic spoons, liquid wash every three to four bites and slow rate. The plan indicated "Husband found to provide thin liquids" and was educated to continue nectar thickened liquids for safe swallowing. R23's quarterly Minimum Data Set dated 9/17/19, identified R23 had intact cognition and required total assistance of one staff with eating. R23's Resident Face Sheet undated, identified R23 had diagnoses which included chronic respiratory failure with hypoxia or hypercapnia, flaccid hemiplegia affecting right dominant side, flaccid hemiplegia affecting left non-dominant side and Amyotrophic lateral sclerosis. R23's Physician Order Report dated 12/12/19, included diet order dated 4/17/19, which indicated nectar thickened liquids and mechanical soft	2 945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 945	Continued From page 33 solids that must be cut into nickel size pieces sitting upright at 90 degrees use small plastic spoons food must have been moist or add moisture alternate solids and liquids every three bites. R23 was interviewed on 12/11/19, at 9:42 a.m. and shook head "yes" when asked if she was able to drink thin water and eat potato chips. Speech language pathologist (SLP) was interviewed on 12/12/19, at 9:48 a.m. and verified R23 was to have received nectar thickened liquids and mechanical soft solids. SLP explained R23 was at risk for aspiration as R23 had no cough reflex and was unable to clear "things' out well. SLP indicated potato chips were not mechanical soft and stated R23 should not eat them. SLP confirmed she was not aware staff were "feeding" R23 food family brought into the facility. The director of nursing was interviewed on 12/12/19, at 2:08 p.m. and stated it was her expectation for therapeutic diet orders to be followed. The facility policy regarding therapeutic diets was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents who need specialized consistency therapeutic diet for eating are receiving these diets. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could	2 945		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 945	Continued From page 34 develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to store and maintain cooking utensils under sanitary conditions for 2 of 2 utensil storage drawers which had the potential to affect 57 residents. Furthermore, the facility failed to clean 4 of 4 dusty shelves and 4 of 4 white cabinets noted with reddish, brownish stains, dark matter, and paint chipped doors near kitchen cabinet handles. Findings include: During initial kitchen tour on 12/9/19, at 12:05 p.m. observed two utensil storage drawers with dust and brownish debris, four shelves below two countertops dusty, and four white kitchen cabinets with scattered reddish, brownish and dark matter with paint chipped areas near kitchen cabinet handles. During interview 12/9/19, at 12: 15 p.m. Dietary Director (DD) indicated that the dirt and debris in	21015	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 35 utensil drawer, and dust on shelving appeared to have not been cleaned by staff for more than a week. DD further verified utensil drawers, shelves and kitchen cabinets should have been cleaned weekly per schedule and currently did not appear those areas had been cleaned for more than a week. When interviewed on 12/12/19, at 11:24 a.m. DD stated she would place request with maintenance to get cabinets painted and stated staff had gone through the drawers and cleaned out the debris and also cleaned the shelves. Review of the undated Facility Cleaning and Sanitizing Policy indicated all food service departments must have an effective cleaning program that includes a cleaning schedule. Procedure includes: identify the cleaning jobs in each area in the kitchen. Review of the facility AM-PM staff weekly cleaning duties dated 12/2/19-12/8/2019, indicated staff to scrub down all shelves on clean side of dish room on Sunday. There was no signature for Sunday to show that cleaning was done. There was no noted specific duties assigned to clean utensil drawers, or cupboards. SUGGESTED METHOD OF CORRECTION: The dietary manager, registered dietician, or administrator, could ensure appropriate cleaning schedule is maintained in the kitchen which includes cabinets, utensil drawers and shelves cleaning. The facility could update or create policies and procedures, and educate staff on these changes and perform competencies. The dietary manager, registered dietician, or administrator could perform audits periodically to ensure compliance. The facility should report	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21015	Continued From page 36 audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 37 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to analyze monthly surveillance data for trends and patterns to reduce the spread of illness and infections. This had the potential to affect all 82 residents residing in the facility. Findings include: The facility's infection control logs were reviewed from September 2019, through November, 2019. The logs identified tracking records of residents with infections, symptoms, cultures and treatment. The type of infections were tracked by rooms and floor for each month. There were 20 infections meeting criteria including 10 urinary tract infections (UTI), six respiratory infections, two soft tissue infections, one gastrointestinal infection, and one fever of unknown origin. There were four "suspected" UTIs on the second floor between 9/18/19, and 10/29/19. These infections were documented on the floor plan by month, but it did not appear to have been investigated to determine if there were common staff providing care or other potential reasons that would explain the infections. Additionally, the data were not evaluated longitudinally as an entire quarter of data. A quarterly report for July through September was submitted to the Quality Council for the October meeting. There were 13 infections meeting criteria including seven urinary tract infections (UTI), three respiratory infections, and three soft tissue infections. The report was a list of infections and indicated most infections appeared to occur in the tracheostomy or ventilated residents; however, there was no evidence of	21390	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 38 further analysis for the cause of the patterns identified. During interview on 12/12/19, at 1:45 p.m. the infection preventionist, registered nurse (RN)-F, stated she was new in her role and still learning the tracking system. RN-F indicated there was no monthly written analysis