CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: 7KXS Facility ID: 00960

						3
1. MEDICARE/MEDICAID PROVIDER (L1) 245266 2.STATE VENDOR OR MEDICAID NO. (L2) 196677400	NO.	3. NAME AND AL (L3) BENEDICTI (L4) 618 EAST 17 (L5) MINNEAPO	INE HEALTH (7TH STREET		OF MINNEAPOLIS (L6) 55404	4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9) 6. DATE OF SURVEY 12/12,		7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual	IPPLIER CATEGO 05 HHA 06 PRTF	ORY 09 ESRD 10 NF	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	03 SNF/NF/Distinct 04 SNF	07 X-Ray 08 OPT/SP	11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	95 (L18) 95 (L17)	Complian	Requirements are Based On:		And/Or Approved Waivers Of Th2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
			and/or Applied Wa		* Code: B*	(L12)
14. LTC CERTIFIED BED BREAKDOW 18 SNF 18/19 SNF 95	'N 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMAR	RKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Shelley Arumba, HFE	NE II		01/21/2020	(L19)	Douglas Larson, Enf	orcement Specialist 02/10/2020 (L20)
P.	ART II - TO BI	E COMPLETED	BY HCFA R	EGIONAI	OFFICE OR SINGLE ST.	ATE AGENCY
DETERMINATION OF ELIGIBILIT			MPLIANCE WITH GHTS ACT:	CIVIL	1. Statement of Finan 2. Ownership/Contro 3. Both of the Above	l Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 02/24/1984	BEGINNING	DATE	ENDING DAT	ΓE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	**
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	spension Date:	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE		
	(L32)			(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

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.

Benedictine Health Center Of Minneapolis January 6, 2020 Page 2

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.

Benedictine Health Center Of Minneapolis January 6, 2020 Page 3

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

Benedictine Health Center Of Minneapolis January 6, 2020 Page 4

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

DOUBLES SLADOW

Telephone: 651-201-4118 Fax: 651-215-9697

Email: doug.larson@state.mn.us

cc: Licensing and Certification File

PRINTED: 02/04/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
n	EMPH	NO ANIZA	IAL	MI EDOEM		С
1111		245266	B. WING		12/	12/20 <u>19</u>
NAME OF F	PROV I DER OR SUPPL I ER	I U AUINI		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET		
BENEDIC	CTINE HEALTH CENT	TER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000	Emergency Prepar conducted on 12/9, recertification surviv	liance with CMS Appendix Z redness Requirements, was /19, through 12/12/19, during a ey. The facility is in compliance Z Emergency Preparedness	F 000			
	was conducted at y investigations were was found not to be federal requirement Requirements for L. The following compusubstantiated: H5266074C. Deficit H5266079C.	gh 12/12/19, a standard survey your facility. Complaint e also conducted. Your facility e in compliance with the ats of 42 CFR 483, Subpart B, Long Term Care Facilities. plaints were found to be siency issued at F610. Siency issued at F684.				
	as your allegation of Department's acceenrolled in ePOC, yat the bottom of the form. Your electron be used as verification	of correction (POC) will serve of compliance upon the eptance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance.				
LABORATOR		acceptable electronic POC, an	NATURE	TITLE		(YE) DATE
TAROKATOK,	T DIKECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATUKE	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) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF F	PROVIDER OR SUPPLIER	245266		STREET ADDRESS, CITY, STATE, ZIP CODE	C 12/12/201 <u>9</u>	
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
F 000	Continued From pa	age 1	F 000			
	validate that substa regulations has be your verification.	our facility may be conducted to antial compliance with the en attained in accordance with				
	Safe/Clean/Comfo CFR(s): 483.10(i)(rtable/Homelike Environment 1)-(7)	F 584		1/24/20	
	comfortable and he	right to a safe, clean, omelike environment, including eceiving treatment and				
	homelike environmuse his or her perspossible. (i) This includes erreceive care and sphysical layout of tindependence and (ii) The facility shall	rovide- e, clean, comfortable, and nent, allowing the resident to conal belongings to the extent esuring that the resident can ervices safely and that the he facility maximizes resident does not pose a safety risk. I exercise reasonable care for e resident's property from loss				
		ekeeping and maintenance y to maintain a sanitary, orderly, terior;				
	§483.10(i)(3) Clear in good condition;	n bed and bath linens that are				
		te closet space in each specified in §483.90 (e)(2)(iv);				
	§483.10(i)(5) Adeq levels in all areas;	uate and comfortable lighting				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266 NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS			(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
			B. WING S 6	C 1 <mark>2/12/2019</mark>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 584	§483.10(i)(6) Con levels. Facilities in 1990 must mainta 81°F; and §483.10(i)(7) For sound levels. This REQUIREM by: Based on observ review, the facility comfortable and fresidents (R26) reconcerns. Findings include: R26's diagnosis li the following diagrotein-calorie mastate, and gastros On 12/9/19, at 4:0 shower and was I been changed an been straightened. During an observ was noted that the which was hangin was leaking down well as dried liquid and some splashed. On 12/9/19, at 4:2	infortable and safe temperature nitially certified after October 1, ain a temperature range of 71 to the maintenance of comfortable ENT is not met as evidenced ration, interview and document railed to ensure a sanitary, nomelike environment for 1 of 2 eviewed with environmental st printed 12/12/19, identified noses: anoxic brain damage, alnutrition, persistent vegetative stomy. 102 p.m. R26 came back from ifted back into bed. Sheets had d the area around the bed had d up. 114 ation on 12/9/19, at 4:19 p.m. it to tubing for R26's g-tube feeding ag from an IV (intravenous) pole, in the pole. There was fresh as d on the pole, floor, bed frame and on the wall and base board.	F 584	It is the policy of Benedictine Health Center Minneapolis to follow all Feder State, and local guidelines, laws and regulations and statutes. This plan of correction is not to be construed as a admission of deficient practice by the facility administrator, employees, age or other individuals. The response to alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citation. The preparations, submission and implementation of this plan of correct will serve as our credible allegation of compliance. F-584 SS: D A. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? "R26 IV pole, bed, and floor was cleaned while surveyor were still preson 12/9/2019 B. How will you identify other residents."	f an e ents, the tion of the tion of the tion to the tion to the tion of the t
	There was no lea	ile providing trach care for R26. king fluid observed at this time, feeding pole and floor were		having the potential to be affected by same deficient practice? " All Nursing and cleaning staff ha	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIE	245266 R RITER OF MINNEAPOLIS		TREET ADDRESS, CITY, STATE, ZIP CODE	12/	C 12/20 <u>19</u>
DENEDIO	STINE HEALTH CEN	TER OF WHINEAPOLIS	N	/IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 584	dirty. On 12/10/19, at 1 base board were dried. On 12/11/19, at 8 present. On 12/11/19, at 8 stated that reside including the floor machines. HSK-B was interv HSK-B stated she of work and just go the only houseked stated she had be and around furnitu. Nursing assistant 12/11/19, at 11:45 notify the nurse if would clean up ar	page 3 209 p.m. the pole, floor, bed and still dirty. All the liquid was 200 a.m. the dried liquid was still 211 a.m. housekeeper (HSK)-Ant rooms were cleaned daily and around and under 212 iewed on 12/11/19, at 8:16 a.m. in just started her second week of off of orientation. She was exper on the fourth floor. HSK-Bern trained to clean all floors are and machines. (NA)-D was interviewed on a.m. and stated she would she saw the tubing leaking and anything on the floor, bed and verified dried liquid in those	F 584	been provide education to under joint responsibility of cleaning a around cleaning and accountable ensure cleaning happens C. What measures will be put in or what systemic changes will y to ensure that the deficient pract not recur? "All staff have been provided to reiterate cleaning responsibil process on January 21, 22, an 2020. D. How will you monitor the correction(s) to ensure the deficient will not recur, i.e., what quality a program will be put into place? "The facility has implemented education for all staff to ensure necessary cleanings to resident equipment in the room occurs of 21, 22, and 23 of 2020. "A system in a tracking tool cleaning of resident equipment room has been established. "The Nursing Managers, Su Director and Maintenance persassist to complete weekly	nd process bility to hto place you make ctice does deducation lities and d 23 of hte practice assurance and all the process of	
	On 12/11/19, at 11 liquid on the floor, On 12/11/19, at 11 registered nurse (RN-E stated the eshould be cleaned have noticed the control of 12/11/19, at 11	1:53 a.m. NA-E verified the dried bed, pole and base board. 2:10 p.m. the clinical manager, RN)-E verified the dried liquid. Expectation was that all rooms didaily and that staff should dried liquid. 2:11 p.m. the director of yerified that all floors would be		assurance audits for 8 weeks a for 2 additional months. Additio may be scheduled based on re quality assurance review. The facility administrator ar designee will monitor the audits completed and results will be re QAPI for need of ongoing moniuntil substantial compliance is a COMPLETION DATE: 01/24/20	and monthly nal training sults of the nd/or sare eviewed in toring or maintained.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ENIDII	245266	B. WING	WI EDCEM		C 42/2040
- 1	PROVIDER OR SUPPLIER	ALL M. AALL LPALIA		STREET ADDRESS, CITY, STATE, ZIP CODE	121	12/20 <u>19</u>
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 584	expected to be clearound machines a dried liquid on pole board. DM stated requipment and horrest. The facility policy remaintenance of equipmerepaired in a mann transmission of information of the control of the cont	aned every day, including and IV poles. DM verified the and IV poles. DM verified the and base nursing would clean the actual usekeeping would clean the egarding cleaning and uipment dated October 2017, and must be maintained and the ection.	F 584			1/24/20
22=D	§483.10(j) Grievan §483.10(j)(1) The ingrievances to the fithat hears grievand reprisal and without reprisal. Such grievances to care and furnished as well as furnished, the behaves idents, and other facility stay. §483.10(j)(2) The infacility must make resolve grievances accordance with the §483.10(j)(3) The foundation on how to file a griet to the resident.	ces. resident has the right to voice acility or other agency or entity ces without discrimination or at fear of discrimination or vances include those with discriment which has been a that which has not been avior of staff and of other er concerns regarding their LTC resident has the right to and the prompt efforts by the facility to the resident may have, in				
F 585 SS=D	indicated equipme repaired in a mann transmission of information o	nt must be maintained and per that would prevent ection. 1)-(4) ces. resident has the right to voice acility or other agency or entity ces without discrimination or at fear of discrimination or vances include those with discreament which has been so that which has not been avior of staff and of other er concerns regarding their LTC resident has the right to and the prompt efforts by the facility to the resident may have, in his paragraph. facility must make information evance or complaint available				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
NAME OF I	PROVIDER OR SUPPLIER	245266	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CODE		C 12/2019
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS	1.567.1	618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 585	of all grievances recontained in this particle of the resident. The include: (i) Notifying resided postings in promin facility of the right (meaning spoken) grievances anonyr of the grievance of can be filed, that is address (mailing a number; a reasonation completing the revito obtain a written grievance; and the independent entities be filed, that is, the Quality Improvement Agency and State program or protect (ii) Identifying a Griesponsible for overeceiving and track conclusions; leading by the facility; main information associexample, the identifying and track conclusions; leading by the facility; main information associexample, the identifying and track conclusions; leading by the facility; main information associexample, the identifying and track coordinating with some cessary in light (iii) As necessary, prevent further potright while the alleginvestigated;	egarding the residents' rights aragraph. Upon request, the a copy of the grievance policy e grievance policy must at individually or through ent locations throughout the to file grievances orally or in writing; the right to file mously; the contact information ficial with whom a grievance or her name, business and email) and business phone able expected time frame for iew of the grievance; the right decision regarding his or her contact information of es with whom grievances may be pertinent State agency, and Organization, State Survey Long-Term Care Ombudsman in advocacy system; in the process of the grievance process, king grievances through to their agany necessary investigations of any necessary investigations attaining the confidentiality of all atted with grievances, for ity of the resident for those ted anonymously, issuing decisions to the resident; and tate and federal agencies as of specific allegations; taking immediate action to ential violations of any resident ged violation is being in §483.12(c)(1), immediately	F 58	35		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	LE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED	
DE		245266	B. W i NG	W ENCEM		
NAME OF PROVIDER	R OR SUPPL I ER	ALL M. AST. DALLA	11 I 17	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	12/20 <u>19</u>
BENEDICTINE H	EALTH CENT	TER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
reporticabuse, and/or anyone provide as requively Ensinclude summathe steems the steems as to we confirm taken I and the (vi) Tall accord of the or if anyone confirm rights we (vii) Maresult of the Steems and the Ste	including in misapproprie furnishing er, to the aduired by State uired and some uired, any corby the facility er date the wind appropriance with State uired ui	d violations involving neglect, juries of unknown source, lation of resident property, by services on behalf of the ministrator of the provider; and	F 585	F-585 SS: D A. Corrective action(s) will be accomplished for those residents f have been affected by the deficient practice? " Grievances expressed by R 23 entered into the Grievance Trackin system.	t s was	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING	(X3) DATE SURVEY COMPLETED	
	ENIDI	245266	B. WING	W EDOEM	C
NAME OF F	200) (IDED OD 01100) IEI	245266	1 I I 17	TREET APPRECA SITY STATE ZIP CORE	12/12/20 <u>19</u>
NAME OF F	PROV I DER OR SUPPL I EF			STREET ADDRESS, CITY, STATE, ZIP CODE	
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREF I X TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLÉTION
F 585	R23 and FM-B ex manager (CM)-A	age 7 pressed concerns to clinical and the facility administrator t placement, not assisting R23	F 585	B. How will you identify other res having the potential to be affecte same deficient practice?	
	with meals timely, computer potentia face due to a brok	and R23's communication Illy falling and hitting R23 in the en piece and staff not mputer properly. FM-B		" All staff has been provide ed understand the importance of regrievances and/or reporting then	cording n to
	explained he had during the past six administrator, how	expressed multiple concerns c months and had met with the vever FM-B stated he had not		member of the management tea C. What measures will be put int or what systemic changes will yo to ensure that the deficient pract	to place ou make
	were ongoing. FM concerns with R23	w-up and felt as if the concerns -B indicated there were B having been mistreated over all as a "few times" since then		not recur? "Review grievance process p all staff on January 21, 22, and 2	
		ing cares, however indicated he		D. How will you monitor the correaction(s) to ensure the deficient will not recur, i.e., what quality as	practice
	and stated staff di head as they were she was able to p	yed on 12/10/19, at 3:29 p.m. d not put her call light near her e supposed to. R23 indicated ush her head against her call		program will be put into place? "The facility has implemented education for all staff on January and 23 of 2020, to ensure all	<i>t</i> 21, 22,
	indicated her call	placed correctly by staff. R23 ight was the only way to notify g assistance due to R23 having		grievances/concerns are reporte followed up on. " All grievances will be tracked concerns Data Base " The Social Services Director	d in the
	on her back restin	d on 12/10/19, at 3:29 p.m. lying g in her bed eyes open ee and call light on the floor not 3's head.		assist to complete monthly quality assurance audits for 3months for grievance/concerns. Additional to may be scheduled based on resiquality assurance review.	ty r raining
	identified R23 had total assistance of	inimum Data Set dated 9/17/19, intact cognition and required two staff for bed mobility.		" The facility administrator and designee will monitor the audits a completed and results will be rev QAPI for need of ongoing monitor.	are viewed in oring or
	R23 had diagnose respiratory failure	sident Face Sheet identified es which included chronic with hypoxia or hypercapnia,		until substantial compliance is m COMPLETION DATE: 1/24/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
NAME OF I	PROVIDER OR SUPPLIE	245266	B. WING_	STREET ADDRESS, CITY, STATE, ZIP COD	C 12/12/201<u>9</u> ⊧
- 1		NTER OF MINNEAPOLIS	1.50	618 EAST 17TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREF I X TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLÉTION
F 585	flaccid hemiplegis side and Amyotro system disease to impacts physical R23's medical regrievance and/or The administration 12/12/19, at 3 FM-B regarding of there was nothing concerns and/or stated they would family regarding of they did not alway The administrato FM-B's concerns The Facility Concerns and/or stated they would family regarding of they did not alway The administrato FM-B's concerns The Facility Concerns and/or stated they would family regarding they did not alway The administrato FM-B's concerns The Facility Concerns a prompt resolution. The resolution. The reconcern or grieval included when a visitor or family more staff member, the concern form and services department in a confidential of decisions would it was received, su taken to investigations regarding the staff member of the concern form and services department in a confidential of decisions would it was received, su taken to investigations regarding the staff member of the concern form and services department in a confidential of decisions would it was received, su taken to investigations regarding the staff member of the concern form and services department in a confidential of decisions would it was received, su taken to investigations regarding the staff member of the concern form and services department in a confidential of the concern form and the concer	a affecting left non-dominant ophic lateral sclerosis (a nervous hat weakens muscles and	F 58	5	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	245266		W. Daniel Drawer Daniel Volume II W. L.	C 12/12/201 <u>9</u>	
TINE HEALTH CENT	ER OF MINNEAPOLIS	r	MINNEAPOLIS, MN 55404		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLÉTION	
Continued From pa	age 9	F 585			
taken by the facility	as a result of the grievance				
		F 609		1/24/20	
involving abuse, ne mistreatment, inclu source and misapp are reported immed hours after the alleg that cause the alleg serious bodily injury the events that cau abuse and do not rethe administrator of officials (including the adult protective serfor jurisdiction in los	eglect, exploitation or ding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in				
investigations to the designated represe accordance with St Survey Agency, with incident, and if the appropriate correct This REQUIREMED by: Based on observations to the designated representations accordingly.	e administrator or his or her entative and to other officials in rate law, including to the State hin 5 working days of the alleged violation is verified ive action must be taken. NT is not met as evidenced tion, interview and document		F-609 SS: D		
	CONTINUE HEALTH CENT SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa confirmed, any corr taken by the facility and the date the wr Reporting of Allege CFR(s): 483.12(c)(§483.12(c) (1) Ensuinvolving abuse, ne mistreatment, inclu source and misapp are reported immed hours after the allege that cause the allege serious bodily injury the events that cause hours after the allege serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily injury the events that cause hours after the serious bodily adult protective ser for jurisdiction in lo accordance with St procedures. §483.12(c)(4) Report incident, and if the appropriate correct This REQUIREME by: Based on observa	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	245266 B. WING	A BUILDING 245266 ROVIDER OR SUPPLIER CTINE HEALTH CENTER OF MINNEAPOLIS SUMMARY STATEMENT OF DEFICENCIES (EACH DEFICENCY) MISS BE PRESCEDED BY FULL (REGULATORY OR LSC IDENTIFYING INFORMATION) 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. Reporting of Alleged Violations CFR(s): 483.12(c)(1) (All) \$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 involve abuse or result in serious bodily injury, or not later than 24 hours 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 amd adult protective services where state law provides for jurisdiction in long-term care facilities) 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. BABAGE TATH STREET MINNEAPOLIS STATE, STATE, ZIP CODE STREET ADDRESS, CITY STATE, ZIP CODE STATE STATE, ZIP CODE STREET ADDRESS, CITY STATE, ZIP CODE STATE STATE, ZIP CODE STATE STATE, ZIP CODE STATE STATE, ZIP CODE STATE STATE, ZIP CODE STATE, ZIP CARCHART STATE, ZIP CARCHART STATE, ZIP CODE STATE STATE, ZIP CODE STATE STATE, ZIP CODE STATE STATE,	