regarding possible causes of the infections, so the facility could implement interventions to prevent infections. RN-F stated she was not aware that further analysis was needed. Further, RN-F stated infections were tracked by unit and displayed on maps. RN-F indicated that location of residents with infections was not evaluated or compared. There were no criteria to determine if there was an outbreak and each infection was evaluated individually. There was also no comparison month to month to determine any pattern. In addition, there were no specific plans developed to address identified infections. The facility Infection Prevention and Control Program policy dated November 16, 2016 identified that the infection prevention and control program existed to assure a safe, sanitary and comfortable environment for residents and personnel and was designed to help prevent the development and transmission of disease and infection. SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing (DON) could review and revise policies/procedures and educate staff regarding infection control surveillance. The DON or designee, along with the quality committee could audit and monitor on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 39 (21) days.	21390		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide person-centered, meaningful activities for 2 of 2 residents (R13, R43) reviewed for activities. Findings include: R13 was observed on 12/9/19, at 5:11 p.m. sitting in a chair in his room watching television (TV). R13 was not observed in the group activity held in the dining room on 12/9/19, at 2:00 p.m.. Staff did not know where R13 was at the time. R13's quarterly MDS (Minimum Data Set) dated 9/3/19, indicated R13's cognition was impaired, did not reject cares and was independent with	21435	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 40 ADLs (activities of daily living). R13's quarterly MDS included diagnoses of dementia, anxiety, depression and traumatic brain disorder. R13's Activity Assessment (AA) dated 12/2/19, indicated R13 was interested in Bingo, Board, Card, Dice games and Dominoes. R13's AA also indicated R13's hobbies were handyman, yard work and handiwork quilt and sew. R13's AA indicated R43 likes exercise, radio, tv, hunting and fishing. music, dine out, fairs, tours, museum, scenic drives, shopping, travel, movies, indoor plants and special events. R13's Activities care plan dated 12/2/19, indicated staff would help R13 with set up with IPAD/Table to view movies or listen to music independently, be reminded of monthly brunch lunch, would enjoy visits from mentor and go to movies and meals outside of facility. R13's annual MDS dated 12/10/18, indicated it was "Very Important" for R13 to get fresh air outside and attend his favorite activities. The annual MDS indicated it was "Somewhat Important" for R13 to keep up with the news and attend group activities. R13 was observed on 12/11/19, at 8:05 a.m. in dark room laying on his side towards the TV with the TV turned on. Nursing Assistant (NA)-F stated on 12/11/19, at 8:06 a.m. R13 liked to stay in his room a lot and sleep. R13 was observed on 12/11/19, at 11:12 a.m. sitting on a chair in his room, head down, eyes closed with his TV turned on.	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 41 NA-A stated on 12/11/19, at 1:31 p.m. R13 was pretty mellow, had no behavior issues and was just a little forgetful. NA-A stated R13 was independent with ADLs and R13 liked to stay in his room and watch TV shows. NA-A stated R13 liked current events and loved to read the newspaper. R13 was observed on 12/12/19, at 9:24 a.m. sitting in his room, TV turned on. Licensed practical nurse (LPN)-A stated on 12/12/19, at 9:25 a.m. R13 stayed in his room, ate his meals in his room and came out of his room once and awhile. LPN-A stated she had seen a friend visit R13 but not seen any family visit. R13 was observed on 12/12/19, at 2:46 p.m. laying on his bed watching TV. R13 was not observed present at any activity held throughout the duration of the survey week from 12/9/19 through 12/12/19. The December 2019, Activities Calendar posted indicated Bingo was held on Sunday afternoons, Games were held on 2nd floor and 3rd floor on Monday 12/9/19, at 2:00 p.m. and music was held on Tuesday and Wednesday afternoon at 2:00 p.m. on 12/10/19, and 12/11/19, at the facility. TR (Therapeutic Recreation) director stated on 12/12/19, at 3:00 p.m. R13 was assessed for activity preference upon admission and thereafter quarterly along with the assessment completed for activity preference with the MDS schedule. TR director stated R13 used to come to Bingo and Pokino and stated R13 used to have a mentor more in the summer. TR director stated R13's	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 42 family from Chicago had visited R13 in October and stated she thought R13 was feeling down from the news about his sister's illness. TR director stated R13 liked outdoor activities and smoked outside everyday. TR director stated she would like R13 to have 2-3 one-to-one (1 to 1) activities a week provided for R13 from activity staff including the chaplain visits. TR director stated R13 used to come to Bingo independently but had not been coming to Bingo. TR director stated R13 used to be outside more but had not now with the weather changed. TR director stated she had tried various things for R13 and R13 needed to be encouraged more and invited to the activities. TR director stated she would now careplan for that. TR director confirmed R13's careplan did not include that and confirmed R13's activity documentation did not include 2-3 a week activity staff 1:1's provided for R13. R13's Individual Attendance Record (IAR) dated September 2019, indicated R13 had attended Bingo and Special Events one time each and had not been invited to Table games or Music. R13's September IAR indicated R13 had three TR (therapeutic recreation) staff visits (1:1s) provided. R13's October 2019, IAR indicated R13 attended Pokeno and Cafe/news one time each and had not been invited to Table games or Music. R13's October IAR indicated R13 had four TR staff visits. R13's November 2019, IAR indicated R13 had attended Table games one time, Social events four times and Special events two times and had not been invited to Music. R13's November IAR indicated R13 had four TR staff visits. R13's December 2019, IAR indicated R13 had not been invited to or attended Bingo or Music, and had not attended any Table games, Pokeno	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 43	21435		

or cafe/news. R13's December IAR indicated R13 had one TR staff visit provided.

R43 was was not observed present on 12/9/19, at 2:00 p.m. in the group activity held in the dining room. Staff did not know where R43 was.

R43's Annual MDS dated 10/14/19, indicated R43's cognition was impaired, had disorganized thinking and delusions. R43's annual MDS indicated R43 needed extensive staff assistance with ADLs and did not reject cares. R43's annual MDS indicated it was "Very Important" for R43 to do her favorite activites and was "Somewhat Important" for R43 with music, animals and group activities.

R43's Activity Assessment (AA) dated 10/15/19, indicated R43 was interested in attending Bingo, Cook/Bake, Handiwork quilt/sew, needlework and paint/draw and also watching TV. R13's AA also indicated R13 was interested in music, reading, clergy visits, radio programs, dining out, fairs/tours/museum trips, plays/movies, scenic drives, shopping, special events, travel, indoor plants and small and large group activities.

R43's care plan dated 10/15/19, indicated R13 would attend 1-2 activities per week, and staff would pain nails with aromatherapy, and chaplain would provide spiritual interaction 1-2 times weekly. R43's Activity car plan dated 10/15/19, did not include R43's interested activities per Activity Assessment completed 10/15/19. R43's care plan dated 12/12/19, edited after survey began, indicated R13 would be invited and needed escort to social and musical programs.