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED
	ENIDI	245266	B. WING	WIEDCEMI	C 12/12/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/12/20 19
				618 EAST 17TH STREET	
BENEDIC	CTINE HEALTH CEN	TER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404	
(X4) ID PREF I X TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 609	Continued From p	age 10	F 609	9	
	and state agency (n money to the administrator (SA) for 1 of 5 residents (R65) ppropriation of property.		A. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? "R65 had a concern entered into	t
				costumer concerns database on	
	stated she had \$3: wallet which was let table. R65 recalled two hours and whe was stolen. R65 st manager (CM)-A tregarding the stole as if there was not facility to let her kninvestigation. R65's quarterly Mi identified R65 had and diagnoses whanxiety.	ged on 12/9/19, at 1:28 p.m. and 5.00 stolen from a zippered eft in her room on her bedside d she left her room for one to en she can back the money tated she notified the clinical wo to three months ago en money. R65 stated she felt than any follow-up and wanted the now the outcome of their minum Data Set dated 11/5/19, a moderate cognitive impairment ich included depression and		12/10/2019 B. How will you identify other reside having the potential to be affected I same deficient practice? " All staff has been provide educe understand the importance of record concerns and missing items to management. C. What measures will be put into por what systemic changes will you to ensure that the deficient practice not recur? " All staff have been provide eductor reiterate concerns and missing it on January 21, 22, and 23 of 2020 D. How will you monitor the correct action(s) to ensure the deficient practice will not recurring what quality assured.	eation to rading place make e does acation terms
	and stated she wa money. CM-A indic	wed on 12/10/19, at 3:18 p.m. as not aware of the stolen cated she would notify the service (DSS) for further		will not recur, i.e., what quality assuprogram will be put into place? "The facility educated all staff to ensure all concerns/missing items January 21, 22, and 23 of 2020 "The Social Services Director w	on
		rm dated 12/10/19, at 3:32 p.m. CM-A during the past 90 days nissing.		assist to complete monthly quality assurance audits for 3months. Add training may be scheduled based o results of the quality assurance rev	litional on
	notification to the a	ord lacked evidence of administrator and/or SA orted \$35.00 stolen on 12/10/19.		" The facility administrator and/o designee will monitor the audits are completed and results will be review QAPI for need of ongoing monitoring	r e wed in
		d 12/11/19, at 8:46 a.m. seated wheelchair watching television.		until substantial compliance is mair COMPLETION DATE: 1/24/2020	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED	
- 1	PROVIDER OR SUPPLIEF	245266 TER OF MINNEAPOLIS	1.766.10	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		C 12/201<u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 609	R65 was interview and stated DSS cand indicated R65 stolen." DSS was interview (three days after or regarding R65's stolen R65 who \$35.00 in her coin bedside table. DS to keep her mone: R65 a replacemer DSS explained the property if the valual During a subsequindicated R65 "she asked if the \$35.0 was not sure. DSS concern form for the total total total total resident's consequent of a resident of a residen	red on 12/11/19, at 11:40 a.m. ame to talk to her "this morning" told DSS, "I thought it was are ved on 12/12/19, at 10:13 a.m. concern was reported to facility tolen money) and stated she in indicated she had lost purse which was left on her indicated she reminded R65 y locked in her drawer and gave at key as R65's key was lost. By only reported missing are was greater than \$50.00. Bent interview at 1:48 p.m. DSS are used to the missing money, however did are missing money without is belongings or money without sent. The policy indicated staff marge of building immediately of appropriation of resident build immediately notify the	F 609			
F 610 SS=D	even did not resul was required to re	ctor of nursing and DSS. If the tin bodily injury the individual port no later than 24 hours. nt/Correct Alleged Violation (2)-(4)	F 610			1/24/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPI A. BUILDING		(X3) DATE SURVEY COMPLETED
	ENIMI	245266	B. W i NG	VI EDVCEME	C 12/12/2019
- 1				STREET ADDRESS, CITY, STATE, ZIP CODE	12/12/20 19
			N	MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLÉTION
F 610	Continued From p	age 12	F 610		
		onse to allegations of abuse, on, or mistreatment, the facility			
	() ()	e evidence that all alleged oughly investigated.			
		vent further potential abuse, on, or mistreatment while the progress.			
	investigations to the designated representation accordance with Survey Agency, with incident, and if the appropriate correct	ort the results of all ne administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken.			
	Based on observative review, the facility an allegation of mit (R23) reviewed for addition, the facility investigate an allegation.	ation, interview and document failed to thoroughly investigate streatment for 1 of 1 resident employee physical abuse. In y failed to thoroughly gation of unwanted advances 1 resident (R380) reviewed for		F-610 SS: D A. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? "R380 was discharged from our than 100 members per care plan	facility.
	at risk for skin breamove resident with R23's investigative R23's daughter recare early AMAr	ated 4/2/19, identified R23 was akdown and directed staff to a two staff and draw sheet. e file dated 7/8/19, indicated ported R23 had received "rough and finger(s) on left hand bent." The file indicated it was		members per care plan B. How will you identify other resider having the potential to be affected by same deficient practice? "All Nursing staff have been educted around following of care plans and the thorough investigation of allegations C. What measures will be put into plor what systemic changes will you may to ensure that the deficient practice not recur?	y the cated he s. lace nake

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
	ENIDH		D. MAINO	W EDOEM		C
<u> </u>		245266	B. WING		12/	12/20 <u>19</u>
NAME OF I	PROVIDER OR SUPPLIER	IU AUIII		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	ER OF MINNEAPOLIS	ı	618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) I D	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREF I X TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF I X TAG	(EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
F 610	Continued From pareported on 7/8/19, alleged allegation of 5:00 a.m. per R23' was half asleep whand left hand 2nd identified the nursillady who is a regul indicated NA-C, R2 met and NA-C "sin NA-C "was working NA's "were providil know to gently tour night." R23's file indated 7/8/19, and it time to care for and R23's size. R23's quarterly Mir 9/17/19, identified required total assis mobility. R23's Resident Far R23 had diagnoses respiratory failure will flaccid hemiplegia flaccid hemiplegia side and Amyotrop system disease that impacts physical fur R23's medical recorder plan not having the side and continued to the side and and continued to the side and Amyotrop system disease that impacts physical fur R23's medical recorder plan not having the side and continued to the side and and continued to the side and and anyotrop system disease that impacts physical fur R23's medical recorder plan not having the side and anyotrop system disease that impacts physical fur R23's medical recorder plan not having the side and the side an	age 13 by R23's family, however the occurred on 7/6/19, "about" is interview and reported "she interview as pulled back if finger was bent back." R23 and assistant (NA) as a "white interview are on the unit" The file interview and clinical manager (CM)-A cerely apologized" to R23 as interview as per care plan and interview as per care plan and interview as per care plan and interview as a lot of interview as a lot of interview as a lot of interview and interview as a lot of interview as a lot of interview as a lot of interview and interview as a lot of	F 610	DEFICIENCY)	provided horough ective practice ssurance rsing staff plan and tion on es audits of . Quality sis for 3 d/or are viewed in pring or paintained.	
	instead of two. Alth interviewed and on record lacked evide regarding care plan	ough other staff were e audit was completed, R23's ence of NA-C re-educated n needed to have been repositioning and further				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION (X2) A. BUILDING		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	245266 ₹ ITER OF MINNEAPOLIS	N. SPECIAL	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		C 12/2019	
(X4) ID PREF I X TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 610	audits of NA-C proaddition to other respectively. R23 was interview communication do and stated staff diproviding cares. Figure 1 a few and incares to tell them rough care happen NA's would cause a person just like with respect." R23 was one staff who time R23 reported she notified CM-A staff. Family member (Figure 1 and properties of the staff).	oviding resident cares in esident interviews. Wed with the use of an electronic evice on 12/9/19, at 1:54 p.m. Id not take their time when R23 explained it was not all staff edicated she "cannot talk during" to slow down. R23 indicated ens at dark time" and indicated ens at dark time" and indicated ens at dark time and indicated ens at dark time and indicated ens at dark time. The ensure them who needs to be treated ensure them who needs to be treated ensure them who needs to be treated ensure them. R23 stated a few months ago there is trough treatment. R23 stated a regarding her concerns with ensure the ensure them. The ensure the ensure them is the ensure them. The ensure the ensure the ensure them is the ensure that the ensure the ensure that the ensur	F 610				
	in bed and assiste NAs whom gently explaining cares a R23 indicated yes	d on 12/9/19, at 5:39 p.m. lying ed to be repositioned by three rolled R23 side to side while and asked R23 if she was okay. by shaking her head. R23 rable while the staff assisted					
	and stated "daily vourselves it's the operative strong." NA to understand and when completing	ewed on 12/12/19, at 6:37 a.m. we turn and reposition people by only way to get it done, I am -C explained R23 was difficult d "usually" used two people R23's cares. NA-C recalled R23 reated roughly with her cares"					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
	ENIDI	245266	B. WING	MI EDOEM		C
	PROVIDER OR SUPPLIEF		B. Wille _	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	12/	12/20 <u>19</u>
(X4) ID PREF I X TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 610	and explained she rough" with R23. In the night R23 commindicated R23's caturning and repositioning and repositioning to gently come barus who could do have likely did her as her cares were rout to move alone" durassist. Furthermoruse two" staff. The director of nu 12/12/19, at 2:08 expectation for star R23's care plan. The facility Abuse indicated mistreat treatment of a res supervisors and manupervision of directors.	e did not remember "being too NA-C remembered she worked uplained of rough treatment and are plan indicated two staff for tioning, however stated "but we when I worked." NA-C ver really asked for help" she A-C explained when turning R23 "alone you had to catch her ck." NA-C stated "only a few of er alone." NA-C further stated alone" the night R23 reported ugh and indicated it was "harder e to R23's size and inability to re, NA-C indicated "but now we was interviewed on o.m. and stated it was her aff to have used two people per Prevention Plan dated 2017, ment was the inappropriate ident. The plan indicated nanagers would provide daily ext care staff to identify aviors, communication quality,				
	R380's discharge	ed as a closed record. MDS dated 7/30/19, identified ognition and diagnosis which				
	R380's Investigati	ve File dated 7/23/19, indicated				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		E SURVEY IPLETED
	ENIDI	245266	B. WING	MI EDGEM		C
	PROVIDER OR SUPPLIER		b. vviive_	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	12/	12/20 <u>19</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(X5) COMPLETION DATE
F 610	R380 expressed to staff member mad registered nurse (I close to "my breas ring and said "whe indicated she said indicated she stay having been scare touching was the vistaff member known administer medicated file lacked evident residents and mor residents and staff R380 was contact at 1:08 p.m. hower call. Family member (File telephone on 12/1 not return the t	the facility social worker that a e unwanted advances when RN)-G rubbed R380's shoulder t" then turned R380's wedding re you get this". R380 "please don't touch me." R380 ed away with her phone due to d and identified the unwanted worst part. The file indicated the cked on R380's room to tion per orders. However, the e of interviewing additional litoring interactions between it. Ed via telephone on 12/11/19, wer did not return the telephone M)-C was contacted via 1/19, at 1:09 p.m. however did bhone call. (RN)-G was interviewed on a.m. and stated he was nister and the cylindrical pain medication instead of denied touching R380 and on R380's door and only 0 acknowledged him and ance. Esing was interviewed on o.m. and stated it was her the investigation to interview	F 61			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	ELE CONSTRUCTION B	COMPLETED
DEVIDI	245266	B. WING	VI ED/CEMI	C 12/12/2019
NAME OF PROVIDER OR SUPPLIES BENEDICTINE HEALTH CEN	NU AUNN	F. PALL	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	12/12/20 15
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDE DEFICIENCY)	D BE COMPLÉTION
unreasonable con punishment with re mental anguish. T and incidents as w would have been i	as the willful infliction of injury, finement, intimidation or esulting physical harm, pain or he plan indicated all accidents rell as allegations of abuse nvestigated.	F 610		
SS=D CFR(s): 483.15(c) §483.15(c)(3) Notice Before a facility transident, the facility (i) Notify the resident representative(s) of the reasons for the language and margacility must send representative of the Long-Term Care (ii) Record the readischarge in the readischarge required (c)(5) of this section discharge required made by the facility resident is transferial (ii) Notice must be before transfer or (A) The safety of in the safety of interesting the safety of intere	ce before transfer. ansfers or discharges a by must- ent and the resident's of the transfer or discharge and e move in writing and in a nner they understand. The a copy of the notice to a the Office of the State ombudsman. sons for the transfer or esident's medical record in aragraph (c)(2) of this section; notice the items described in f this section. ing of the notice. iffied in paragraphs (c)(4)(ii) and on, the notice of transfer or d under this section must be by at least 30 days before the rred or discharged. In made as soon as practicable	F 623		1/24/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	245266 FER OF MINNEAPOLIS	ı e	STREET ADDRESS, CITY, STATE, ZIP CODE 118 EAST 17TH STREET MINNEAPOLIS, MN 55404		C 12/20 <u>19</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 623	be endangered, un this section; (C) The resident's allow a more immediate paragraph (c) (D) An immediate required by the resunder paragraph (c) (E) A resident has days. §483.15(c)(5) Commotice specified in must include the focili The reason for (ii) The reason for (iii) The location to transferred or discivity A statement of including the name and telephone number and telephone number to obtain an appear completing the form hearing request; (v) The name, add telephone number Long-Term Care C) (vi) For nursing fact and developmental disabilities, the matelephone number the protection and developmental disabilities and Bill of Rights A codified at 42 U.S.	ider paragraph (c)(1)(i)(D) of health improves sufficiently to ediate transfer or discharge, c)(1)(i)(B) of this section; transfer or discharge is ident's urgent medical needs, c)(1)(i)(A) of this section; or not resided in the facility for 30 tents of the notice. The written paragraph (c)(3) of this section ollowing: transfer or discharge; which the resident is harged; the resident's appeal rights, e, address (mailing and email), neets; and information on how I form and assistance in m and submitting the appeal ress (mailing and email) and of the Office of the State	F 623				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	N. V. A. ST. V. STORY, AND ADDRESS OF THE PARTY OF THE PA	
NAME OF I	PROVIDER OR SUPPLIE	245266 ER		STREET ADDRESS, CITY, STATE, ZIP CODE	C 12/12/2019
BENEDIO	CTINE HEALTH CEI	NTER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 623	disorder or relate email address ar agency responsit advocacy of indivestablished under for Mentally III Individual Section 11 Individual Section 12 Individual Section 13 Individual Section 14 Individual Section 15 Indings Include: Reserved Individual Section 16 Indings Include: Reserved Individual Section Individual Individual Section Individual Individu	d disabilities, the mailing and ad telephone number of the ole for the protection and riduals with a mental disorder resident the Protection and Advocacy dividuals Act. anges to the notice. in the notice changes prior to sfer or discharge, the facility recipients of the notice as soon ce the updated information le. tice in advance of facility closure dility closure, the individual who is of the facility must provide in prior to the impending closure eay Agency, the Office of the Care Ombudsman, residents of the resident representatives, as for the transfer and adequate residents, as required at § ENT is not met as evidenced the wand document review, the rovide written hospital transfer didents who had a facility-initiated for 2 of 2 residents (R27, R381) obtalizations.	F 623	F-623 SS: D A. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? " All residents moving forward will receive Discharge/Transfer Notice. B. How will you identify other resider having the potential to be affected by same deficient practice? " The charge nurses will provide to	nts / the

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
	ENINI	245266	B. WING	VI EDVEENIE	C 12/12/2010
- 8	PROVIDER OR SUPPLIE	RUAUN	IU V	STREET ADDRESS, CITY, STATE, ZIP CODE	12/12/20 <u>19</u>
BENEDIC	CTINE HEALTH CEI	NTER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 623	Continued From	page 20	F 623		
F 623	record (MR) reveresponsible party R27's Significant (MDS) dated 9/2/2 was impaired. R27's Discharge MDS dated 9/8/1 to an acute hospin R27's Entry MDS re-admitted to the R27's Discharge MDS dated 9/27/discharged to an R27's Entry MDS re-admitted to the R27's En	aled R27 was his own Change Minimum Data Set B/19, indicated R27's cognition Assessment Return Anticipated 9, indicated R27 was discharged tal. dated 9/16/19, indicated R27 e facility. Assessment Return Anticipated 19, indicated R27 was acute hospital. dated 10/3/19, indicated R27 e facility.	F 623	with the appropriate appeal information outlined in the regulation in the appropriate instances as indicated to Discharge and Transfer flow sheet to patient/representative as the patent leaving the building when possible. The notice is unable to be provided in urgent situations, the social worker provide the required Transfer and Discharge notice with the appropriate appeal information as outlined in the regulation in the appropriate instance indicated by the Discharge and Transflow sheet to the pt./representative is mailing the next business day. C. What measures will be put into por what systemic changes will you not the proper in the properties of	by the oo the is when m will te e e es as as asfer by
	dated 10/21/19, in an acute hospital R27's Entry MDS re-admitted to the R27's progress n	dated 11/5/19, indicated R27		to ensure that the deficient practice not recur? "Transfer/Discharge packets upon to include Notice of Discharge & Be Agreement "Education was provided to social workers, charge nurses and floor nurse on the discharge and transfer notice	lated d Hold al ırses
	breath (SOB) and and was admitted 9/16/19, indicated and was readmitt R27's medical rea a Notice of Trans R27. R27's PN dated 9 to the hospital for (oxygen) sats (sat the hospital. PN oreturned from the	d decreased oxygen saturations to the hospital. PN dated R27 returned from the hospital ed to the facility. Review of cord (MR) revealed no evidence fer or Discharge was provided to P/27/19, indicated R27 was sent SOB and decreased O2 turation) and was admitted to dated 10/3/19, indicated R27 hospital and was readmitted to w of R27's MR revealed no		and procedures on January 21, 22, 23 of 2020 D. How will you monitor the correctivaction(s) to ensure the deficient prawill not recur, i.e., what quality assurprogram will be put into place? "Transfer/Discharge and Bed Hoagreements included in transfer/discipacket "Education was provided to social workers, charge nurses and floor nuon the discharge and transfer notice and procedures on January 21, 22, 23 of 2020	and ve ctice rance Id charge al urses e policy