R43 was observed on 12/9/19, at 5:23 p.m. sitting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 44 on a chair in her room with her head down, eyes closed and TV turned on. R43 was observed on 12/10/19, at 9:57 a.m. sitting on a chair in her room with the TV turned on. RN-A stated on 12/10/19, at 9:58 a.m. R43 does not see her family, talked to herself and stated once staff engage R13 in a conversation R13 will talk with you. NA-B stated on 12/10/19, at 3:20 p.m. R43 could walk alone with her walker but needed staff assistance to stand up. NA-B stated she did not know R43's whereabouts but thought possibly she was downstairs for music. R43 was observed on 12/11/19, at 8:00 a.m. sitting on a chair in her room. R43 stated she went to some activities and had not went down to the music program yesterday. R43 was observed on 12/11/19, at 11:13 a.m. sitting in her room head down, eyes closed and TV turned on. NA-A stated on 12/11/19, at 11:14 a.m. R43 loved to watch TV shows and stated R43 talked to herself. NA-A stated sometimes R43 would talk to staff depending on her mood but mostly talked to herself. NA-A stated she had seen R43 join in a couple of activities and stated R43 liked playing cards and one of her favorites to play was "Whisk and Spades". NA-A stated she had not seen R43's family in the facility. Occupational therapy (OT) staff stated on 12/11/19, at 11:25 a.m. R43 had two triggered fingers on her right hand in stuck down position	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 45 and left pinkie finger with not full extension. OT stated R43 and arthritis in her fingers and needed staff assistance with her hands at times. R43 was observed on 12/12/19, at 9:08 a.m. sitting at a table in dining room looking around. R43 was observed on 12/12/19, at 9:14 a.m. sitting in her room TV turned on. R43 was not observed present at any activity held throughout the duration of the survey week from 12/9/19 through 12/12/19. The December 2019, Activities Calendar posted indicated Bingo was held on Sunday afternoons, Games were held on 2nd floor and 3rd floor on Monday 12/9/19, at 2:00 p.m. and music was held on Tuesday and Wednesday afternoon at 2:00 p.m. on 12/10/19, and 12/11/19, at the facility. During interview with TR director on 12/12/19, at 3:08 p.m. TR director stated R43 liked music, church, lunch brunch and attending group activities. TR director stated lunch brunch was held monthly. TR director stated R43 should have one to two activity staff 1:1's provided a week including the chaplain visits. TR director stated R43 had no family and liked TV in her room. TR director stated the activity staff knew which activities residents preferred by their care plans and confirmed R43's present careplan did not include R43's favorite activites or preferences. TR director stated she would careplan R43's favorite activites and preferences and replace R43's present careplan. TR director confirmed R43's activity documentation indicated R43 was not being provided one to two activity staff 1:1's a week as she would like.	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 46 R43's IAR dated September 2019, indicated R43 had not been invited to Bingo each week or invited to Games and had attended Bingo one time, had not attended Pokeno, had not been invited to or attended music and had no chaplain visits provided. R43's September IAR indicated R43 had five TR staff visits (1:1's) provided for the month. R43's IAR dated October 2019, indicated R43 had not been invited to or attended Bingo or Games, had not attended Pokeno, had not been invited to or attended music and had no chaplain visits provided. R43's October IAR indicated R43 had seven TR staff visits provided for the month. R43's IAR dated November 2019, indicated R43 had not been invited to or attended Bingo, had attended Pokeno one time, had not been invited to or attended music and had no chaplain visits provided. R43's November IAR indicated R43 had two TR staff visits provided for the month. R43's IAR dated December 2019, indicated R43 had not been invited to or attended Bingo or Games, had not attended Pokeno, had not been invited to or attended music, had no chaplain visits, and had not been invited to church services every week. R43's December IAR indicated R43 had two TR staff visits provided. Facility Activities policy was requested for review and , and was not made available. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and or revise policies and procedures to ensure all residents received a comprehensive activity assessment to assist with developing individualized, resident centered interventions. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality	21435		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21435	Continued From page 47 assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending	21530		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 48 physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility consulting pharmacist (PharmD) failed to identify and report staff failures to notify the provider of weight gain of greater than two pounds while taking a diuretic medication for 1 of 5 residents (R65) reviewed for unnecessary medication use. Findings include: R65's physician order summary dated 11/20/19, identified diagnoses including chronic respiratory failure with hypoxia, dependence on respirator, chronic obstructive pulmonary disease, tracheostomy, polyneuropathy, and venous insufficiency. On 6/12/18, R65's Lasix order, a medication used to manage edema (swelling), was decreased from 40 milligrams (mg) orally (o) to 20 mgs (o). Special instructions included with this order were to do weekly weights on R65 and notify the certified nurse practitioner (CNP) if R65 gained more than two pounds (lbs). Record review revealed several weekly weight gains of greater or equal to two pounds: - 7/18/19 - 7/25/19 = 10.8 lbs - 8/29/19 - 9/5/19 = 9.8 lbs	21530	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 49 - 9/26/19 - 10/3/19 = 9.0 lbs - 10/17/19 - 10/24/19 = 6.1 lbs - 10/31/19 - 11/7/19 = 3.2 lbs - 12/5/19 - 12/12/19 = 7.8 lbs Record review revealed a lack of evidence that these weight gains had been communicated with the CNP with the exception of a telephone order found in the paper chart dated 10/3/19, indicating a 9 lb weight gain. The provider responded to continue to monitor. R65's MRRs dated 1/2/19, 2/26/19, 3/6/19, 4/17/19, 5/14/19, 5/2/19, 6/11/19, 7/16/19, 8/13/19, 9/16/19, 10/15/19, and 11/13/19, were all reviewed. No weight changes or notifications to the CNP were addressed in the MRRs. During an interview on 12/12/19, at 12:49 p.m. the PharmD stated he had not been aware of the order to contact CNP with a two pound weight gain, and noted that order would usually be tied directly to the medication order. The PharmD verified the weight gain assessment would have been part of the MRR. The facility's medication regimen review policy was requested for review and none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee and the consulting pharmacist could review and/or revise policies and procedures to ensure the consultant pharmacist monitors and reports irregularities in resident's medications and associated orders. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 50 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the provider of weight gain of greater than two pounds while taking a diuretic medication for 1 of 5 residents (R65) reviewed for unnecessary medication use.	21540	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 51 Findings include: R65's physician order summary dated 11/20/19, identified diagnoses including chronic respiratory failure with hypoxia, dependence on respirator, chronic obstructive pulmonary disease, tracheostomy, polyneuropathy, and venous insufficiency. On 6/12/18, R65's Lasix order, a medication used to manage edema (swelling), was decreased from 40 milligrams (mg) orally (o) to 20 mgs (o). Special instructions included as an additional order dated 6/19/18, stated "NOTE: patients lasix decreased from 40 to 20 mg. If patient gains more than 2 lbs update NP during clinic hours". Record review of R65's weekly weights in the vital signs section of Matrix, the electronic health record, from June through December 12, 2019, revealed several weekly weight gains of greater or equal to two pounds: - 7/18/19 - 7/25/19 = 10.8 lbs - 8/29/19 - 9/5/19 = 9.8 lbs - 9/26/19 - 10/3/19 = 9.0 lbs - 10/17/19 - 10/24/19 = 6.1 lbs - 10/31/19 - 11/7/19 = 3.2 lbs - 12/5/19 - 12/12/19 = 7.8 lbs Record review revealed a lack of evidence that these weight gains had been communicated with the CNP with the exception of a telephone order found in the paper chart dated 10/3/19, indicating a 9 lb weight gain. The provider responded to continue to monitor. RN-D was interviewed on 12/12/19, at 11:10 a.m. and stated he did not know there was an order to call the CNP with a weight increase of two pounds or more. RN-D verified the order and	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 52	21540		

reviewed several weeks that indicated a weight of two pounds or greater, including the weight dated 10/31/19, which was two pounds higher than the weight dated 10/24/19. RN-D stated the nursing assistants weighed the residents and notified the nurse if there had been a weight gain. RN-D stated typically the nurse would leave a voice mail message for the CNP and the message would be documented in the progress notes. RN-D also verified there was no documentation notifying the CNP of the two pound weight gain. RN-D found a telephone order (TO) message left in R65's paper chart for R65's provider after a 9 pound weight gain. A physician directed staff to continue to observe R65. RN-D was unable to find any other documentation regarding notification of weight gain in either the electronic progress notes or in the TO's in the paper chart. RN-D stated the weight gain would be important likely because of R65's congestive heart failure.

During an interview on 12/12/19, at 11:30 a.m., the director of nutrition services (RD) stated that she was responsible for assessing R65's nutritional status in the minimum data set (MDS) and care area assessments (CAA). The RD also created the goal and approaches for R65's care plan. Additionally, the RD reviewed R65's record monthly including an assessment of R65's weekly weights and addressed R65's weight in the progress notes. The RD did not specifically evaluate R65's weight changes week to week and stated she did not know whether or not the provider was notified of weight gains of two pounds or more.

The pharmacist (PharmD) was interviewed on 12/12/19, at 12:18 p.m. and verified that a chart review including vital signs would be done with every monthly medication regimen review (MRR)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 53 completed. PharmD stated that typically an order for specific weight gain monitoring would be tied directly to a medication order. PharmD verified none of the two pound weight gains were noted in the MRRs completed for the past year. The facility medication administration and monitoring policy was requested and none provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sanitary, comfortable and homelike environment for 1 of 2 residents (R26) reviewed with environmental concerns.	21695	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 54 Findings include: R26's diagnosis list printed 12/12/19, identified the following diagnoses: anoxic brain damage, protein-calorie malnutrition, persistent vegetative state, and gastrostomy. On 12/9/19, at 4:02 p.m. R26 came back from shower and was lifted back into bed. Sheets had been changed and the area around the bed had been straightened up. During an observation on 12/9/19, at 4:19 p.m. it was noted that the tubing for R26's g-tube feeding which was hanging from an IV (intravenous) pole, was leaking down the pole. There was fresh as well as dried liquid on the pole, floor, bed frame and some splashed on the wall and base board. On 12/9/19, at 4:27 p.m., registered nurse (RN)-D was observed while providing trach care for R26. There was no leaking fluid observed at this time, however the tube feeding pole and floor were dirty. On 12/10/19, at 1:09 p.m. the pole, floor, bed and base board were still dirty. All the liquid was dried. On 12/11/19, at 8:00 a.m. the dried liquid was still present. On 12/11/19, at 8:11 a.m. housekeeper (HSK)-A stated that resident rooms were cleaned daily including the floor and around and under machines. HSK-B was interviewed on 12/11/19 at 8:16 a.m. HSK-B stated she just started her second week	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 55	21695		

of work and just got off of orientation. She was the only housekeeper on the fourth floor. HSK-B stated she had been trained to clean all floors and around furniture and machines.

Nursing assistant (NA)-D was interviewed on 12/11/19, at 11:45 a.m. and stated she would notify the nurse if she saw the tubing leaking and would clean up anything on the floor, bed and baseboard. NA-D verified dried liquid in those areas.

On 12/11/19, at 11:53 a.m. NA-E verified the dried liquid on the floor, bed, pole and base board.

On 12/11/19, at 12:10 p.m. the clinical manager, registered nurse (RN)-E verified the dried liquid. RN-E stated the expectation was that all rooms should be cleaned daily and that staff should have noticed the dried liquid.

On 12/11/19, at 12:11 p.m. the director of maintenance (DM) verified that all floors would be expected to be cleaned every day, including around machines and IV poles. DM verified the dried liquid on pole, floor, bed frame and base board. DM stated nursing would clean the actual equipment and housekeeping would clean the rest.

The facility policy regarding cleaning and maintenance of equipment dated October 2017, stated equipment must be maintained and repaired in a manner that would prevent transmission of infection.

SUGGESTED METHOD OF CORRECTION: The administrator, maintenance director, or designee could review and revise policies and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 56 procedures, and training for staff regarding cleanly environment. The administrator, maintenance director, or designee could perform environmental rounds/audits periodically to ensure clean, comfortable, and homelike environment is adequately maintained. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall	21880		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 57 have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to promptly respond or resolve grievances expressed by 1 of 1 resident (R23) reviewed for concerns regarding cares with staff. Findings include: Family member (FM)-B was interviewed via telephone on 12/9/19, at 4:57 p.m. and stated R23 and FM-B expressed concerns to clinical manager (CM)-A and the facility administrator regarding call light placement, not assisting R23 with meals timely, and R23's communication computer potentially falling and hitting R23 in the face due to a broken piece and staff not positioning the computer properly. FM-B explained he had expressed multiple concerns	21880	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 58	21880		

during the past six months and had met with the administrator, however FM-B stated he had not received any follow-up and felt as if the concerns were ongoing. FM-B indicated there were concerns with R23 having been mistreated over the summer as well as a "few times" since then by facility staff during cares, however indicated he did not receive follow up.