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
	PROVIDER OR SUPPLIER	245266 ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP CODE S18 EAST 17TH STREET		C 12/201 <u>9</u>
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 623	Continued From pa	ge 21	F 623			
F 623	evidence a Notice of provided to R27. R27's PN dated 10// to the hospital for Sand was admitted. R27 returned from readmitted to the farevealed no evidend Discharge was provident to the hospital for Sand was admitted. R27 returned from readmitted to the farevealed no evidend readmitted to the farevealed no evidend Discharge was providend providence of the resident with a copy resident with a copy service of the resident w	of Transfer or Discharge was 21/19, indicated R27 was sent OB and decreased O2 sats PN dated 11/5/19, indicated the hospital and was icility. Review of R27's MR ce a Notice of Transfer or vided to R27. 29/19, indicated R27 was sent OB and decreased O2 sats PN dated 12/4/19, indicated the hospital and was icility. Review of R27's MR ce a Notice of Transfer or vided to R27. RN)-A stated on 12/12/19, at d not make residents aware of or transfer or provide the v of the Notice of Transfer or	F 623	" Audits will occur Monthly for the months to ensure that all transfer/Discharge and Bed Hold fraccompanied the patient when appropriate. " The facility administrator and/ordesignee will monitor the audits are completed and results will be review QAPI for need of ongoing monitori until substantial compliance is mail COMPLETION DATE: 1/24/2020	orms or e ewed in ng or	
	The Business Office 12/11/19, at 3:39 p. implemented giving representative notice when the facility inite the hospital. R27's Notices of Votansfer or Dischart 10/21/19, 11/29/19,	e Manager (BOM) stated on m. the facility had not yet the residents and/or their tes of transfer or discharge diated residents' transfers to bluntary Resident/Patient age dated 9/8/19, 9/27/19, revealed no evidence of e notice being provided to him, e medical transfer.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED	
	ENIDH	245266	B. WING	W EDOEM		0	
NAME OF F	PROVIDER OR SUPPLIER	243200	I U V	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	12/20 <u>19</u>	
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404			
(X4) ID PREF I X TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE	
F 623	Continued From pa	ge 22	F 623				
		d as a closed record and R381 was her own responsible					
	R381's Admission R381's cognition wa	MDS dated 5/29/19, indicated as intact.					
	R381 was transferr	Assessment MDS dated 6/4/19, indicated ed to an acute hospital, was 81 was expected to return.					
	R381's PN dated 6/ R381 was sent to the	/4/19, at 11:36 p.m. indicated ne hospital.					
		/5/19, at 12:51 p.m. indicated to the hospital and was on surgery.					
	Transfer or Dischar evidence of R381's	oluntary Resident/Patient ge dated 6/4/19, revealed no signature, the notice being the reason for the medical					
		egarding Notice of Transfer or uested for review, and was not					
	Notice of Bed Hold CFR(s): 483.15(d)(Policy Before/Upon Trnsfr 1)(2)	F 625			1/24/20	
	§483.15(d) Notice of	of bed-hold policy and return-					
	nursing facility trans the resident goes o nursing facility mus	se before transfer. Before a sfers a resident to a hospital or n therapeutic leave, the t provide written information to dent representative that					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		(X3) DATE SURVEY COMPLETED
	ENIDI	245266	B. WING	WI EDGEME	C
	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	12/12/20 <u>19</u>
BENEDIC	CTINE HEALTH CEN	ITER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404	
(X4) ID PREF I X TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 625	any, during which return and resum facility; (ii) The reserve by plan, under § 447 (iii) The nursing facility. The nursing facility facility for this section. §483.15(d)(2) Beauth to return (iv) The information of this section. §483.15(d)(2) Beauth time of transfer hospitalization or facility must proving resident represent specifies the durates described in para This REQUIREM by: Based on intervity facility failed to enhospitalized were for 2 of 2 resident hospitalization. Findings include: R27 stated on 12 recently been hospitalization heart and had not had wanted his bord Review of R27's in R27 was his own Resident Census	f the state bed-hold policy, if the resident is permitted to e residence in the nursing ed payment policy in the state '.40 of this chapter, if any; acility's policies regarding which must be consistent with of this section, permitting a	F 625	F-625 SS: D A. Corrective action(s) will be accomplished for those residents fo have been affected by the deficient practice? " All residents moving forward wil receive bed holds appropriately. B. How will you identify other reside having the potential to be affected b same deficient practice? " Bed hold policy was reviewed a beholds will be obtained regardless payer source C. What measures will be put into p or what systemic changes will you n	nts y the and of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
p	ENDI	245266	B. WING	VI EDGEN	12/	C 12/20<u>19</u>		
NAME OF I	PROVIDER OR SUPPLIER	IU AUINI		STREET ADDRESS, CITY, STATE, ZIP CODE				
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 625	(MDS) dated 9/23/1 was impaired. R27's Discharge As MDS dated 9/8/19, to an acute hospital R27's Entry MDS dre-admitted to the free R27's Discharge As MDS dated 9/27/19 discharged to an ar R27's Entry MDS dre-admitted to the free R27's Discharge As dated 10/21/19, including an acute hospital. R27's Entry MDS dre-admitted to the free R27's progress not R27 was sent to the breath (SOB) and conditionand was admitted. R27 returned from readmitted to the free R27's PN dated 9/2 to the hospital for S (oxygen) sats (saturdated 10/3/19, indichospital and was reference R27's PN dated 10 to the hospital for S (and was admitted.)	hange Minimum Data Set 19, indicated R27's cognition seessment Return Anticipated indicated R27 was discharged I. ated 9/16/19, indicated R27 facility. seessment Return Anticipated 0, indicated R27 was cute hospital. ated 10/3/19, indicated R27 facility. seessment Return Anticipated licated R27 was discharged to ated 11/5/19, indicated R27 facility. e (PN) dated 9/8/19, indicated the hospital for shortness of decreased oxygen saturations PN dated 9/16/19, indicated the hospital and was acility. 27/19, indicated R27 was sent SOB and decreased O2 ration) and was admitted. PN cated R27 returned from the teadmitted to the facility. (21/19, indicated R27 was sent soB and decreased O2 sats PN dated 11/5/19, indicated the hospital and was PN dated 11/5/19, indicated the hospital and was	F 625	to ensure that the deficient pract not recur? "Facility bed hold policy was with Education provided to Busi Office, HIM, Charge Nurses and nurses regarding bed hold policy January 21, 22, and 23 of 2020 hold to be obtained regardless source. D. How will you monitor the corraction(s) to ensure the deficient will not recur, i.e., what quality a program will be put into place? "Facility bed hold policy was Education provided to BON Charge Nurses and floor nurses bed hold policy on January 21, of 2020. Bed hold to be obtained regardless of payer source upoutransfer from facility. In urgent seed hold will be obtained within by social worker or designee. "Social worker or designee complete audit on bed holds for 10 days out of the month for 3 r "The facility administrator and designee will monitor the audits completed and results will be required. QAPI for need of ongoing monituntil substantial compliance is r COMPLETION DATE: 1/24/202	reviewed ness d floor by on a Bed of payer rective assurance reviewed. M, HIM. Is regarding 22, and 23 d n/prior to situations, 24 hours will a the first months. In the first months are with months. In the first months are with months and many months are with mon			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	СОМ	E SURVEY IPLETED
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<u> </u>		245266	B. WING	VI ELILA EIVI	12/	12/20 <u>19</u>
NAME OF I	PROV I DER OR SUPPL I ER	I U AUINI		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET		
BENEDIC	CTINE HEALTH CENT	TER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 625	R27's PN dated 11 to the hospital for Sand was admitted. R27 returned from readmitted to the factor of the R27's record lacke provided to R27 up. Registered Nurse (9:26 a.m. when a remergency room (resident's name or papers where it sasends the top copy and triplicate copie confirmed R27's beand triplicate were been written on the sending nurse and and triplicate copy written R27's name line. Licensed Social W 12/12/19, at 11:52 were to sign the beat they wanted their but LSW-A stated if the she would call the	age 25 /29/19, indicated R27 was sent SOB and decreased O2 sats PN dated 12/4/19, indicated the hospital and was	F 625	DEFICIENCY)	PRIATE	
	signature as she d wanted their bed h resident about the held automatically	d she did not get the resident's id not ask the resident if they eld or not, but just informed the bed hold as the "The bed was for 18 days for MA residents." be Manager (BOM) stated on				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	СОМ	E SURVEY IPLETED
	EVIDI	A 100 Areas	D. MAINO	// EDOEM		С
NAME OF		245266	B. WING		12/	12/20 <u>19</u>
NAME OF	PROV I DER OR SUPPL I ER	NO AVINI		FREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CEN	TER OF MINNEAPOLIS		INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	.D BE	(X5) COMPLETION DATE
F 625	no MA wanted their Health Unit Coordi 12/11/19, at 3:39 pfamily signatures or resident received the admission. BOM stated on 12 signatures with resonot get signatures already agreed to admission and resources beds were "presum BOM stated on 12 copy of the bed how to the hospital and leaves a message stated she mailed resident's family if family. BOM stated signature for bed how to the hospital and leaves a message stated she mailed resident's family if family. BOM stated signature for bed how to the hospital and leaves a message stated she mailed resident's family if family. BOM stated signature for bed how to the hospital and leaves a message stated she mailed resident's family if family. BOM stated signature for bed how to the signature out to the signature on the besignature on the besignature BO Direct "That's our system R27's Bed Hold Potential".	p.m. she presumed residents r beds held while hospitalized. nator (HUC) stated on .m. BOM was responsible for an bed holds. HUC stated the he Bed Hold policy upon (12/19, at 12:01 p.m. she got sidents' representative and did with residents as they had she Bed Hold policy upon idents with MA insurance the ned held." (11/19, at 3:50 p.m. the top ld form goes out with resident LSW-A calls the hospital and regarding the bed hold. BOM out the bed hold to the the responsible party was the dishe had not gotten R27's holds as he was his own and was unable to sign when he hospital. BOM stated R27 insible party, therefore she had gnature. BOM stated she did pon getting R27's signature om the hospital. BOM ature on the bed holds were ut were written on by staff D. When asked about the ed hold not being R27's ctor with no explanation stated,	F 625			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
D	ENIDII	245266	B. WING	MEDCEM		C 1 2/2019
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	TER OF MINNEAPOLIS		LIN	141	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 625	evidence of R27's whether R27 wants	signature nor indicated ed his bed held or not. Boxes OT on the notifications forms	F 625			
	evidence R381 wa Review of R381's I from the facility on	a closed record and revealed s her own responsible party. MR revealed R381 transferred 6/4/19, was admitted to the and did not return to the facility 1.				
		MDS dated 5/29/19, indicated vas intact and Medicare (MC) source.				
	R381 was transfer	Assessment MDS dated 6/4/19, indicated red to an acute hospital, was 881 was expected to return.				
		2/12/19, at 11:52 a.m. she did or private pay residents as				
	not get signatures were their own res see the point in it. I signatures for bed guardians. BOM st	712/19, at 12:01 p.m. she did on bed holds for residents who ponsible party as she did not BOM stated she only got holds with families and rated R381 was on MC had not discussed a bed hold				
	R381 was sent to t	6/4/19, at 11:36 p.m. indicated the hospital. R381's PNs dated t381 was admitted to the				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	СОМ	E SURVEY IPLETED
	ENIDI	245266	B. WING	VI EDCEM		C 12/2019
- 1	PROVIDER OR SUPPLIER		F PALIS	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		12/20 13
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 636 SS=D	hospital and was a R381's Bed Hold I 6/21/19, did not resignature nor indiciple held or not. Buthe notifications for unchecked. Facility Process Foundation Forms Policy Notification Forms Policy Notification completed at the thospital". The Proneed for signature Comprehensive A CFR(s): 483.20(b) §483.20 Resident The facility must of a comprehensive, reproducible assefunctional capacity §483.20(b) Comprehensive, reproducible assefunctional capacity §483.20(b) The A facility must mal assessment of a regoals, life history a resident assessment by CMS. The assethe following:	Policy Notification dated eveal evidence of R381's cated whether R381 wanted her oxes for I DO or I DO NOT on orm for R381 was left. Or Completing Bed Hold Policy and undated indicated, "Bed Hold Forms must always be cime the resident is sent to the cess indicated there were notes. ssessments & Timing (1)(2)(i)(iii) Assessment conduct initially and periodically accurate, standardized ssment of each resident's year end of each resident's year end of each strengths, and preferences, using the ent instrument (RAI) specified essment must include at least and demographic information tine.	F 625			1/31/20
		avior patterns.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	EVIDII	245266	B. WING	WIEDCEM		C		
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS	IVI	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	12/12/20 <u>19</u>			
	CLIMANA DV CT	TEMENT OF DEFICIENCIES		· .	·ION			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F 636	I .	•	F 636	3				
	(ix) Continence. (x) Disease diagno (xi) Dental and nutro (xii) Skin Condition (xiii) Activity pursuit (xiv) Medications. (xv) Special treatm (xvi) Discharge pla (xvii) Documentation regarding the addit on the care areas to the Minimum Data (xviii) Documentation the Minimum Data (xviii) Documentation assessment. The sinclude direct obsevith the resident, as	sis and health conditions. sis and health conditions. sitional status. s. t. ents and procedures. nning. on of summary information ional assessment performed riggered by the completion of Set (MDS). on of participation in assessment process must rvation and communication s well as communication with tensed direct care staff						
	timeframes prescri chapter, a facility massessment of a re timeframes specific through (iii) of this a prescribed in §413 apply to CAHs. (i) Within 14 calend excluding readmiss significant change mental condition. (I "readmission" mea following a tempora or therapeutic leave (iii) Not less than or	en required. Subject to the bed in §413.343(b) of this nust conduct a comprehensive esident in accordance with the ed in paragraphs (b)(2)(i) section. The timeframes .343(b) of this chapter do not dar days after admission, sions in which there is no in the resident's physical or For purposes of this section, as a return to the facility ary absence for hospitalization e.) acce every 12 months.						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCT I ON		E SURVEY PLETED
NAME OF F	PROVIDER OR SUPPLIE	245266 :R	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12 <i>I</i> °	C 12/201 <u>9</u>
- 1		NTER OF MINNEAPOLIS	a seek at	618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREF I X TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 636	Based on intervir facility failed to en Assessment (CA completed for 1 or Findings include: R3's most curren an assessment re was not processed 12/2/19, by RN-E seven triggered of decisions with the documentation not [worksheet]". Record review of triggered sections RN-E was interview of triggered sections RN-E was interview and stated she we the MDSs and CA several sections 11/20/19, compresincomplete. RN-E completed becaute Additionally, RN-E was important becaute Accopy of R3's curreceived on 12/12 areas # (number) of daily life, #6 ur nutritional status,	ew and document review, the nsure the resident Care Area A) was timely and thoroughly of 1 resident (R3) reviewed.	F 636	,	ing frames ed MDS nonthly eview	
	signed 12/12/19 I approaches docu	ne document was electronically by RN-E. Corresponding imented in the care plan had not lice 5/29/19, or earlier.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	COMP		E SURVEY PLETED
	ENIDII	245266	B. WING	W ENCEM		0
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS	IVI	STREET ADDRESS, CITY, STATE, ZIP CODE S18 EAST 17TH STREET	121	12/20 <u>19</u>
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 636	Continued From pa	ge 31	F 636			
	Resident Assessme (2018) indicated the basis of developmeresident care plan. types of assessment Comprehensive As be scheduled (called date (ARD)) within comprehensive asset the ARD of the prevent The MDS and CAA than 14 days after the ARD of the precompleted for R65 ARD for the facility	evious Quarterly Assessment was dated 8/22/19 and the Annual Assessment was				
	were electronically However, the CAA 12/12/19, which wa days after the ARD The facility policy for	or RAI completion was w but was not provided. nd Revision	F 657			1/31/20
	§483.21(b)(2) A corbe- (i) Developed withir the comprehensive (ii) Prepared by an includes but is not I (A) The attending p	interdisciplinary team, that imited to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	l'	X3) DATE SURVEY COMPLETED
	ENDI	245266	B. WING	W ENCEME	С
NAME OF I	PROVIDER OR SUPPLIEF	245266	I U V	STREET ADDRESS, CITY, STATE, ZIP CODE	12/12/20 <u>19</u>
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS	I .	618 EAST 17TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 657	resident. (C) A nurse aide was resident. (D) A member of for the extent puther resident and the resident and the resident resident and their resident not practicable for resident's care plates (F) Other approprises as deteror as requested by (iii) Reviewed and team after each as comprehensive an assessments. This REQUIREMED by: Based on observative review, the facility for 3 of 3 residents and engage in the revision of their case conferences. Findings include: R44's Admission Modulated to face and admitted to face intact and communicated intact a	with responsibility for the cood and nutrition services staff. In acticable, the participation of the resident's representative(s). The participation of the resident's representative is determined the development of the nutre staff or professionals in the resident. The resident revised by the interdisciplinary revised duranterly review research, including both the resident. The short met as evidenced retain, interview and document failed to provide the opportunity of (R44, R64, R66) to participate development, review, and re plans and attend care Minimum Data Set (MDS) dated of R44 was cognitively intact, could be understood by others cility on 10/8/19. Baseline Care plan dated R44 was alert and cognitively	F 657	F-657 SS: D A. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? " All residents moving forward will invited to attend care conferences ar response to request will be documer the resident srecord and conference occur within 7 days of MDS closing. B. How will you identify other resident having the potential to be affected by same deficient practice? " All residents or Guardians resport to request to attend care conference be documented in the care conference be documented in the care conference note all care conferenced will occur of day of MDS closing.	be nd nted in ce will nts / the onse s will ce

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ENIDII	245266	B. W i NG	VI ENCEM	C
NAME OF F	PROVIDER OR SUPPLIER	INTERNATION AND ADDRESS OF THE PARTY.	1 II - II 1 77	STREET ADDRESS, CITY, STATE, ZIP CODE	12/12/20 <u>19</u>
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS		618 EAST 17TH STREET	
				MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 657	Continued From p	age 33	F 657		
	nor had he received invitations to a care. When interviewed Clinical Manager (process was to hawith residents after setup quarterly the sets up the care corpresent ninety per the care conference the resident's room.	ot attended a care conference ed any written or verbal e conference meeting. on 12/10/19, at 3:55 p.m. CM) indicated the facility we an initial care conference radmission and then they were creafter. The Social worker onferences and CM usually cent of the time. Sometimes see are held in CM's office or in a. CM indicated could not recall are conference meeting with		C. What measures will be put in or what systemic changes will you to ensure that the deficient praction not recur? "All social worker staff will be to this Plan of Correction on Janu 2020 "It will be documented during a conferences what day the resider invited and by what means (oral of D. How will you monitor the correction(s) to ensure the deficient put will not recur, i.e., what quality as program will be put into place?	u make ce does educated lary 21, care int was of written) ective practice
	on 12/11/19, at 3:: not been schedule meeting was abou was planning on m and that she usual weeks after admis Review of undated Comprehensive As indicated residents will be involved in person-centered or resident and repre plan is not practical resident's medical Requested docum written invitation gi participate in care	facility's policy titled, seessments and Care Planning, and resident representatives the comprehensive are planning. If participation of sentative in development of able, explanation must be in		" All social worker staff had edithis Plan of Correction on January 2020. " The facility has implemented Assurance Program to ensure all residents will be invited to care conferences and that the care not reflect the invitation and all care conference occur within 7 days of MDS closing. " The Social Director and staff complete monthly care conference audits on current residents for the months. Additional training may be scheduled based on results of the assurance review " The facility administrator and designee will monitor the audits a completed and results will be reviously applied to the complete completed and results will be reviously substantial compliance is mathematical compliance is mathematical compliance.	y 21, a Quality tes f the will be note ee oe e quality /or are ewed in ring or
	R64				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	DING COM		E SURVEY PLETED
	PROVIDER OR SUPPLIER	245266 FER OF MINNEAPOLIS	I SEL	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		C 12/20<u>19</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 657	R64's Annual MDS was cognitively into understands with or self understood. During interview with p.m. R64 stated he years and did not reconferences. R64's that." On 12/10/19, at 4: revealed care plan completed by DSS and goes to out to sure whether he with conference meeting. When interviewed revealed R64's lass She stated R64 ne conferences and with most of the time. The meeting included ER64's code status of the time. The meeting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the time. The eting included ER64's code status of the eting included ER6	dated 11/5/19, indicated R64 act, had clear speech, elear comprehension and made with R64 on 12/09/19, at 5:08 a had lived at facility for many emember attending care stated, "I don't remember doing 14 p.m. interview with CM ning scheduling would be a Sometimes resident leaves Starbucks but I cannot say for as present during his last care g. on 12/11/19, at 3:32 p.m. DSS at care conference was 5/24/19, wer goes to his care was usually out of the building the last care conference DSS, dietary, and nursing and was reviewed. facility's policy titled, as sessments and Care Planning, and resident representatives the comprehensive are planning. If participation of sentative in development of able, explanation must be in	F 657	7		
	Requested docume written invitation gir	entation of DSS verbal or ven to R44 to attend and planning and did not get one.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
p	ENINI	245266	B. WING_	W EDGEM	C 12/12/201<u>9</u>
	245266 ME OF PROVIDER OR SUPPLIER ENEDICTINE HEALTH CENTER OF MINNEAPOLIS X4) ID SUMMARY STATEMENT OF DEFICIENCIES		101	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	LIVI
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 657	Continued From p	page 35	F 65	7	
	During interview v p.m. R66 stated s conferences, had admission to the f her care decisions	he wanted to attend care only one care conference since acility, did not feel included in			
	R66 had admitted cognition was inta (Gastroesophage R66's Quarterly Mextensive staff as	to the facility on 7/2/19, ct, and had diagnoses of GERD al Reflux Disease) and anxiety. IDS indicated R66 needed sistance with activities of daily	i		
	7/9/19, indicated I problems, needed a G-tube and had	R66 communicated with no I extensive staff assistance, had diagnoses including paraplegia			
	required a tube fe did not indicate who needed to be repl 7/22/19, indicated with ADLs and gro and was able to m	eding related to dysphagia but nen or how often the G-tube aced. R66's care plan dated R66 required staff assistance boming and personal hygiene			
	10:57 a.m. he was		t		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	COM	E SURVEY MPLETED
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- 1	PROVIDER OR SUPPLIER	ALL M. ASSETT OF A DATE		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		/12/20 <u>19</u>
	T					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 657	Continued From pa	age 36	F 65	7		
		M-A stated R66 had had to wait our for response from staff for				
	manager, stated of services scheduled and invited the res the care conference conferences. RN-A	RN)-A, who was also nurse in 12/12/19, at 9:54 a.m. social id the resident care conferences ident and/or representative to be and documented the care a stated she attended care sidents but had not yet 66.				
	communication wa staff walked out of following up for R6 were doing what sl she would have like her debit card bein informed of who had only one care confi	2/19, at 2:18 p.m. she thought is a big issue at the facility as her room and forgot about 6 and R66 wondered if staff he had requested. R66 stated ed to known the outcome of g stolen and had not been ad taken it. R66 stated she had erence held in August and ause Licensed social worker out on leave.				
	at 8:44 a.m. R66 h 8/7/19, which R66 Dietitian stated car three months. Diet	med in R66's MR on 12/12/19, ad a care conference held on and FM-A had attended. e conferences were held every itian confirmed no care care en held with R66 and/or FM-A				
	scheduled the new care conference for admission, then he three months after	2/12/19, at 11:13 a.m. she ly admitted resident their first our to six weeks after ld a care conference every LSW-A stated she did not e conferences within the 7-day				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	COM	E SURVEY IPLETED
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	PROVIDER OR SUPPLIER		IUI	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		12/20 19
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 657	assessment period had not ever sche stated she would a timeline for reside scheduled that she care conferences LSW-B had gone only SW presently Review of R66's Mare conference of 8/7/19. The Director of Nu 2:08 p.m. she experiod plans and state included in their planting data and/or representation comprehensive period would incorpore preferences. Facility policy Res Care Planning data the right to patreatment or change the schedule of the preference of the schedule of the patreatment or change the schedule of the sched	d for the quarterly review and duled them that way. LSW-A ask corporate if there was a nt care conferences to be e should follow. LSW-A stated "were behind" schedule since out on leave and she was the at the facility. IR revealed no evidence of a completed with R66 since arising stated on 12/12/19, at ected staff to follow residents and the testing the facility were to be an of care. In prehensive Assessments and the ded 11/2017, indicated residents are planning rate the resident's personal and the facility and the facility participation in the ded 2017, indicated residents articipate in planning care and ges in care and treatment and	F 65	7		
	planning.	e in person-centered care erest/Needs Each Resident (1)	F 67	9		1/20/20
	the comprehensive	es. facility must provide, based on e assessment and care plan es of each resident, an ongoing				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	ELE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED
	ENIDI	245266	B. WING	<u>VI ENCEMI</u>	C 12/12/2019
NAME OF I	PROVIDER OR SUPPLIER	NU AUNN	I N. J. W	STREET ADDRESS, CITY, STATE, ZIP CODE	2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS	A SHIP IN	618 EAST 17TH STREET	
DENEDIO	TINE HEALIN OLK	TER OF MININEAF OLIS		MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTION
F 679	program to suppor activities, both factindividual activities designed to meet physical, mental, a each resident, end and interaction in This REQUIREME by: Based on observative, the facility person-centered, residents (R13, Rational R13 was observed in a chair in his room of the dining room of not know where R13's quarterly MI 9/3/19, indicated R13's quarterly MI 9/3/19, indicate	tresidents in their choice of dity-sponsored group and and independent activities, the interests of and support the and psychosocial well-being of couraging both independence the community. ENT is not met as evidenced ation, interview and document	F 679	,	ents y the used blace nake does I to ector vities cess vities.
	indicated R43 likes and fishing, music	s exercise, radio, tv, hunting , dine out, fairs, tours, rives, shopping, travel, movies,		and sheet to help staff identify activiting that the resident that need remindin attend. D. How will you monitor the correct	ties g to

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(сом	E SURVEY PLETED
	PROVIDER OR SUPPLIER	245266 ₹ ITER OF MINNEAPOLIS	1 6	STREET ADDRESS, CITY, STATE, ZIP CODE 118 EAST 17TH STREET MINNEAPOLIS, MN 55404		0 12/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 679	R13's Activities ca staff would help R to view movies or be reminded of menjoy visits from meals outside of f R13's annual MDS was "Very Importate outside and attend annual MDS indic Important" for R13 attend group active R13 was observed dark room laying the TV turned on. Nursing Assistant 8:06 a.m. R13 like sleep. R13 was observed sitting on a chair in closed with his TV NA-A stated on 12 pretty mellow, had just a little forgetful independent with his room and water liked current even newspaper. R13 was observed sitting in his room in his room and water liked current even newspaper.	are plan dated 12/2/19, indicated 13 with set up with IPAD/Table listen to music independently, onthly brunch lunch, would nentor and go to movies and facility. So dated 12/10/18, indicated it ant" for R13 to get fresh air dhis favorite activities. The ated it was "Somewhat 3 to keep up with the news and inities. don 12/11/19, at 8:05 a.m. in on his side towards the TV with (NA)-F stated on 12/11/19, at ed to stay in his room a lot and don 12/11/19, at 11:12 a.m. In his room, head down, eyes a turned on. 2/11/19, at 1:31 p.m. R13 was an obehavior issues and was all. NA-A stated R13 was ADLs and R13 liked to stay in the TV shows. NA-A stated R13 ts and loved to read the	F 679	action(s) to ensure the deficient previll not recur, i.e., what quality assign program will be put into place? "The facility has implemented a Assurance Program to ensure all residents will activity preference a attendance is tracked and lack of attendance tracked "The Activity Director and staff complete monthly quality assurance audits on current residents. Addit training may be scheduled based results of the quality assurance re "The facility administrator and/designee will monitor the audits at completed and results will be revied QAPI for need of ongoing monitor until substantial compliance is ma COMPLETION DATE: 1/20/2026	a Quality a Quality nd will ce ional on view. or e ewed in ing or intained.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
D	ENINI	245266	B. WING	<u>II EDC</u> EM	C 12/12/201<u>9</u>
	PROVIDER OR SUPPLIE	R NTER OF MINNEAPOLIS	l 618	REET ADDRESS, CITY, STATE, ZIP CODE BEAST 17TH STREET	LIVI
DENEDI	5 T T T T T T T T T T T T T T T T T T T	TIER OF MINITED A GETS	MI	NNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 679		page 40 a.m. R13 stayed in his room,	F 679		
	ate his meals in h	nis room and came out of his while. LPN-A stated she had t R13 but not seen any family			
	R13 was observe laying on his bed	ed on 12/12/19, at 2:46 p.m. watching TV.			
		erved present at any activity held ration of the survey week from 12/12/19.	1		
	indicated Bingo w Games were held Monday 12/9/19, on Tuesday and	019, Activities Calendar posted vas held on Sunday afternoons, d on 2nd floor and 3rd floor on at 2:00 p.m. and music was held Wednesday afternoon at 2:00 , and 12/11/19, at the facility.	Ė		
	12/12/19, at 3:00 activity preference quarterly along we for activity preference director stated R ² . Pokino and statemore in the summarially from Chical and stated she the from the news abdirector stated R ² smoked outside a would like R13 to activities a week staff including the stated R13 used but had not been	Recreation) director stated on p.m. R13 was assessed for e upon admission and thereafter ith the assessment completed ence with the MDS schedule. TR 13 used to come to Bingo and d R13 used to have a mentor ner. TR director stated R13's ago had visited R13 in October ought R13 was feeling down out his sister's illness. TR 13 liked outdoor activities and everyday. TR director stated she have 2-3 one-to-one (1 to 1) provided for R13 from activity e chaplain visits. TR director to come to Bingo independently coming to Bingo. TR director to be outside more but had not	R		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION) сом	E SURVEY IPLETED
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 679	she had tried varineeded to be encactivities. TR direcareplan for that. careplan did not in activity document activity staff 1:1's R13's Individual A September 2019, Bingo and Special not been invited to September IAR in (therapeutic recreprovided. R13's October 20 Pokeno and Cafe not been invited to October IAR indicated. R13's November attended Table gafour times and Special four tim	ther changed. TR director stated ous things for R13 and R13 ouraged more and invited to the ctor stated she would now TR director confirmed R13's nclude that and confirmed R13's ation did not include 2-3 a week provided for R13. Ittendance Record (IAR) dated indicated R13 had attended I Events one time each and had of Table games or Music. R13's dicated R13 had three TR ation) staff visits (1:1s) 19, IAR indicated R13 attended (news one time each and had of Table games or Music. R13's attended (news one time, Social events ecial events two times and had of Music. R13's November IAR of four TR staff visits. 2019, IAR indicated R13 had ames one time, Social events ecial events two times and had of Music. R13's November IAR of four TR staff visits. 2019, IAR indicated R13 had or attended Bingo or Music, ded any Table games, Pokeno B's December IAR indicated R13 visit provided.	F 679			
		S dated 10/14/19, indicated as impaired, had disorganized				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
	ENIDH		D. WINO	W EDOEM		С
		245266	B. WING	Miller i dina je im	12/	12/201 <u>9</u>
NAME OF I	PROV I DER OR SUPPL I ER	NO AVIND		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET		
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 679	thinking and delusi indicated R43 need with ADLs and did MDS indicated it w do her favorite acti	age 42 ions. R43's annual MDS ded extensive staff assistance not reject cares. R43's annual as "Very Important" for R43 to vites and was "Somewhat with music, animals and group	F 679			
	indicated R43 was Cook/Bake, Handir paint/draw and also indicated R13 was clergy visits, radio fairs/tours/museun drives, shopping, s	essment (AA) dated 10/15/19, interested in attending Bingo, work quilt/sew, needlework and o watching TV. R13's AA also interested in music, reading, programs, dining out, n trips, plays/movies, scenic special events, travel, indoor and large group activities.				
	would attend 1-2 a would pain nails wi would provide spiri weekly. R43's Activity Assessment care plan dated 12 began, indicated R	ctivities per week, and staff ith aromatherapy, and chaplain tual interaction 1-2 times vity car plan dated 10/15/19, 3's interested activities per nt completed 10/15/19. R43's /12/19, edited after survey 13 would be invited and ocial and musical programs.				
		on 12/9/19, at 5:23 p.m. sitting oom with her head down, eyes ned on.				
		on 12/10/19, at 9:57 a.m. her room with the TV turned				
		/10/19, at 9:58 a.m. R43 does talked to herself and stated				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	ENIDH	245266	B. WING	MI EDGEN	C
	PROVIDER OR SUPPLIER	TER OF MINNEAPOLIS	B. WIING_	STREET ADDRESS, CITY, STATE, ZIP CODI 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	12/12/201 <u>9</u> E
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLÉTION
F 679	Continued From pa	age 43	F 67	9	
	once staff engage talk with you.	R13 in a conversation R13 will			
	walk alone with her assistance to stand	110/19, at 3:20 p.m. R43 could walker but needed staff up. NA-B stated she did not abouts but thought possibly s for music.			
	sitting on a chair in	on 12/11/19, at 8:00 a.m. her room. R43 stated she ities and had not went down to yesterday.			
		on 12/11/19, at 11:13 a.m. head down, eyes closed and			
	loved to watch TV sto herself. NA-A state to staff depending to herself. NA-A state a couple of activities cards and one of h	11/19, at 11:14 a.m. R43 shows and stated R43 talked ated sometimes R43 would talk on her mood but mostly talked ated she had seen R43 join in as and stated R43 liked playing er favorites to play was "Whisk a stated she had not seen facility.			
	12/11/19, at 11:25 a fingers on her right and left pinkie finge stated R43 and art	py (OT) staff stated on a.m. R43 had two triggered hand in stuck down position er with not full extension. OT hritis in her fingers and needed th her hands at times.			
		on 12/12/19, at 9:08 a.m. dining room looking around.			
	R43 was observed	on 12/12/19, at 9:14 a.m.			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION		E SURVEY IPLETED
	EVIDI	NO ACIZA	1/31/	// EDOEM		С
		245266	B. WING	/ 	12/	12/201 <u>9</u>
NAME OF I	PROV I DER OR SUPPL I ER	NUAUIN		REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS		8 EAST 17TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE	(X5) COMPLETION DATE
F 679	Continued From p	age 44	F 679			
	sitting in her room	TV turned on.				
		rved present at any activity held ation of the survey week from 2/12/19.				
	indicated Bingo wa Games were held Monday 12/9/19, a on Tuesday and W	19, Activities Calendar posted as held on Sunday afternoons, on 2nd floor and 3rd floor on t 2:00 p.m. and music was held lednesday afternoon at 2:00 and 12/11/19, at the facility.				
	3:08 p.m. TR direct church, lunch brur activities. TR direct held monthly. TR cone to two activity including the chap R43 had no family director stated the activities residents and confirmed R43 include R43's favo director stated she activites and preferent careplant activity documents	ith TR director on 12/12/19, at stor stated R43 liked music, sch and attending group tor stated lunch brunch was director stated R43 should have staff 1:1's provided a week lain visits. TR director stated and liked TV in her room. TR activity staff knew which preferred by their care plans B's present careplan did not rite activites or preferences. TR would careplan R43's favorite rences and replace R43's TR director confirmed R43's attion indicated R43 was not et to two activity staff 1:1's a d like.				
	had not been invited invited to Games a time, had not atter invited to or attend visits provided. R4	eptember 2019, indicated R43 ed to Bingo each week or and had attended Bingo one ided Pokeno, had not been ed music and had no chaplain 3's September IAR indicated traff visits (1:1's) provided for				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	EVIDII	045000	D MAING	VI EDOEM		С	
NAME OF F	PROVIDER OR SUPPLIER	245266	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	12/20 <u>19</u>	
- 1				118 EAST 17TH STREET			
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAPOLIS	1	/IINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 679 F 684 SS=D	had not been invite Games, had not attinvited to or attende visits provided. R43 had seven TR staff R43's IAR dated Not had not been invite attended Pokeno of to or attended must provided. R43's Not two TR staff visits provided. R43's Not two TR staff visits provided to or attended pohad not been invited Games, had not attinvited to or attende visits, and had not every week. R43's had two TR staff visits provided two TR staff visits provided to or attende visits, and had not every week. R43's had two TR staff visits provided to a staff visits provided to	ctober 2019, indicated R43 d to or attended Bingo or tended Pokeno, had not been ed music and had no chaplain 3's October IAR indicated R43 visits provided for the month. ovember 2019, indicated R43 d to or attended Bingo, had ne time, had not been invited ic and had no chaplain visits ovember IAR indicated R43 had provided for the month. ecember 2019, indicated R43 d to or attended Bingo or tended Pokeno, had not been ed music, had no chaplain been invited to church services December IAR indicated R43 sits provided. Dicy was requested for review made available.	F 679			1/31/20	
	by:	v and document review, the		F 684			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
D	ENINI	245266	B. WING	VLEDCEM		୍ର 12/20 <u>19</u>
- 1	PROVIDER OR SUPPLIE	R ITER OF MINNEAPOLIS	A SHOW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET	LIV	
DENEDIO	TINE HEALIH OLI	TER OF MINITER OLIO		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	Continued From p	page 46	F 684			
	treatment during resident (R381) re	et upon request for medical a change in condition for 1 of 1 eviewed for hospitalization.		 A. As noted in 2567, resident did return to facility and in addition, d require surgical intervention. B. The licensed nurses for that seems of the seems of	id not shift were	
	Findings include:	ed as a closed record.		counseled at the time of this issue reminded to include resident s rego to the hospital in addition to the	equest to	
	R381 was intervite at 4:06 p.m. and of the facility 5/2019 which resulted in 6/4/19, she had a injected and X-ray (CT) to look for procompleted at her returned to the fa and the physician every two hours. evening or early resensation in her to a neurological che however felt as if assess due to the loss of sensation she requested to evaluation, however 1831 was told by sending me" and see me in the moof sensation was 911 herself from 18 she was admitted bed rest. R381 in reported the loss called 911 herself	ewed via telephone on 12/9/19, explained R381 was admitted to , due to issues with her spine paralysis. R381 indicated on myelogram (a contrast dye ys or computed tomography roblems in the spinal canal) spinal surgeon's office and cility during the evening hours ordered neurological checks R381 recalled later in the night she started having a lack of oes. R381 stated she requested eck to have been completed, the nurse was unaware how to enurse's lack of concern with the in R381's toes. R381 indicated go to the hospital for further wer after waiting almost an hour the facility nurse "they were not the in house provider "would rning." R381 indicated the loss progressing and decided to call her cell phone. R381 indicated to the hospital and placed on dicated from the time she first of sensation to the time she it was over two hours.		findings from their focused asses C. Review of expectations regar resident choice and professional of practice with a reported or ider change in condition. D. IDT will audit progress notes presence of indications of change condition; if present verify follow u occurred. Four record reviews fo presence of this follow up, report Quality Council for further directic Compliance Date: 1/31/2020	sment. ding standard tiffied for e of up r	
		Plan dated 5/24/19, identified pain related to significant spine				