R23 was interviewed on 12/10/19, at 3:29 p.m. and stated staff did not put her call light near her head as they were supposed to. R23 indicated she was able to push her head against her call light when it was placed correctly by staff. R23 indicated her call light was the only way to notify staff when needing assistance due to R23 having been non-verbal.

R23 was observed on 12/10/19, at 3:29 p.m. lying on her back resting in her bed eyes open computer near face and call light on the floor not within reach of R23's head.

R23's quarterly Minimum Data Set dated 9/17/19, identified R23 had intact cognition and required total assistance of two staff for bed mobility.

R23's undated Resident Face Sheet identified R23 had diagnoses which included chronic respiratory failure with hypoxia or hypercapnia, flaccid hemiplegia affecting right dominant side, flaccid hemiplegia affecting left non-dominant side and Amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function).

R23's medical record lacked evidence of a written grievance and/or concern form and follow-up.

The administrator was interviewed via telephone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 59 on 12/12/19, at 3:40 p.m. and verified he met with FM-B regarding concerns, however indicated there was nothing in writing regarding the concerns and/or follow-up. The administrator stated they would usually sit down and talk to the family regarding concerns, however indicated they did not always document the conversations. The administrator indicated he thought R23 and FM-B's concerns had been "handled." The Facility Concerns Grievances Policy dated 6/2019, indicated after receiving a concern there was a prompt response by the associates to acknowledge the receipt of the concern, investigate, seek resolution and keep the resident appropriately apprised of progress toward resolution. The resident/ resident representative had a right to receive a written response to their concern or grievance if requested. The policy included when a resident, resident representative, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards the form to the social services department, grievance officer, designees in a confidential container. All written grievance decisions would include the date the grievance was received, summary of the grievance, steps taken to investigate, pertinent findings or conclusions regarding the concern, a statement whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance and the date the written decision was issued. SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding the grievance process for reviewing and following up with complainants. The administrator and or designee, could re-educate all staff on the policies and	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	B. WING _____ A. BUILDING: _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 60 procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21880		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21925	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 61	21925		

facility failed to provide written hospital transfer notices to the residents who had a facility-initiated hospital transfer for 2 of 2 residents (R27, R381) reviewed for hospitalizations.

Findings include:

R27 stated on 12/10/19, at 9:13 a.m. he had recently been hospitalized for too much fluid in his heart and had not had any staff discuss with him regarding a notice of transfer to the hospital and his appeals rights. Review of R27's medical record (MR) revealed R27 was his own responsible party.

R27's Significant Change Minimum Data Set (MDS) dated 9/23/19, indicated R27's cognition was impaired.

R27's Discharge Assessment Return Anticipated MDS dated 9/8/19, indicated R27 was discharged to an acute hospital.
R27's Entry MDS dated 9/16/19, indicated R27 re-admitted to the facility.
R27's Discharge Assessment Return Anticipated MDS dated 9/27/19, indicated R27 was discharged to an acute hospital.
R27's Entry MDS dated 10/3/19, indicated R27 re-admitted to the facility.
R27's Discharge Assessment Return Anticipated dated 10/21/19, indicated R27 was discharged to an acute hospital.
R27's Entry MDS dated 11/5/19, indicated R27 re-admitted to the facility.

R27's progress note (PN) dated 9/8/19, indicated R27 was sent to the hospital for shortness of breath (SOB) and decreased oxygen saturations and was admitted to the hospital. PN dated 9/16/19, indicated R27 returned from the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 62	21925		

and was readmitted to the facility. Review of R27's medical record (MR) revealed no evidence a Notice of Transfer or Discharge was provided to R27.

R27's PN dated 9/27/19, indicated R27 was sent to the hospital for SOB and decreased O2 (oxygen) sats (saturation) and was admitted to the hospital. PN dated 10/3/19, indicated R27 returned from the hospital and was readmitted to the facility. Review of R27's MR revealed no evidence a Notice of Transfer or Discharge was provided to R27.

R27's PN dated 10/21/19, indicated R27 was sent to the hospital for SOB and decreased O2 sats and was admitted. PN dated 11/5/19, indicated R27 returned from the hospital and was readmitted to the facility. Review of R27's MR revealed no evidence a Notice of Transfer or Discharge was provided to R27.

R27's PN dated 11/29/19, indicated R27 was sent to the hospital for SOB and decreased O2 sats and was admitted. PN dated 12/4/19, indicated R27 returned from the hospital and was readmitted to the facility. Review of R27's MR revealed no evidence a Notice of Transfer or Discharge was provided to R27.

Registered Nurse (RN)-A stated on 12/12/19, at 9:26 a.m. nurses did not make residents aware of their appeal rights for transfer or provide the resident with a copy of the Notice of Transfer or Discharge when leaving for the hospital.