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	СОМ	E SURVEY IPLETED
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NAME OF DR	OMDER OR SURRUER	245266	B. WING	PIDEET ADDRESS CITY STATE ZID CODE	12/	12/201 <u>9</u>
NAME OF FR	OVIDER OR SUPPLIER	I O LOUIN		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDICT	INE HEALTH CENT	ER OF MINNEAPOLIS	MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
Horilian February Feb	medications per orncision care as ordactivities, monitor abain, and pain assessable statement of the control of	d staff to administer ders, cervical collar, thoracic dered, encourage out of bed and record any complaints of essment per protocol. Minimum Data Set dated 381 had intact cognition. Area Assessment dated 6/4/19, I neuropathic pain and multiple d indicated R381 would have o stabilize her spine. Jephone Encounter dated 381 was requesting to go to "not feeling well and report feel any sensation on both legs might be behavioral and ention. Plan: try to reassure c, ok to send patient to the ED ment]." Jote (PN) and Physician Order d 6/4/19 through 6/5/19, and				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
	ENIDI	245266	B. WING	WI EDGEM		C 12/2010	
	PROVIDER OR SUPPLIEF CTINE HEALTH CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		12/12/20 <u>19</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 684	-The PO dated 6/4 every two hours for the PO dated 6/4 called due to R383 toes. I want to call call was called. PO PN dated 6/5/19, completed which is subsequent PN dated R381's Diagnoses R381's Diagnoses R381's medical restaff sending R383 resident request. The facility investigned at the facility investigned experience at the call 911 due to not toes. The facility investigned experience at the call 911 due to not toes. The facility investigned experience at the call 911 due to not toes. The facility investigned experience at the call 911 due to not toes. The facility investigned experience whom could clearly and "take relayed the order for the call 911." "Su written just that was informed," however on-call provider investigations."	al/19, indicated check resident or 24 hours; al/19, indicated the on call was a "stated I cannot wiggle my 911. And resident call 911. On 0 "do not send;" indicated R381 had an x-ray showed "negative results." A sted 6/5/19, indicated the 381 was admitted and R381 all fusion surgery. The report dated 6/9/19, indicated es which included paraplegia, roical and thoracic regions. The cord lacked evidence of facility and to the hospital per PO and/or gative file dated 6/11/19, and congue no pain with orders to any two hours for 24 hours" "just all indicated she wanted to having been able to wiggle her urse called on call provider at anded the phone to another explain the situation "more orders." The second nurse of the resident's assigned nurse of the resident's assigned nurse of the resident's assigned nurse of the resident was any and the resident to ED."		34			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	DECEMBER NO. 10.	LETED
	ENDI	245266	B. WING_	MI EDCEM	C 12/1	2/2019
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	TER OF MINNEAPOLIS	W	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET		<u> </u>
	ı			MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	Continued From pa	age 49	F 68	4		
	via telephone on 12 explained he was r 6/4/19, however the misunderstanding provider so the oth speak to the provider stated he informed and "ready to call 9 indicated the provider permission to send herself can do it." I sure if R381's neur	nurse (LPN)-B was interviewed 2/11/19, at 1:12 p.m. and not assigned to R381 on ere was "some between the nurse" and on call er nurse had asked LPN-B to der on the telephone. LPN-B the provider R381 was in pain 211" per the nurse. LPN-B der "told me I can't give I to the hospital but the resident LPN-B indicated he was not rological status had been d not physically see or talk to				
	telephone on 12/12	ctitioner was called via 2/19, at 1:26 p.m., however and did not return call.				
	12/12/19, at 4:04 p expectation if a res	sing was interviewed on .m. and stated it was her sident was insisting to go into rse would send them and notify r.				
	at 2:19 p.m. and ver R381 on 6/4/19, ar an order to "check" however was unaw needed to be asse R381 notified LPN- not have sensation her toes and asked explained to asses legs, hands and ey and obtained a set	ewed via telephone 12/13/19, erified she was assigned to not recalled she had received on R381 every two hours, ware R381's neurological status ssed as well. LPN-C stated of the could not wiggle of to go to the hospital. LPN-C is R381 she touched R381's wes "to see if she felt anything" of vital signs. LPN-C stated call provider and recalled she				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
- 1	PROVIDER OR SUPPLIER	245266 RITER OF MINNEAPOLIS	l le	STREET ADDRESS, CITY, STATE, ZIP CODE 118 EAST 17TH STREET MINNEAPOLIS, MN 55404		C 12/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
	the day, however not understand he to explain. LPN-C R381 had been he orders not to send to call 911 herself. The facility Reside Resident Rights Facility acted to provide to appropriate Neurological Assembly indicated neurological formation. The polymorphism in polymorphism in polymorphism in polymorphism in polymorphism in polymorphism in neurological formation in the provider in neurological fur Increase/Prevent CFR(s): 483.25(c) Mobility §483.25(c) Mobility §483.25(c) (1) The resident who enter range of motion divarge of motion underside the provider in motion divarge of motion divarge of motion divarge of motion divarge of motion divarge in polymorphism.	R381 had a myelogram earlier in LPN-C stated the provider could be and asked for another nurse indicated the provider asked if aving behavior issues and gave at R381 to the hospital for R381. The Rights and Notification of Policy dated 2017, indicated the otect and ensure the rights of licy included residents had the element Policy dated 2018, gical observation and to have been completed with a self and an acute change of licy indicated the assessment and an acute change of licy indicated the assessment aining vital signs, check pupil bility which included the resident ities, ask resident to squeeze plantar and dorsiflex note of any abnormalities or change inclinated to refer any abnormalities or change inction. Decrease in ROM/Mobility (1)-(3)	F 684			1/31/20
		trates that a reduction in range				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	l'	X3) DATE SURVEY COMPLETED
	ENIDII	245266	B. W I NG	W ENCEME	C
- 1	PROVIDER OR SUPPLIER	NO AUNI	HJ V	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET	12/12/20 <u>19</u>
BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS	1	MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 688	motion receives apservices to increas prevent further decisions and services appropria assistance to main the maximum pracreduction in mobilit This REQUIREME by: Based on observareview, the facility for a motion (ROM) for a reviewed for rehab program. Findings include: R43 was observed sitting on a chair in back and forth. Registered nurse (2:26 p.m. R43 had shoulders, back and R43's Annual MDS R43's cognition was thinking, delusions Annual MDS did not function for ROM for R43's Care Area Area Area Area Area Area Area A	sident with limited range of propriate treatment and erange of motion and/or to crease in range of motion. Sident with limited mobility the services, equipment, and tain or improve mobility with ticable independence unless a yis demonstrably unavoidable. NT is not met as evidenced tion, interview and document failed to implement a range of maintain or improve range of 2 of 2 residents (R43, R66) illitation and restorative on 12/10/19, at 9:57 a.m. her room rubbing her knees RN)-F stated on 12/12/19, at arthritis with pain in her	F 688	F 688 A. R43□s finger is at 95% full exter and 100% full flexion. Palm Protector present in resident□s in her location choice as she uses this when she chooses to. Pain assessment compon 1/13/2020 essentially unchanged she decides when she wants to use topical creams. R66 was provided wanother copy of the ROM exercise pshe had worked on with therapy in the past and continues to be able to perthese exercises. B. Residents are screened annually 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 discussion. C. Review of communication forms nursing and therapy to use as tools to communicate changes in functional or for implementation or change to exercise programs. D. Residents with a restorative or	or of of of oldeted as with lan ne form y and cise

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
	ENIDII	245266	B. WING	MI EDCEN	C 12/12/2019
NAME OF I	PROV I DER OR SUPPL I ER	NU AUNN		STREET ADDRESS, CITY, STATE, ZIP COL	
BENEDIO	CTINE HEALTH CENT	TER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLÉTIO
F 688		ord did not reveal evidence of	F 688	exercise program will be inclu	
	R43's care plan da limited in ability to grooming, and to b mobility and fingers contracted. R43's canything regarding	mpleted or a palm protector to a right hand. Ited 7/3/18, indicated R43 was dress/undress self, maintain bathe self related to impaired a 4 and 5 on right hand care plan did not indicate a right hand palm protector to dis contracted fingers.		random audit of four residents week period of time for compl program and coordination or p devices along with presence is care. Review of audit results Council for further direction. Compliance Date: 1/31/2020	etion of oresence of n plan of
		1/19, at 8:00 a.m. her arms e and stiff the Tylenol pain			
	11:13 a.m. when R her walker she wou	NA)-A stated on 12/11/19, at 43 gets ready to stand up with uld rub her legs and say they A-A stated R43 was			
	on 12/11/19, at 11:: hands slightly bent therapy) confirmed bent down. OT starfacility with triggere middle fingers and they were stuck do seen R43 and state eating and doing hot stated she did R43 was independ own. OT stated she months ago and ha her exercises. OT this as she did not	sitting on a chair in her room 25 a.m. with fingers on both down. OT (occupational I R43's fingers were slightly ted R43 was admitted to the ed fingers on her right little and were bent down and stated own. OT stated therapy had ed R43 was independent with er own right hand exercises. not monitor R43's exercises as ent and could complete on her e had observed R43 four to five ad seen R43 able to complete stated she did not document monitor. OT stated yearly erapy service ended were			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	СОМ	E SURVEY PLETED
	ENINII	245266	B. WING	VI EDCEM		୦ 1 2/2019
- 1	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER OF MINNEAPOLIS	N. Sec. 18	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET	LΙ	
	I			MINNEAPOLIS, MN 55404		I-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	completed by thera baseline function a capacity. OT stated screening for R43 R43's fingers OT s not changed but th had only 95% exte 100% extension whinstructed R43 now hand fingers and to on both hands now palm protector she hand. Nursing staff longer applied the R43 was observed holding onto her was unassisted. Physical therapy st 9:24 a.m. residents were not monitored completed yearly swhose therapy had confirmed R43 had completed since er PT stated since it h R43's therapy had a screening completed she with the completed by the completed by the state of the result	apy to see if resident was at and maximum functional dishe had not completed a when it was due. Looking at tated R43 triggered fingers had elittle pinkie on left hand now asion instead of the previous nen therapy ended. OT vinclude exercises on her left old R43 to complete exercises vidaily. OT stated R43 had a applied herself on her right interviewed stated R43 no palm protector. on 12/12/19, at 9:08 a.m. alker ambulating down the hall aff (PT) stated on 12/12/19, at swho could do their own ROM disherence but therapy creenings for those residents and needed ROM. PT I not had a screening anding therapy over a year ago. I nad been over a year since stopped and she had not had eved by therapy for over a year. Yould put in for a screening to lerapy for R43.	F 688	·		
	Summary dated 6/2 contracture diagno 6/15/18, and indica goal 6/28/18. R43's discharged from the	Il Therapy PN and Discharge 28/18, indicated R43 had a sis for R43's right hand dated ated at the R43 had met her therapy of OT note indicated R43 was erapy with a right hand palmovery night and R43 was to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3		E SURVEY IPLETED
	EVIDI			MI EDOEM		С
<u> </u>	= NLLL	245266	B. WING	VI EIIISE IVI	12/	12/20 <u>19</u>
NAME OF I	PROVIDER OR SUPPLIER	IU AUIII		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET		
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 688	perform self passive fingers. R43's OT progress indicated therapy heed to pick up R4 PN did not indicate of ROM exercises mention whether Ruse, and did not reperformed of R43's contractures. Review of R43's Pl 12/11/19, did not rescreening complete follow up and/or mexercises. R66 stated on 12/1 wondered why ther her and wondered help her more. R66's quarterly ME R66's cognition waincluded anxiety, de R66's quarterly ME function ROM in bineeded extensives mobility, total staff did not reject cares.	anote (PN) dated 10/25/18, and screened R43 and did not 3 for therapy services. R43's review of R43's performance for her right hand, did not 43's palm protector was still in veal screening had been a left hand for possible. Ns from 10/26/18, through eveal evidence of any OT ed for R43's hands nor any conitoring of R43's ROM 1/19, at 8:17 a.m. she capy services had ended for if therapy should be able to 0.8 dated 10/7/19, indicated s intact and diagnoses epression and paraplegia. OS indicated R66 had limited lateral lower extremities, staff assistance with bed dependence with toileting and is. 1/9/19, indicated R66 had was paraplegic, and had teral lower extremities with	F 688			
	R66's care plan da	ted 7/22/19, indicated R66				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIE	245266 R NTER OF MINNEAPOLIS	l 6	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET IINNEAPOLIS, MN 55404		C 12/20<u>19</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	needed staff assi positioning and tr ROM of lower ext R66's care plan or that ROM exer R66's physician or R66's rehab pote PT stated on 12/2 admitted to the fastrengthening and see if restorative R66 discharged f RN-A, who was a 12/12/19, at 9:54 after admitting to RN-A stated she exercises being power with a R66 had no behat evening staff combut not on the day stated R66 used confirmed on R66 ROM listed for stated R66 stated on 12 completed therapt to the facility. R66 paper with instruct after therapy was thought communication.	stance with ADLs including ansfers r/t weakness, impaired tremities and restless legs. Id not indicate any rehab goals cises should be completed. Inder dated 7/5/19, indicated intial was good. Inder dated 1:09 a.m. R66 had incility with therapy for downled look in therapy notes to program had been planned after				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		1 6	18 EAST 17TH STREET	C 12/12/201 <u>9</u>
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG		
her room yesterda exercises in her ro had told her they would know what a be completed for FPT Daily Treatmer R66 was educated provided written in R66 to use; however of any follow up are exercises. The facility Restoration 2017, indicated restorative needs. nursing care promindependence in a splints/braces and Free of Accident HCFR(s): 483.25(d) Accide The facility must e §483.25(d)(1) The as free of accidents. See QUIREME by: Based on observative, the facility	y looking for a paper for ROM om and had not found one and yould get her a paper so she and how often ROM needed to R66's strengthening exercises. It Note dated 8/1/19, indicated on performing exercises and structions and cues on form for the R66's MR lacked evidence ad/or monitoring of R66's ROM active Program policy dated sidents would be assessed/reassessed for The policy indicated restorative oted resident's highest level of reas including ROM, ADLs. azards/Supervision/Devices (1)(2) Ints. Insure that - I resident environment remains a hazards as is possible; and a resident receives adequate asistance devices to prevent action, interview and document failed to investigate causal	F 689		
reassess and impl	ement additional falls		of autonomy related to her desire to smoke for as long as possible in the	9041
	Continued From pater room yesterda exercises in her room yesterda exercises in her room had told her they would know what a be completed for FPT Daily Treatment R66 was educated provided written in R66 to use; however of any follow up an exercises. The facility Restora 2017, indicated restorative needs. nursing care promindependence in a splints/braces and Free of Accident HCFR(s): 483.25(d) §483.25(d) Accide The facility must e §483.25(d)(1) The as free of accident supervision and as accidents. This REQUIREMED by: Based on observative related to far reassess and implications.	A 245266 PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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. 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	245266 B. WING	## PROVIDER OR SUPPLIER ### PROVIDER OR SUPPLIER ### PROVIDER OR SUPPLIER ### PROVIDER OR SUPPLIER ### PROVIDER OF MINNEAPOLIS ### SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPRICIENCY MUST BE PROCEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION) ### CONTINUED OR DESCRIPTION OF THE APPROPRIA ### CONSTRUCTION OR DESCRIPTION OF THE APPROPRIA ### CONSTRUCTION OF THE APPROPRIA ### CONSTRU

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION S	(X3) DATE SURVEY COMPLETED		
	ENINI	245266	B. WING	MI ENCEM	C 12/12/20	19
	PROVIDER OR SUPPLIEF	TER OF MINNEAPOLIS	1.00	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET		<u></u>
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMP	X5) PLETION ATE
F 689		oservation dated 10/2/19,	F 689	course of her terminal disease. B. Review of expectations post to including RCA process with IDT, I and LPNs. C. Review of RCA and subsequents.	RN□s	
	identified R38 was staff to continue of R38's admission MR38 with moderate diagnoses which is schizophrenia. The independent with a and had no falls for R38's Falls Care Faurvey began, identified to continue the continue to the continue t	anot at risk for falls and directed urrent plan of care. MDS dated 10/7/19, identified a cognitive impairment and included cancer, anemia and a MDS indicated R38 was activities of daily living (ADLs) or six months prior to admission. Plan edited on 12/11/19, after intified R38 was at risk for falls chronic pain, unsteadiness,		changes or implementation of modifications to plan of care for c residents with falls since 1/1/2020 examples from recent resident fa included in this education. D. Audit of RCA and plan of care changes for three residents post one month. Review of audit resul Quality Council for further direction Director of Nursing or designee. Compliance Date: 1/31/2020	urrent). Case lls fall for lts with	
	weakness, impaired decision making of decline and direct see if she needs a independently adjustaff assist with trafootrests attached personal items with medication review footwear, when trassume a standing Care Plan dated 1 assistance with trastaff to provide as as R38 requests a without assistance	ed safety and judgment ue to cancer and functional ed staff to check R38 hourly to assistance, R38 can ust bed height as desires, two ansfers, high back w/c with for mobility, call light and thin reach, comprehensive by pharmacist, ensure proper ansferring encourage R38 to g position slowly. R38's ADL 2/6/19, identified R38 needed ansfers for toileting and directed sist with cares following toileting and remind not to transfer				
	Follow-up and Pro	ogress Notes (PN) were 29/19, through 12/12/19, and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	EMBH	245266	B. WING	WIED/CEM		C
	PROVIDER OR SUPPLIER	245266 TER OF MINNEAPOLIS	IU V	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET	12/	12/20 <u>19</u>
DENEDI	STINE HEALIN OLN	TER OF MINNEAF OLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	-The RIF dated 10 room when attempreported she felt lig carpet by her beds 10/29/19, indicated underlying illness/interventions call li assist as needed a slowly. Analysis of indicated R38 desipossible and chose New interventions time; -The PN dated 11/a w/c for R38 per I walker; -The RIF dated 11 attempting to go to carpet by her beds 11/8/19, indicated blank and current requested to use wassume standing puse call light, discu (IDT) and fall comeffectiveness was implemented indiculated 11/when trying to get bathroom; -The PN dated 11/when trying to get bathroom; -The RIF dated 11/get up and fell nex dated 11/20/19, incleft blank and curreplace and used for	age 58 /29/19, indicated R38 fell in her oring to get out of bed R38 ghtheaded and fell onto the side. The follow-up dated dincident was related to condition pain current ght in plan used to request assume standing position intervention effectiveness ared to remain independent as are not to seek assist from staff, implemented were none at this 1/19, indicated hospice ordered R38's request instead of a 1/8/19, indicated R38 fell when the bathroom and fell on the side. The follow-up dated incident related to was left interventions call light in place when needed assistance, position slowly, remind R38 to use sfalls with interdisciplinary mittee. Analysis of intervention left blank. New interventions ated "not at this time;" 8/19, indicated R38 fell down out of bed on her way to the 11/19, indicated R38 was using encouraged R38 to use w/c for tated when reminded; 1/20/19, indicated R38 tried to to the bed. The follow-up dicated incident related to was ent interventions call light in reeded assistance, assume slowly, w/c for mobility, remind slowly, w/c for mobility, remind	F 689			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COM	E SURVEY IPLETED			
	ENINI	245266	B. W I NG	WI EDCEM		C
- 1	PROVIDER OR SUPPLIEI CTINE HEALTH CEN		U	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	12/	/12/20 <u>19</u>
(VA) ID	STIMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	Continued From p	page 59	F 68	9		
	to use call light, and Analysis of interver R38 was indepensassistance. New ithis time;" -The PN dated 11 R38 reported to swas currently using R38 on benefits owalking without a however R38 insignal risks such as falls; -The RIF dated 17 R38 fell when she chair then tripped dated 11/21/19, in R38's impaired mawareness deficit place remind R38 assistance with traposition slowly, we encourage w/c useffectiveness indivintermittently whe would ask when we choose to use w/c implemented "not-The PN dated 11 heard yelling and room doorway R3 said she could no been experiencing R38 to use call light -The RIF dated 12 room while walking The follow-up data related to was left	ention effectiveness indicated dent and chose not to seek staff intervention implemented "not at /21/19, at 4:48 p.m. indicated taff she "often feels weak" and ag w/c intermittently educated f a walker as a step between device and using a w/c, sted on trying walker reviewed floor rugs and how to prevent /21/19, at 9:10 p.m. indicated a tried to get up from rocking on the carpet. The follow-up dicated incident was related to obility and judgment/ safety current interventions call light in to use when needing ansfers, assume standing for for mobility, non-ambulatory, ed. Analysis of intervention cated R38 used w/c in encouraged to use w/c R38 yould she stop using and R38 as desired. New interventions				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	ENIDI	245266	B. W I NG	MI EDOEM		C	
	PROVIDER OR SUPPLIER	245266 TER OF MINNEAPOLIS	В. WINO	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET	12/	12/20 <u>19</u>	
DENEDI	STINE HEALIN SEN	TER OF MININEAR SEIS		MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 689	staff assist with traposition slowly. Ar effectiveness R38 and not call for as implemented "not-The RIF dated 11 R38 fell onto the fl carpet when R38 the bathroom. R38 when she sat on the follow-up dated 11 related to was left assume standing transfers, w/c for remind to use call intervention effect interventions implesubsequent RIF dindicated R38 was her balance and where balance and where the follow-up dated 11 for same day" and effectiveness was interventions implesubsequent RIF dindicated current if for same day" and effectiveness was interventions implesubsequent PN dated 11 R38's carpet was of R38's room for subsequent PN dated R38 appencouraged to use had been monitore R38 was noted to times during the s	ansfers, assume standing alysis of intervention chose to use w/c intermittently sist. New interventions at this time;" /23/19, at 2:20 a.m. indicated oor in front of her bed onto the attempted to get up and go to 3 reported she lost balance he edge of the bed. The /23/19, indicated incident blank and current interventions position slowly, staff assist mobility, call light in place light and w/c. Analysis of veness was left blank. New emented were not at this time. A sted 11/23/19, at 12:15 p.m. trying to get her pop then lost as found on the floor by her The follow-up dated 11/23/19, interventions "see early report lysis of intervention left blank and new emented "not at this time;" 24/19, indicated R38 had a "tab look for a phone to answer, educated about tab alarm for eed;" /25/19, at 9:49 a.m. indicated rolled up and placed in corner guardian to pick up. A sted 11/25/19, at 2:52 p.m. eared to be weak and was a call light for assistance and ed throughout the shift, however attempt to self-transfer two		9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
- 8	PROVIDER OR SUPPLIER	245266 ER OF MINNEAPOLIS	1.000.10	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	12 <i>i</i> ′	C 12/201 <u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	R38 attempted to gather the follow-up date incident was relate judgment/ safety at interventions staff a standing position sto use w/c for mobuse call light. Analy effectiveness R38 assist and w/c interventions imple continue current planter and judgment/ safe interventions R38 to prior to the fall. indicated incident was to recall how and/odo prior to the fall. indicated incident was to recall how and/odo prior to the fall. indicated incident was to recall how and/odo prior to the fall. indicated incident was to recall how and/odo prior to the fall. indicated incident was sist with transfer standing positions R38 to light and frequently assist with transfer standing position sand w/c. Analysis of was left blank. New "not at this time coand had difficulty safe and	grab the bed control and fell. d 11/25/19, indicated the d to impaired balance and wareness deficit current assist with transfers, assume lowly, call light in place, remind lity and not self-transfer and to visis of intervention was not using call light for mittently as desired. New mented "not at this time an of care;" 28/19, indicated R38 was next to her bed and was unable or what she was attempting to The follow-up dated 11/28/19, was related to "hospice-cancer mobility, impaired cognition by awareness deficit. Current of use call light for assist, call a used items close to R38, staff is, w/c for all mobility, assume lowly, remind to use call light of intervention effectiveness of interventions implemented intinue current plan of care;" 28/19, indicated R38 was a floor and seemed lethargic	F 689			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D. MAIN C.	VI EDOEW		C
NAME OF		245266	B. WING	DIRECT ADDRESS OF COME	12/	12/20 <u>19</u>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET		
BENEDI	CTINE HEALTH CEN	TER OF MINNEAPOLIS	l	MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	intervention effecti intermittently and of interventions imple -The RIF dated 11, R38 was found lyin recall what she wa follow-up dated 11, related to hospice,	veness R38 chose to use w/c did not use call light. New emented "not at this time;" /30/19, at 4:00 a.m. indicated ag by door and was unable to s attempting to do. The /30/19, indicated incident was cancer throat, impaired	F 689			
	awareness deficit. checks, staff assis w/c for mobility, ca items near, remind light and w/c, and a Analysis of interve continued not to us interventions imple-The PN dated 11/R38 had been rest smoke. Administer	Cognition and judgment/ safety Current interventions hourly t to bathroom and transfers, Il light in place, frequently used I not to self-transfer, use call assume standing slowly. Intion effectiveness R38 Is e w/c or call light. New Immemmed "not at this time;" 30/19, at 11:21 p.m. indicated I less asked staff to take her to The ded Ativan (anti-anxiety) once It effective. R38 seemed				
	lethargic "noted wheed." R38 had been and the RIF dated 12 sitting on the floor attempting to go to dated 12/5/19, indicated 12	nen trying to transfer self out in on continuous supervision; /5/19, indicated R38 was found next to her bed due to the bathroom. The follow-up cated incident was related to throat, impaired mobility, cognition and judgement/ deficit. Current interventions room and with transfers, w/c for a place, assume standing I hourly checks. Analysis if veness R38 chose not call for ic intermittently continued i38 "does not welcome." New				
	carry w/c leg/ foot	emented R38 would accept to rests on back of w/c in a bag allow on chair at all times;				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	СОМ	E SURVEY IPLETED
	EVIDII			MICROCIA		С
		245266	B. WING	VI EIIISEIVI	12/	12/201 <u>9</u>
NAME OF F	PROVIDER OR SUPPLIER	IO AUINI		STREET ADDRESS, CITY, STATE, ZIP CODE	Line I V	
BENEDIO	CTINE HEALTH CENT	TER OF MINNEAPOLIS		618 EAST 17TH STREET		
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	-The RIF dated 12/on the floor due to bathroom. The folk incident related to vinterventions hourly transfers and bathrused items within restanding position s w/c and not to self-falls in facility. Anal effectiveness was limplemented "not a care;" -The RIF dated 12/to the floor when slibathroom, intervenibed per care plan. West 4th Floor Nur 12/11/19, identified toileting and directed toileting requests Renown and to check R38's medical recording requests Renown and to check R38's medical recording requests Renown and to check R38 was interviewed and refused to ansend refused to ansend refused to lean to he Nursing assistant (/8/19, indicated R38 was found attempting to use the ow-up dated 12/8/19, indicated was left blank and current by checks, staff assist with room, call light and frequently each, w/c for mobility, assume lowly, remind to use call light, stransfer, meet and discuss lysis of intervention left blank. New interventions at this time continue plan of /9/19, indicated R38 slid down the attempted to go to the tion R38 was assisted to her raing Care Work Sheet dated R38 needed staff assist for ed staff to assist R38 to the R38 was able to make needs as R38 hourly. Ord lacked evidence of root onitoring for effectiveness of mplementation of additional fall ed on 12/10/19, at 3:56 p.m.	F 689			

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
- 1	PROVIDER OR SUPPLIER	245266 TER OF MINNEAPOLIS	I PER II	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		C 12/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	outside to smoke. R38 to the bathrod and was not award R38. RN-E was intervie and verified R38's yesterday and exp developed was ho IDT and fall comm however stated it I R38 not fall due to independent. RN-I R38 assistance to hourly checks. DON was interview and stated due to "probably" not refleplaced R38 at incrindicated R38 was and declined and I moved around as with R38 and "told "really" needed to The facility Integral dated 2013, indicated 2013, indi	age 64 Ify due to R38 wanting to go NA-E stated staff would assist om when R38 would request e of a toileting schedule for wed on 12/12/19, at 11:34 a.m. Fall Care Plan was updated dained the last intervention urly checks. RN-E indicated the ittee had discussed R38's falls, had been "challenging" to help R38's desire to remain indicated staff should offer the bathroom when they did wed on 12/12/19, at 1:58 p.m. R38's "rapid" decline was ected in the care plan which heased risk for falls. DON offered a bedside commode had the furniture in the room well. DON indicated she met "R38 she was unsafe and consider using a device. Itted Fall Management Policy Itted residents with risk for an individualized resident had eveloped. Care plan based on the finding of the fall When a resident fell the fall would be evaluated for ng factors and addressed. The fall and care plan changes and ented additional interventions.	F 689			
F 756	•	view, Report Irregular, Act On	F 756	3		1/31/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER	245266 TER OF MINNEAPOLIS	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		C 12/201<u>9</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 756 SS=D	CFR(s): 483.45(c) §483.45(c) Drug R §483.45(c)(1) The must be reviewed licensed pharmaci §483.45(c)(2) This of the resident's management of the resident of the resident of the resident of the resident's medical irregularity has been action has been the physician should of the resident's medical irregularity has been the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should of the resident's medical irregularity has been the physician should be physician shou	regimen Review. drug regimen of each resident at least once a month by a st. review must include a review edical chart. pharmacist must report any attending physician and the irector and director of nursing, must be acted upon. Clude, but are not limited to, any e criteria set forth in paragraph for an unnecessary drug. Es noted by the pharmacist must be documented on a seport that is sent to the n and the facility's medical or of nursing and lists, at a dent's name, the relevant drug, or the pharmacist identified. Physician must document in the record that the identified en reviewed and what, if any, ken to address it. If there is to be medication, the attending ocument his or her rationale in	F 75	6		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
	EVIDI			W EDOEM		C
-	J= [/] [] []	245266	B. WING	VI II IVI	12/	12/20 <u>19</u>
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CEN	TER OF MINNEAPOLIS		18 EAST 17TH STREET		
			N	MINNEAPOLIS, MN 55404		
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 756	Continued From pa	age 66	F 756			
F 756	requires urgent act This REQUIREME by: Based on interview facility consulting p identify and report provider of weight pounds while takin 5 residents (R65) r medication use. Findings include: R65's physician or identified diagnose failure with hypoxia chronic obstructive tracheostomy, poly insufficiency. On 6/12/18, R65's to manage edema from 40 milligrams Special instruction to do weekly weigh certified nurse prac more than two pour	tion to protect the resident. INT is not met as evidenced w and document review, the charmacist (PharmD) failed to staff failures to notify the gain of greater than two g a diuretic medication for 1 of reviewed for unnecessary der summary dated 11/20/19, es including chronic respiratory a, dependence on respiratory e pulmonary disease, meuropathy, and venous Lasix order, a medication used (swelling), was decreased (mg) orally (o) to 20 mgs (o). s included with this order were ents on R65 and notify the cititioner (CNP) if R65 gained ands (lbs). ealed several weekly weight equal to two pounds: = 10.8 lbs = 9.8 lbs = 9.0 lbs 19 = 6.1 lbs 9 = 3.2 lbs	F 756	F 756 A. EHR for R65 was reviewed sporder noted in 2567. The reporting parameters portion was discontinutes deniced by the second seco	g ued as at esidents eporting ng and king in orting dily s with ays.	
		ealed a lack of evidence that				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		E SURVEY IPLETED
	ENIDH	245200	D MINO	VI EDOEM		С
NAME OF E	PROVIDER OR SUPPLIER	245266	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/	12/20 <u>19</u>
- 1				118 EAST 17TH STREET		
BENEDIC	STINE HEALTH CENT	ER OF MINNEAPOLIS	N	MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 756		ige 67 xception of a telephone order chart dated 10/3/19, indicating	F 756			
	a 9 lb weight gain. continue to monitor	The provider responded to				
	4/17/19, 5/14/19, 5/8/13/19, 9/16/19, 10 reviewed. No weigh	7/2/19, 6/11/19, 7/16/19, 0/15/19, and 11/13/19, were all at changes or notifications to essed in the MRRs.				
	the PharmD stated order to contact CN gain, and noted tha directly to the medi	on 12/12/19, at 12:49 p.m. he had not been aware of the IP with a two pound weight torder would usually be tied cation order. The PharmD gain assessment would have RR.				
F 757 SS=D	was requested for in Drug Regimen is F	ation regimen review policy review and none was provided. ree from Unnecessary Drugs 1)-(6)	F 757			1/31/20
	Each resident's dru	essary Drugs-General. g regimen must be free from . An unnecessary drug is any				
	§483.45(d)(1) In exduplicate drug thera	cessive dose (including apy); or				
	§483.45(d)(2) For 6	excessive duration; or				
	§483.45(d)(3) With	out adequate monitoring; or				
	§483.45(d)(4) With use; or	out adequate indications for its				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	EVIDU	245266	B. WING	MENCEM		C 1 2/2019
- 1	PROVIDER OR SUPPLIER	FER OF MINNEAPOLIS	l e	STREET ADDRESS, CITY, STATE, ZIP CODE S18 EAST 17TH STREET MINNEAPOLIS, MN 55404		12/20 10
	0.0000000	ATTENTION OF DEPLOYED AND A				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 757	Continued From pa	age 68	F 757			
		e presence of adverse ch indicate the dose should be inued; or				
	stated in paragraph section. This REQUIREME	combinations of the reasons hs (d)(1) through (5) of this				
	facility failed to not of greater than two	w and document review, the ify the provider of weight gain pounds while taking a diuretic 5 residents (R65) reviewed for cation use.		F 757 Refer to plan of action for 756.		
	Findings include:					
	identified diagnose failure with hypoxia chronic obstructive	der summary dated 11/20/19, es including chronic respiratory a, dependence on respirator, e pulmonary disease, rneuropathy, and venous				
	to manage edema from 40 milligrams Special instruction order dated 6/19/1 decreased from 40	Lasix order, a medication used (swelling), was decreased (mg) orally (o) to 20 mgs (o). s included as an additional 8, stated "NOTE: patients lasix to 20 mg. If patient gains date NP during clinic hours".				
	signs section of Ma record, from June					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF L	PROVIDER OR SUPPLIER	245266	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE		C 12/20<u>19</u>
		FER OF MINNEAPOLIS	l 618	B EAST 17TH STREET NNEAPOLIS, MN 55404	lbs I V I	
(X4) ID PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 757	these weight gains the CNP with the efound in the paper a 9 lb weight gain. continue to monito RN-D was interviewed stated he did a call the CNP with a pounds or more. Freviewed several was two pounds or greatoly 1/31/19, which was weight dated 10/24 assistants weighed nurse if there had stated typically the message for the Codocumented in the verified there was CNP of the two potelephone order (Tochart for R65's progain. A physician of observe R65. RN-documentation regain in either the ethe TO's in the pay weight gain would R65's congestive in the state of the two potelephones.	= 9.8 lbs = 9.0 lbs 19 = 6.1 lbs 9 = 3.2 lbs 9 = 7.8 lbs ealed a lack of evidence that had been communicated with exception of a telephone order chart dated 10/3/19, indicating The provider responded to r. wed on 12/12/19, at 11:10 a.m. not know there was an order to a weight increase of two exception that indicated a weight of ater, including the weight dated as two pounds higher than the last two pounds weight gain. RN-D found a last two pounds weight gain. RN-D found a last two pounds weight like than the last two pounds weight like than the last two pounds weight gain. RN-D found a last two pounds weight gain. RN-D found a last two pounds weight like than the last two pounds weight like to continue to D was unable to find any other last than the last two pounds weight like than the last two pounds weight like than the last two pounds weight last two pounds weight like than the last two pounds weight like than the last two pounds weight last two pounds higher than that two pounds higher than that two pounds higher than the last two pounds higher than the	F 757			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIP AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		LE CONSTRUCTION 3		E SURVEY PLETED		
	ENIDH	245266	B. WING	W EDOEM		C
	PROVIDER OR SUPPLIER	nd agni	IU V	STREET ADDRESS, CITY, STATE, ZIP CODE	12 <i>l</i> °	12/20 <u>19</u>
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 757	the director of nutritishe was responsible nutritional status in and care area assecreated the goal and plan. Additionally, monthly including a weights and address progress notes. The evaluate R65's weights	ge 70 tion services (RD) stated that e for assessing R65's the minimum data set (MDS) essments (CAA). The RD also d approaches for R65's care the RD reviewed R65's record n assessment of R65's weekly esed R65's weight in the e RD did not specifically ght changes week to week and know whether or not the	F 757			
F 808	provider was notified pounds or more. The pharmacist (Ph 12/12/19, at 12:18 preview including vital every monthly med completed. Pharmation of specific weight of directly to a medical none of the two pout the MRRs completed. The facility medical monitoring policy we provided.	narmD) was interviewed on c.m. and verified that a chart all signs would be done with ication regimen review (MRR) Distated that typically an order gain monitoring would be tied attion order. PharmD verified and weight gains were noted in the distance of the past year.	F 808			1/31/20
	CFR(s): 483.60(e)(§483.60(e) Therape §483.60(e)(1) Ther prescribed by the a §483.60(e)(2) The delegate to a regist task of prescribing	1)(2) eutic Diets apeutic diets must be	F OUE			1/3 1/20