The Business Office Manager (BOM) stated on 12/11/19, at 3:39 p.m. the facility had not yet implemented giving the residents and/or their representative notices of transfer or discharge

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 63 when the facility initiated residents' transfers to the hospital. R27's Notices of Voluntary Resident/Patient Transfer or Discharge dated 9/8/19, 9/27/19, 10/21/19, 11/29/19, revealed no evidence of R27's signature, the notice being provided to him, or the reason for the medical transfer. R381 was reviewed as a closed record and revealed evidence R381 was her own responsible party. R381's Admission MDS dated 5/29/19, indicated R381's cognition was intact. R381's Discharge Assessment Return-Anticipated MDS dated 6/4/19, indicated R381 was transferred to an acute hospital, was unplanned, and R381 was expected to return. R381's PN dated 6/4/19, at 11:36 p.m. indicated R381 was sent to the hospital. R381's PN dated 6/5/19, at 12:51 p.m. indicated R381 was admitted to the hospital and was awaiting spinal fusion surgery. R381's Notice of Voluntary Resident/Patient Transfer or Discharge dated 6/4/19, revealed no evidence of R381's signature, the notice being provided to her, or the reason for the medical transfer. The facility policy regarding Notice of Transfer or Discharge was requested for review, and was not provided. SUGGESTED METHOD OF CORRECTION:	21925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	B. WING	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21925	Continued From page 64 The administrator or designee could review and revise policies and procedures regarding notices of transfer/discharge. Facility staff could be educated on these policies and procedures. The administrator or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21925		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to report timely an allegation of stolen money to the administrator and state agency (SA) for 1 of 5 residents (R65) reviewed for misappropriation of property. Findings include: R65 was interviewed on 12/9/19, at 1:28 p.m. and stated she had $35.00 stolen from a zippered wallet which was left in her room on her bedside table. R65 recalled she left her room for one to	21995	Corrected.	1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 65	21995		

two hours and when she can back the money was stolen. R65 stated she notified the clinical manager (CM)-A two to three months ago regarding the stolen money. R65 stated she felt as if there was not any follow-up and wanted the facility to let her know the outcome of their investigation.

R65's quarterly Minimum Data Set dated 11/5/19, identified R65 had moderate cognitive impairment and diagnoses which included depression and anxiety.

CM-A was interviewed on 12/10/19, at 3:18 p.m. and stated she was not aware of the stolen money. CM-A indicated she would notify the director of social service (DSS) for further follow-up.

R65's Concern Form dated 12/10/19, at 3:32 p.m. indicated R65 told CM-A during the past 90 days R65 had $35.00 missing.

R65's medical record lacked evidence of notification to the administrator and/or SA regarding the reported $35.00 stolen on 12/10/19.

R65 was observed 12/11/19, at 8:46 a.m. seated in her room in her wheelchair watching television.

R65 was interviewed on 12/11/19, at 11:40 a.m. and stated DSS came to talk to her "this morning" and indicated R65 told DSS, "I thought it was stolen."

DSS was interviewed on 12/12/19, at 10:13 a.m. (three days after concern was reported to facility regarding R65's stolen money) and stated she spoke to R65 whom indicated she had lost $35.00 in her coin purse which was left on her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21995	Continued From page 66 bedside table. DSS indicated she reminded R65 to keep her money locked in her drawer and gave R65 a replacement key as R65's key was lost. DSS explained they only reported missing property if the value was greater than $50.00. During a subsequent interview at 1:48 p.m. DSS indicated R65 "shrugged her arms" when DSS asked if the $35.00 had been stolen, as if R65 was not sure. DSS indicated she completed a concern form for the missing money, however did not notify the SA. The facility Abuse Prevention Plan dated 2017, indicated misappropriation of resident property included the deliberate misplacement, exploitation or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. The policy indicated staff would notify the charge of building immediately of any reports of misappropriation of resident property whom would immediately notify the administrator, director of nursing and DSS. If the even did not result in bodily injury the individual was required to report no later than 24 hours. SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding reporting of all alleged abuse/neglect/mistreatment. The administrator and or designee, could re-educate all staff on the policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21995		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults	22000		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 67 Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 68 misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to thoroughly investigate an allegation of mistreatment for 1 of 1 resident (R23) reviewed for employee physical abuse. In addition, the facility failed to thoroughly investigate an allegation of unwanted advances from staff for 1 of 1 resident (R380) reviewed for abuse. Findings include: R23's care plan dated 4/2/19, identified R23 was at risk for skin breakdown and directed staff to move resident with two staff and draw sheet. R23's investigative file dated 7/8/19, indicated R23's daughter reported R23 had received "rough care early AM ...And finger(s) on left hand bent back causing pain." The file indicated it was reported on 7/8/19, by R23's family, however the alleged allegation occurred on 7/6/19, "about" 5:00 a.m. per R23's interview and reported "she was half asleep when blanket was pulled back ...and left hand 2nd finger was bent back." R23 identified the nursing assistant (NA) as a "white lady who is a regular on the unit" The file indicated NA-C, R23 and clinical manager (CM)-A	22000	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 69	22000		

met and NA-C "sincerely apologized" to R23 as NA-C "was working that night." The file identified NA's "were providing care as per care plan and know to gently touch her shoulder during the night." R23's file included NA-C written statement dated 7/8/19, and indicated R23 "takes a lot of time to care for and it is hard to be gentle" due to R23's size.

R23's quarterly Minimum Data Set (MDS) dated 9/17/19, identified R23 had intact cognition and required total assistance of two staff for bed mobility.

R23's Resident Face Sheet undated, identified R23 had diagnoses which included chronic respiratory failure with hypoxia or hypercapnia, flaccid hemiplegia affecting right dominant side, flaccid hemiplegia affecting left non-dominant side and Amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function).

R23's medical record lacked evidence of R23's care plan not having been followed when R23 was turned and repositioned with one staff instead of two. Although other staff were interviewed and one audit was completed, R23's record lacked evidence of NA-C re-educated regarding care plan needed to have been followed regarding repositioning and further audits of NA-C providing resident cares in addition to other resident interviews.

R23 was interviewed with the use of an electronic communication device on 12/9/19, at 1:54 p.m. and stated staff did not take their time when providing cares. R23 explained it was not all staff "just a few" and indicated she "cannot talk during cares to tell them" to slow down. R23 indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 70	22000		

"rough care happens at dark time" and indicated NA's would cause pain and were "degrading I am a person just like them who needs to be treated with respect." R23 stated a few months ago there was one staff who was providing cares during the time R23 reported rough treatment. R23 stated she notified CM-A regarding her concerns with staff.

Family member (FM)-B was interviewed via telephone on 12/9/19, at 4:57 p.m. and stated he felt R23 was "mistreated." FM-B identified R23 told him NA-C was "very rough" when providing cares.

R23 was observed on 12/9/19, at 5:39 p.m. lying in bed and assisted to be repositioned by three NAs whom gently rolled R23 side to side while explaining cares and asked R23 if she was okay. R23 indicated yes by shaking her head. R23 appeared comfortable while the staff assisted her.

NA-C was interviewed on 12/12/19, at 6:37 a.m. and stated "daily we turn and reposition people by ourselves it's the only way to get it done, I am pretty strong." NA-C explained R23 was difficult to understand and "usually" used two people when completing R23's cares. NA-C recalled R23 stated she was "treated roughly with her cares" and explained she did not remember "being too rough" with R23. NA-C remembered she worked the night R23 complained of rough treatment and indicated R23's care plan indicated two staff for turning and repositioning, however stated "but we did her as a one ...when I worked." NA-C indicated she "never really asked for help" she had her routine. NA-C explained when turning and repositioning R23 "alone you had to catch her to gently come back." NA-C stated "only a few of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 71	22000		

us who could do her alone." NA-C further stated "we likely did her alone" the night R23 reported her cares were rough and indicated it was "harder to move alone" due to R23's size and inability to assist. Furthermore, NA-C indicated "but now we use two" staff.

The director of nursing was interviewed on 12/12/19, at 2:08 p.m. and stated it was her expectation for staff to have used two people per R23's care plan.

The facility Abuse Prevention Plan dated 2017, indicated mistreatment was the inappropriate treatment of a resident. The plan indicated supervisors and managers would provide daily supervision of direct care staff to identify inappropriate behaviors, communication quality, physical contact and/ or burn out.

R380 was reviewed as a closed record.

R380's discharge MDS dated 7/30/19, identified R380 had intact cognition and diagnosis which included anxiety.

R380's Investigative File dated 7/23/19, indicated R380 expressed to the facility social worker that a staff member made unwanted advances when registered nurse (RN)-G rubbed R380's shoulder close to "my breast" then turned R380's wedding ring and said "where you get this". R380 indicated she said "please don't touch me." R380 indicated she stayed away with her phone due to having been scared and identified the unwanted touching was the worst part. The file indicated the staff member knocked on R380's room to administer medication per orders. However, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 72 file lacked evidence of interviewing additional residents and monitoring interactions between residents and staff. R380 was contacted via telephone on 12/11/19, at 1:08 p.m. however did not return the telephone call. Family member (FM)-C was contacted via telephone on 12/11/19, at 1:09 p.m. however did not return the telephone call. Registered Nurse (RN)-G was interviewed on 12/12/19, at 6:08 a.m. and stated he was attempted to administer R380's medication, however R380 was upset and wanted her narcotic pain medication instead of the Tylenol. RN-G denied touching R380 and stated he knocked on R380's door and only entered when R380 acknowledged him and welcomed his entrance. The director of nursing was interviewed on 12/12/19, at 2:14 p.m. and stated it was her expectation during the investigation to interview additional residents. The facility Abuse Prevention Plan dated 2017, indicated abuse was the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. The plan indicated all accidents and incidents as well as allegations of abuse would have been investigated. SUGGESTED METHOD OF CORRECTION: The administrator could review policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00960	A. BUILDING: _____ B. WING _____	C 12/12/2019

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 73 administrator and or designee, could re-educate all staff on the policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	22000		