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
	EVIDI		1731/	W EDOEM		
<u> </u>	= \	245266	B. WING	VI - II IVI	12/1	12/20 <u>19</u>
NAME OF I	PROVIDER OR SUPPLIER	NU AUNN		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	TER OF MINNEAPOLIS	ı	18 EAST 17TH STREET		
BENEBI				MINNEAPOLIS, MN 55404		
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 808	law. This REQUIREME by: Based on observareview, the facility of diets per physician 1 resident (R23) reassistance in room. Findings include: R23 was observed room lying on her bed elevated connected herself without (NA)-B began to as sauce, pears in juice potato chips from a R23 three bites of of regular water frobite of tuna sandwiregular water. NA-I tuna sandwich ther cranberry juice. At (CM)-A entered and exited. At 6:29 nectar thick cranber NA-B fed R23 a bit dry potato chip the cranberry juice. R2 potato chips and/or NA-B was interview and verified R23 w consistency) water	NT is not met as evidenced tion, interview and document failed to ensure prescribed orders were received for 1 of eviewed during dining to a ventilator. R23 was dently move her arms and/or at assistance. Nursing assistant esist R23 to eat vegetables in the central transfer of the carry juice and some purchase of the sandwich, Jello and a canister in room. NA-B gave a dry potato chip then a drink of a cap with a straw then a ch followed by another drink of B gave R23 two more bites of a drink of nectar thick 6:20 p.m. clinical manager d dropped off plastic spoons p.m. CM-A returned with extra erry juice and exited the room. The of the sandwich and another in a drink of nectar thick is did not cough during bites of	F 808	F 808 A. Nursing assistant received counseling regarding following plat care, assignment sheet and to obtassistance from the licensed staff questions he/she may have. B. Observation of random morni evening shift meals on the unit inversor four meals. C. Review of expectations related following plan of care including die and if issues arise to seek clarification licensed staff. D. Random audit of meal assistation other units for 30 days, then report Quality Council for further direction Director of Nursing or designee responsible. Compliance Date: 1/31/2020	ain with any ng and olved d to t orders tion nce on	
	water" as NA-B tur	ned to R23 and NA-B asked				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	ENIDH	245266	B. WING	VI EDCEM		C
- 1	PROVIDER OR SUPPLIER	INTERNATION IN	IUI	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET	12/	12/20 <u>19</u>
				MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 808	Continued From pa	age 72	F 808	3		
		family purchased R23 snacks potato chips from the canister R23's diet orders.				
	identified R23 was nutrition related to secondary to Amyonervous system di and impacts physic ventilator with trac	tatus Care Plan dated 4/17/19, at risk for compromised diagnosis of dysphagia otrophic lateral sclerosis (a sease that weakens muscles cal function), dependence on heostomy and directed staff to id texture per physician orders.				
	Plan of Care dated tolerated nectar th soft solid cut up in small bites with pla three to four bites indicated "Husban	rapy Progress and Updated I 5/1/19, indicated R23 safely ickened liquids, mechanical to nickel size pieces, using astic spoons, liquid wash every and slow rate. The plan d found to provide thin liquids" to continue nectar thickened allowing.				
	9/17/19, identified	nimum Data Set dated R23 had intact cognition and stance of one staff with eating.				
	R23 had diagnose respiratory failure flaccid hemiplegia flaccid hemiplegia	ce Sheet undated, identified s which included chronic with hypoxia or hypercapnia, affecting right dominant side, affecting left non-dominant whic lateral sclerosis.				
	included diet order nectar thickened li solids that must be	rder Report dated 12/12/19, dated 4/17/19, which indicated quids and mechanical soft cut into nickel size pieces degrees use small plastic				

TFICATION NUMBER:	A. BUILDING	3	(X3) DATE SURVEY COMPLETED	
245266	B. WING	MI EDCEM		C
AUNI	NUT		12/	12/2019
PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
d liquids every three 11/19, at 9:42 a.m. asked if she was eat potato chips. It (SLP) was 9:48 a.m. and verified ectar thickened solids. SLP explained in as R23 had no e to clear "things' out hips were not R23 should not eat as not aware staff hilly brought into the Interviewed on tated it was her liet orders to be therapeutic diets was epare/Serve-Sanitary rements. from sources				1/20/20
	245266 INNEAPOLIS DEFICIENCIES PRECEDED BY FULL YING INFORMATION) In moist or add d liquids every three 11/19, at 9:42 a.m. asked if she was eat potato chips. It (SLP) was 9:48 a.m. and verified ectar thickened solids. SLP explained in as R23 had no e to clear "things' out hips were not R23 should not eat as not aware staff hilly brought into the interviewed on tated it was her liet orders to be therapeutic diets was	245266 B. WING	245266 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 F DEFICIENCIES PRECEDED BY FULL YING INFORMATION) F 808 In moist or add It liquids every three 11/19, at 9:42 a.m., asked if she was eat potato chips. It (SLP) was 9:48 a.m., and verified ectar thickened solids. SLP explained in as R23 had no e to clear "things" out nips were not R23 should not eat as not aware staff ailly brought into the interviewed on tated it was her liet orders to be therapeutic diets was expare/Serve-Sanitary F 812 F 812 F 812 F 808 F 808	245266 B. WING

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	,	X3) DATE SURVE COMPLETED	
	EMBH	A	D WING	W EDOEME	С	
NAME OF	200) (IDED OD OUDDUIED	245266	B. WING	TDEET ADDRESS (ATV. STATE 71D CODE	12/12/201	9
NAME OF	PROVIDER OR SUPPLIER	IU AVIIII		STREET ADDRESS, CITY, STATE, ZIP CODE S18 EAST 17TH STREET		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ETION
F 812	and local laws or re (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for \$483.60(i)(2) - Stor serve food in according standards for food This REQUIREME by: Based on observative review, the facility fooking utensils ur 2 utensil storage ditto affect 57 resider failed to clean 4 of white cabinets notes stains, dark matter kitchen cabinet hare Findings include: During initial kitche p.m. observed two dust and brownish countertops dusty, cabinets with scatted dark matter with pacabinet handles. During interview 12 Director (DD) indicutensil drawer, and have not been cleaweek. DD further views 12 week.	egulations. oes not prohibit or prevent produce grown in facility compliance with applicable bod-handling practices. does not preclude residents ods not procured by the facility. e, prepare, distribute and dance with professional service safety. NT is not met as evidenced tion, interview and document ailed to store and maintain der sanitary conditions for 2 of rawers which had the potential its. Furthermore, the facility 4 dusty shelves and 4 of 4 and with reddish, brownish and paint chipped doors near	F 812	F812 SS: D A. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? "Moving forward all utensils will be stored using sanitary practices B. How will you identify other resident having the potential to be affected by same deficient practice? "All residents have the potential to affected under inappropriate sanitary conditions of storage C. What measures will be put into prorough the work of the potential to ensure that the deficient practice contrecur? "All dietary staff will receive educations on cleaning practices, sche and assignments on January 13 or January 17th 2020. "Dietary Manager will develop proof tracking cleaning and assignments with audits	e nts the be lace ake does ation dules,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED		
	ENINI	245266	B. WING	ALEDCEMI	12/²	C 1 2/2019
- 1	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET		
BENEDIC	TINE HEALTH CEN	TER OF MINNEAPOLIS	l N	/INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 812	Continued From p	age 75	F 812			
	weekly per schedu those areas had b week.	ule and currently did not appear een cleaned for more than a		D. How will you monitor the correct action(s) to ensure the deficient pra will not recur, i.e., what quality assurance will be not into place?	ctice	
	stated she would p to get cabinets pai	on 12/12/19, at 11:24 a.m. DD blace request with maintenance inted and stated staff had gone rs and cleaned out the debrische shelves.		program will be put into place? "The facility has implemented education for dietary staff on Januar or January 17th 2020. "A weekly spot check tools for sa storage of utensils will be used.		
	Sanitizing Policy ir departments must program that inclu-	ated Facility Cleaning and ndicated all food service have an effective cleaning des a cleaning schedule. s: identify the cleaning jobs in itchen.		" The Dietary Manager will assist complete monthly quality assurance audits for 3 months, based on week checks Additional training may be scheduled based on results of the q assurance review. " The facility administrator and/or	e ly spot uality	
	cleaning duties da indicated staff to s side of dish room	lity AM-PM staff weekly ted 12/2/19-12/8/2019, crub down all shelves on clean on Sunday. There was no lay to show that cleaning was		designee will monitor the audits are completed and results will be review QAPI for need of ongoing monitorin until substantial compliance is main	ved in g or	
			F 880	COMPLETION DATE: 01/20/2020)	1/31/20
	infection prevention designed to provide comfortable environments.	stablish and maintain an on and control program le a safe, sanitary and conment and to help prevent the transmission of communicable				
	program.	on prevention and control stablish an infection prevention				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			СОМ	E SURVEY PLETED		
	ENIDII	245266	B. WING_	MIEDCEM		C 12/2019
- 1	PROVIDER OR SUPPLIER CTINE HEALTH CEN		IUI	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 880	and control progra a minimum, the form \$483.80(a)(1) A syreporting, investigation and communicable staff, volunteers, voluntee	m (IPCP) that must include, at llowing elements: restem for preventing, identifying, ating, and controlling infections e diseases for all residents, isitors, and other individuals under a contractual d upon the facility assessment ng to §483.70(e) and following standards; ten standards, policies, and a program, which must include, to: veillance designed to identify cable diseases or ney can spread to other lity; hom possible incidents of ease or infections should be transmission-based precautions revent spread of infections; isolation should be used for a	F 88			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	l i	COMF	SURVEY PLETED
	ENIDH		D. MAINO	W EDOEME		
NAME OF I		245266	B. WING	270557 ADDD500 OLTV 07475 7/D 0005	12/1	2/2019
NAME OF I	PROV I DER OR SUPPL I ER	IV AVIII		STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET	a I V	
BENEDIO	CTINE HEALTH CENT	TER OF MINNEAPOLIS		MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	by staff involved in §483.80(a)(4) A sylidentified under the corrective actions to §483.80(e) Linens. Personnel must had transport linens so infection. §483.80(f) Annual The facility will con IPCP and update to the facility failed to anafor trends and patter illness and infection affect all 82 resident Findings include: The facility's infection from September 20. The logs identified with infections, syntreatment. The typrooms and floor for infections meeting tract infections (UT)	direct resident contact. stem for recording incidents a facility's IPCP and the aken by the facility. Indle, store, process, and as to prevent the spread of as necessary. Note in the process and as to prevent the spread of as to reduce the spread of as the prevent to reduce the spread of as the potential to a tracking in the facility. It racking records of residents and the of infections were tracked by the each month. There were 20 criteria including 10 urinary in six respiratory infections,	F 880	F880 SS: D A. Corrective action(s) will be accomplished for those residents for have been affected by the deficient practice? " Infection prevention plan was reviewed and remains appropriate. A potential infection identified is monitive by IP and IDT via progress notes, changes in orders, internal infection tracking tool and through verbal reports. How will you identify other resides having the potential to be affected by same deficient practice? " Staff reviewed infection plan and accompanying tools at staff meeting	Any ored ort ents y the	
	infection, and one were four "suspect between 9/18/19, a were documented	ctions, one gastrointestinal fever of unknown origin. There ed" UTIs on the second floor and 10/29/19. These infections on the floor plan by month, but have been investigated to		January 31, 2020. All staff receive infection prevention education as pa onboarding, skills fairs, annually and periodically throughout any given ye C. What measures will be put into por what systemic changes will you m	l ar. blace	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	Name of the Owner	LETED
- 1	PROVIDER OR SUPPLIER	245266 ₹ ITER OF MINNEAPOLIS	1.000.10	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	1 2/1	; 2/20 <u>19</u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	determine if there care or other pote the infections. Ad evaluated longitud data. A quarterly report submitted to the Comeeting. There were infections and ind to occur in the tracking submitted to the Comeeting. There were infections and ind to occur in the tracking submitted to occur in the tracking infection preventions and individually. There month to month to month to month to month to month in the care of the infections were tracking systemally six as need infections were tracking with infections was need infections were tracking to the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were no cri an outbreak and experience in the care were not care were not critical to the care were not care were not critical to the care were not care	were common staff providing ntial reasons that would explain ditionally, the data were not dinally as an entire quarter of some state of the october were 13 infections meeting seven urinary tract infections reatory infections, and three soft. The report was a list of icated most infections appeared cheostomy or ventilated er, there was no evidence of the cause of the patterns. In 12/12/19, at 1:45 p.m. the conist, registered nurse (RN)-F, ew in her role and still learning em. RN-F indicated there was no nalysis regarding possible ctions, so the facility could entions to prevent infections. It was not aware that further ded. Further, RN-F stated acked by unit and displayed on atted that location of residents is not evaluated or compared. It is not evaluated or compared. It is not evaluated or comparison of determine any pattern. In the re no specific plans developed	F 880	to ensure that the deficient practice not recur? "All infections, including potent actual, with rates and patterns are reviewed by IP, IDT, and QA. Prevences such as review of period procedures or visual observational of cares are conducted if potential infections are identified. If an outb pattern were identified on a particula additional steps would be taken sureview of staffing patterns, proced review by unit or individual 1:1 rev D. How will you monitor the correlaction(s) to ensure the deficient provided in the program will be put into place? "Infection tracking reports with will continue to go to QA for review individual confirmed infection will be audited for potential root cause identification as noted in internal electronic tracking tool daily for we and then at least one random infection desired number of audits and course the QA piece. COMPLETION DATE: 1/31/2020	ial and ventive care I audits reak or ular unit uch as ural iew. ctive cactice curance analysis v. Any oe eeks ction if n note I of	
		on Prevention and Control ated November 16, 2016				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
NAME OF F		245266	B. WING	STREET ADDRESS CITY STATE 710 CODE		C 12/20 <u>19</u>
- 1	PROVIDER OR SUPPLIER CTINE HEALTH CEN	TER OF MINNEAPOLIS	N. APR. III	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	program existed to comfortable environmental personnel and was	rage 79 infection prevention and control of assure a safe, sanitary and comment for residents and signed to help prevent the transmission of disease and	F 880			

F9246131

PRINTED: 01/21/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245266	B. WING		12/12/2019	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTION	
K 000	INITIAL COMMEN	тѕ	К0	00		
	ALLEGATION OF ODEPARTMENT'S ASIGNATURE AT THE PAGE OF THE CMUSED AS VERIFICATION ON SITE REVISIT OF CONDUCTED TO SUBSTANTIAL COREGULATIONS HAD ACCORDANCE WAS AN	MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. Lety Code survey was Alinnesota Department of Experiment of the Fire Marshal Division on Experiment of Minneapolis was Let and the requirements for Alicare/Medicaid at 42 CFR, Life Safety from Fire, and the Life Safety from Fire, and the Life Safety Code (LSC), Experiment S		EPOC		
_ABORATORY	' DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Electronically Signed

Event ID: 7KXS21

Facility ID: 00960

01/20/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CONTRACTOR OF DESICIENCIES (AVX). PROVIDED (SUPPLIED CLASSICS)

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	JITIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED			
		245266	B. WING_		12	/12/2019		
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP COL 618 EAST 17TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of volto correct the deficit 2. The actual, or proceed of the correct of the deficit of the correct of the corrido automatic fire department of the correct of the corrido automatic fire department of the correct of the corre	pections Division Suite 145 I-5145, OR @state.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date. If title of the person rection and monitoring to ence of the deficiency. Center of Minneapolis is a man a full basement that was built be nined to be of Type II(222) floor of this facility that sleeping-rooms, is divided into ents. The facility is fully ut by an automatic fire end has a fire alarm system with the corridors and spaces are that is monitored for intrement notification. apacity of 95 beds and had a	K 00					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED 12/12/2019	
		245266 B. WING			12		
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 920	NOT MET as evid	at 42 CFR, Subpart 483.70(a) is denced by: ent - Power Cords and Extens	K 00			12/17/19	
	Extension Cords Power strips in a used for compone patient-care-relate (PCREE) assemb by qualified perso 10.2.3.6. Power's may not be used electronics), exce rooms that do not PCREE meet UL strips for non-PCI (outside of vicinity care rooms, powe standards. All po precautions. Exte substitute for fixe- Extension cords to immediately upon which it was insta 10.2.4. 10.2.3.6 (NFPA 9 (NFPA 70), 590.3 This REQUIREM by: Based on observ facility did not use cords in a manne precautions per N Facilities Code, s 10.5.2.2 and NFP	patient care vicinity are only ents of movable ed electrical equipment oles that have been assembled annel and meet the conditions of strips in the patient care vicinity for non-PCREE (e.g., personal ept in long-term care resident truse PCREE. Power strips for 1363A or UL 60601-1. Power REE in the patient care rooms (r) meet UL 1363. In non-patient er strips meet other UL exer strips are used with general ension cords are not used as a diviring of a structure. Used temporarily are removed a completion of the purpose for exercised and meets the conditions of (P), 10.2.4 (NFPA 99), 400-8 (D) (NFPA 70), TIA 12-5 (ENT is not met as evidenced exercised and extension or that exercises general IFPA 99 (2012), Health Care ections 10.2.3.6, 10.2.4, A 70 (2011), National Electrical 100.8, 590.3(D), and TIA 12-5.		K- Tag 920 SS=D 1) What Corrective Action (s) accomplished for those fire sat requirements found to have be deficient.	fety		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A ₂ BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245266	B. WING			12/1	2/2019
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				6	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET IINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 920	within the affected refindings include: On a facility tour be and 3:00 PM on 12. Room 222 had a reventilator, there was	tween the hours of 11:00 AM /12/2019, it was revealed that sident on a life support s patient-care-related t plugged into a power-strip	K 9	920	" New Power strips have been deployed and mounted to medical for all ventilator rooms with only Uf approved patient care items plugged. 2) How will you identify related fir features having the potential to be affected by the same deficient pracand what corrective action will be to the New Power strips have been deployed and mounted to medical for all ventilator rooms. 3) What measure will be put into or what systemic changes you will to ensure that the deficiency does recur. "Power strips (1363A Hospital will be installed in vent rooms and ends will be marked with colored to make them easily identifiable. 4) How the corrective action (s) will not recur, i.e., what quality ass program will be put into place inclutime frames and person (s) resporting frames and person (s) resporting frames and person (s) resporting to ensure all wrooms have 1363 Hospital Grade Strips and will audit them weekly from th. "The facility administrator and/odesignee will report finding of the a QAPI. COMPLETION DATE: 12/17/2019	e safety ctices aken. Carts place make not Grade) plugin ape to vill be practice urance uding nsible. a Quality vent Power or 2 or audit to	



Protecting, Maintaining and Improving the Health of All Minnes ot ans

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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

Benedictine Health Center Of Minneapolis January 6, 2020 Page 2

"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,

Toward Stapeon

Douglas Larson, Enforcement Specialist Minnesota Department of Health

Benedictine Health Center Of Minneapolis January 6, 2020 Page 3

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

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 ****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.

Minnesota Department of Health

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

01/16/20 Electronically Signed

STATE FORM If continuation sheet 1 of 74 7KXS11

(X6) DATE

TITLE

PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 000 Continued From page 1 2 000 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/inf obul.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

Minnesota Department of Health

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.

STATE FORM 7KXS11 If continuation sheet 2 of 74

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 000 Continued From page 2 2 000 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 2 540 MN Rule 4658.0400 Subp. 1 & 2 Comprehensive 2 540 1/31/20 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:

Minnesota Department of Health

H. discharge potential;I. dental condition;J. activities potential;

STATE FORM 6899 7KXS11 If continuation sheet 3 of 74

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 540 Continued From page 3 2 540 K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced Based on interview and document review, the Corrected. 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

Minnesota Department of Health

areas # (number)4 communication, #5 activities of daily life, #6 urinary incontinence, #11 falls, #12

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 540 Continued From page 4 2 540 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

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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

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PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 540 Continued From page 5 2 540 nursing, or designee could educate staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 2 570 2 570 MN Rule 4658.0405 Subp. 4 Comprehensive 1/31/20 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 Based on observation, interview and document Corrected. 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

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conferences.

Findings include:

revision of their care plans and attend care

and admitted to facility on 10/8/19.

R44's Admission Minimum Data Set (MDS) dated 10/14/19, indicated R44 was cognitively intact. had clear speech, could be understood by others

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resident and representative in development of plan is not practicable, explanation must be in

Requested documentation of DSS verbal or

resident's medical record.

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will be involved in the comprehensive

resident's medical record.

person-centered care planning. I participation of resident and representative in development of plan is not practicable, explanation must be in

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 570 Continued From page 8 2 570 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.

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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

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 570 Continued From page 9 2 570 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

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had not ever scheduled them that way. LSW-A

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 570 Continued From page 10 2 570 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

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ensure compliance.

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PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 570 Continued From page 11 2 570 TIME PERIOD FOR CORRECTION: Twenty One (21) days. 2 830 MN Rule 4658.0520 Subp. 1 Adequate and 2 830 1/31/20 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 Based on observation, interview and document Corrected. 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

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hospitalization.

Findings include:

condition for 1 of 1 resident (R381) reviewed for

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.

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-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

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 13 2 8 3 0 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

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staff assist with transfers, assume standing position slowly. Analysis of intervention

and not call for assist. New interventions

implemented "not at this time:"

effectiveness R38 chose to use w/c intermittently

-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

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT I PL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUM		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					С
00960			B. WING		12/12/2019
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDBESS CITY S	STATE, Z I P CODE	<u> </u>
NAIVIE OF	FROVIDER OR SUFFLIER				
BENEDI	CTINE HEALTH CEN	I ER OE MINNEAP	T 17TH STRE POLIS, MN 5		
	CLIMANA DV CT				DDECTION (177)
(X4) I D PREF I X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE COMPLETE
				DEFICIENCY)	
2 830	Continued From pa	age 15	2 830		
	follow up dated 11	/22/10 indicated incident			
		/23/19, indicated incident blank and current interventions			
		position slowly, staff assist			
		nobility, call light in place			
		light and w/c. Analysis of			
		veness was left blank. New			
	interventions imple	emented were not at this time. A	4		
	subsequent RIF da	ated 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				
		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,		' ∥		
		educated about tab alarm for			
	her safety and agre				
		/25/19, at 9:49 a.m. indicated			
		olled up and placed in corner			
		guardian to pick up. A			
	•	ited 11/25/19, at 2:52 p.m.			
		eared to be weak and was			
	•	call light for assistance and			
		ed throughout the shift, howeve	T		
		attempt to self-transfer two			
	times during the sh	/25/19, at 3:40 p.m. indicated			
		grab the bed control and fell.			
		ed 11/25/19, indicated the			
		ed to impaired balance and			
		wareness deficit current			
		assist with transfers, assume			
		slowly, call light in place, remind			
		ility and not self-transfer and to			
		ysis of intervention			
		was not using call light for			
assist and w/c intermittently as desired. New interventions implemented "not at this time					

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 16 2 8 3 0 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

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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 Minnesota Department of Health

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NAME OF F	PROVIDER OR SUPPLIER			STATE, Z I P CODE			
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	light and w/c, and a Analysis of interver continued not to us interventions imple -The PN dated 11/3 R38 had been restl smoke. Administer and was somewhal lethargic "noted whoed." R38 had bee -The RIF dated 12/sitting on the floor attempting to go to dated 12/5/19, indichospice, cancer of balance, impaired of	not to self-transfer, use call assume standing slowly. Intion effectiveness R38 are w/c or call light. New amented "not at this time;" 30/19, at 11:21 p.m. indicated less asked staff to take her to led Ativan (anti-anxiety) once to effective. R38 seemed aren trying to transfer self out in on continuous supervision; 1/5/19, indicated R38 was found linext to her bed due to line bathroom. The follow-up cated incident was related to throat, impaired mobility, cognition and judgement/					
	staff assist to bathre mobility, call light in position slowly and intervention effective assist and used whereminders which R interventions imple carry who leg/ foot in however would note. The RIF dated 12/ on the floor due to bathroom. The folk incident related to interventions hourly transfers and bathres used items within in standing position swip who are more to self-falls in facility. Anal effectiveness was lightly and interventions was a self-falls in facility.	deficit. Current interventions from and with transfers, w/c for a place, assume standing hourly checks. Analysis if weness R38 chose not call for c intermittently continued 38 "does not welcome." New mented R38 would accept to rests on back of w/c in a bag allow on chair at all times; (8/19, indicated R38 was found attempting to use the ow-up dated 12/8/19, indicated was left blank and current y checks, staff assist with room, call light and frequently each, w/c for mobility, assume lowly, remind to use call light, transfer, meet and discuss lysis of intervention left blank. New interventions at this time continue plan of					

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 18 2 8 3 0 -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 vesterday and explained the last intervention developed was hourly checks. RN-E indicated the

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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

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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

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[emergency department]."

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

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resident request.

staff sending R381 to the hospital per PO and/or

The facility investigative file dated 6/11/19, indicated R381 had myelogram on 6/4/19, and returned experiencing no pain with orders to

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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

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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

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PRINTED: 01/30/2020 **FORM APPROVED** Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREF**I**X CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 8 3 0 Continued From page 24 2 8 3 0 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. MN Rule 4658.0525 Subp. 2 A Rehab - Range of 2 8 9 0 1/31/20 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

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by:

unavoidable; and

the resident's clinical condition demonstrates

This MN Requirement is not met as evidenced

that a reduction in range of motion is

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anything regarding a right hand palm protector to

R43 stated on 12/11/19, at 8:00 a.m. her arms

be applied for R43's contracted fingers.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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		00960		B. WING	_		12/2019
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, Z I P CODE		
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2 890	Continued From pa	ge 26		2 890			
	and legs were sore medication helped.	and stiff the Tylenol	pain				
	11:13 a.m. when R	NA)-A stated on 12/ 43 gets ready to star Id rub her legs and s A-A stated R43 was	nd up with				
	on 12/11/19, at 11:2 hands slightly bent therapy) confirmed bent down. OT stat facility with triggere middle fingers and they were stuck down seen R43 and state eating and doing he OT stated she did rown. OT stated she months ago and has her exercises. OT states as she did not a screenings after the completed by thera baseline function and capacity. OT stated screening for R43 v R43's fingers oT stated screening fo	sitting on a chair in last a.m. with fingers of down. OT (occupation R43's fingers were seed R43 was admitted fingers on her right were bent down and wn. OT stated therapted R43 was independer own right hand extent and could complete had observed R43 d seen R43 able to stated she did not down of the last and could complete had not complete had maximum function she had not complete had no	on both onal slightly d to the t little and I stated by had dent with ercises. The services as the term of the services at the				

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contractures.

performed of R43's left hand for possible

Review of R43's PNs from 10/26/18, through 12/11/19, did not reveal evidence of any OT

STATE FORM 6899 7KXS11 If continuation sheet 28 of 74 Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 890 Continued From page 28 2 8 9 0 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

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see if restorative program had been planned after

R66 discharged from therapy.

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 890 Continued From page 29 2 8 9 0 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

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2017, indicated residents would be

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attending physician.

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

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 945 Continued From page 31 2 945 This MN Requirement is not met as evidenced Based on observation, interview and document Corrected. 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

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cranberry juice. R23 did not cough during bites of

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

potato chips and/or thin water.

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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

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 2 945 Continued From page 33 2 945 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 the rapeutic 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

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cabinet handles.

dust and brownish debris, four shelves below two

During interview 12/9/19, at 12: 15 p.m. Dietary Director (DD) indicated that the dirt and debris in

countertops dusty, and four white kitchen cabinets with scattered reddish, brownish and dark matter with paint chipped areas near kitchen

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FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21015 Continued From page 35 21015 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

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these changes and perform competencies. The

administrator could perform audits periodically to ensure compliance. The facility should report

dietary manager, registered dietician, or

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PRINTED: 01/30/2020 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21015 Continued From page 36 21015 audit findings to Quality Assurance Performance Improvement (QAPI) for further recommendations and to determine compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21390 MN Rule 4658.0800 Subp. 4 A-I Infection Control 21390 1/31/20 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

I. methods for maintaining awareness of current standards of practice in infection control.

disinfectants, antiseptics, gloves, and

incontinence products; and

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21390 Continued From page 37 21390 This MN Requirement is not met as evidenced Based on interview and document review, the Corrected. 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

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residents; however, there was no evidence of

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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

TIME PERIOD FOR CORRECTION: Twenty-one

a regular basis to ensure compliance.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00960	B. WING	FINIZ	C 12/12/201<u>9</u>	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
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21390	Continued From page 39		21390			
	(21) days.					
21435	MN Rule 4658.090 Recreation Program	0 Subp. 1 Activity and m; General	21435		1/31/20	
	home must provide recreation program based on each indistrengths, and nee meet the physical, well-being of each comprehensive rescomprehensive pla 4658.0400 and 46 provided opportuni	al requirements. A nursing e an organized activity and not the program must be ividual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the sident assessment and an of care required in parts 58.0405. Residents must be ties to participate in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of the activity and not care required in the lopment of th				
	by: Based on observat review, the facility t person-centered, n	tion, interview and document failed to provide neaningful activities for 2 of 2 3) reviewed for activities.		Corrected.		
	Findings include:					
		on 12/9/19, at 5:11 p.m. sitting m watching television (TV).				
		ved in the group activity held in 12/9/19, at 2:00 p.m Staff did 13 was at the time.				
	9/3/19, indicated R	OS (Minimum Data Set) dated 13's cognition was impaired, and was independent with				

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21435 Continued From page 40 21435 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

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closed with his TV turned on.

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PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21435 Continued From page 41 21435 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

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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

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PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 42 21435 21435 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

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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

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

indicated R13 had four TR staff visits.

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

FORM APPROVED Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21435 Continued From page 44 21435 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.

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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

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PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21435 Continued From page 45 21435 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

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week as she would like.

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

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21435 Continued From page 46 21435 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

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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

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PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21435 Continued From page 47 21435 assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21530 MN Rule 4658.1310 A.B.C Drug Regimen Review 21530 1/31/20 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

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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

physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending

if the medical director is not the attending

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21530 Continued From page 48 21530 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 Based on interview and document review, the Corrected. 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

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-8/29/19 - 9/5/19 = 9.8 lbs

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Continued From page 49 21530 21530 -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

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ongoing compliance.

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STATEMEN			(X3) DATE SURVEY COMPLETED	,		
		00960	B. WING	FINIZ	C 12/12/201 9	•
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAR	17TH STRE OLIS, MN 5			
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21530	Continued From pa	age 50	21530			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
21540	MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540		1/31/2	20
	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 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.					
	by: Based on interview facility failed to noti of greater than two	ent is not met as evidenced and document review, the fy the provider of weight gain pounds while taking a diuretic 5 residents (R65) reviewed for cation use.		Corrected.		

6899

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21540 Continued From page 51 21540 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.

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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

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pounds or more.

provider was notified of weight gains of two

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)

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
00960			B. WING		C 12/12/201 9	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21540	for specific weight directly to a medical none of the two por the MRRs complet. The facility medical monitoring policy with provided. SUGGESTED METAD METAD METAD NOTE CONSULTING Pharmacon policies and process and process medication usage. With the pharmacis reviews on a regular	D stated that typically an order gain monitoring would be tied ation order. PharmD verified und weight gains were noted in ted for the past year. Ition administration and was requested and none THOD OF CORRECTION: The ctor of nursing (DON) and cist could review and revise dures for proper monitoring of The DON or designee, along st, could audit medication ar basis to ensure compliance.	21540			
21695	MN Rule 4658.141 Housekeeping, Op Subp. 4. Housekeep provide housekeep necessary to maint comfortable interio	5 Subp. 4 Plant peration, & Maintenance seeping. A nursing home must bing and maintenance services tain a clean, orderly, and pr., including walls, floors, fixtures, equipment, lighting,	21695			1/31/20
	by: Based on observat review, the facility to comfortable and ho	tion, interview and document failed to ensure a sanitary, omelike environment for 1 of 2 viewed with environmental		Corrected.		

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21695 Continued From page 54 21695 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.

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HSK-B stated she just started her second week

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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

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designee could review and revise policies and

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PRINTED: 01/30/2020 FORM APPROVED Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21695 Continued From page 56 21695 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. 21880 MN St. Statute 144.651 Subd. 20 Patients & 21880 1/31/20 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

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Americans Act, section 307(a)(12) shall be

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

posted in a conspicuous place.

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21880 Continued From page 57 21880 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 Corrected. 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

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positioning the computer properly. FM-B explained he had expressed multiple concerns

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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.

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The administrator was interviewed via telephone

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21880 Continued From page 59 21880 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.

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The administrator and or designee, could re-educate all staff on the policies and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
DOC NO			A. BUILDING:		C					
_		00960			12/12/2019					
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
BENEDICTINE HEALTH CENTER OF MINNEAP 618 EAST 17TH STREET MINNEAPOLIS, MN 55404										
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)						
21880	Continued From pa	age 60	21880							
		dministrator could develop a to ensure ongoing compliance.								
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty one								
21925	MN St. Statute 144 Residents of HC F	.651 Subd. 29 Patients & ac.Bill of Rights	21925		1/31/20					
	shall not be arbitra Residents must be proposed discharg justification no late discharge from the transfer to another notice shall include the proposed actio telephone number ombudsman pursu Act, section 307(a) of this right, may cl notice period ends shortened in situat control, such as a review, the accomi residents, a changi treatment program resident's welfare, prohibited by the p paying for the resid the medical record reasonable effort to without disrupting r	ers and discharges. Residents rily transferred or discharged. notified, in writing, of the e or transfer and its r than 30 days before facility and seven days before room within the facility. This e the resident's right to contest n, with the address and of the area nursing home ant to the Older Americans (12). The resident, informed hoose to relocate before the The notice period may be ions outside the facility's determination by utilization modation of newly-admitted e in the resident's medical or , the resident's own or another or nonpayment for stay unless ublic program or programs dent's care, as documented in Facilities shall make a caccommodate new residents froom assignments.								
	by: Based on interview	and document review, the		Corrected.						

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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

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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

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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

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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

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Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21925 Continued From page 63 21925 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.

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SUGGESTED METHOD OF CORRECTION:

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING_ 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET

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	21925				
	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.					
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults	21995		1/31/20		
	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.		Corrected.			
	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					

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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.

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(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

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 21995 Continued From page 66 21995 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. 22000 22000 MN St. Statute 626.557 Subd. 14 (a)-(c) 1/31/20 Reporting - Maltreatment of Vulnerable Adults

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FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 22000 Continued From page 67 22000 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

unsupervised. Under this section, a facility knows

facility and persons outside the facility, if

of a vulnerable adult's history of criminal

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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

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cares to tell them" to slow down. R23 indicated

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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

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Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 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

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staff member knocked on R380's room to administer medication per orders. However, the

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00960 12/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET BENEDICTINE HEALTH CENTER OF MINNEAP MINNEAPOLIS, MN 55404 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) 22000 Continued From page 72 22000 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

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all alleged abuse/neglect/mistreatment. The

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