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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: B8BR

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY September 5, 2014 (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Angela Richey, HFE NEII 01/07/2014
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 02/06/2014
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/27/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5266

At the time of the standard survey completed on July 15, 2013, the facility was not in substantial compliance and the conditions in the facility constituted Immediate Jeopardy (IJ) to resident health or safety. The most serious deficiency at the time of the survey was found to be an isolated deficiency that constituted immediate jeopardy (Level J), whereby corrections were required. As a result of the survey findings, the Minnesota Department of Health imposed State Monitoring effective August 4, 2013. (42 CFR 488.422)

The Centers for Medicare and Medicaid Services (CMS) imposed the following enforcement remedy:

Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective October 12, 2013

A civil money penalty for the deficiency cited at F155. (42 CFR 488.430 through 488.444)

In accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 12, 2013, due to denial of payment for new admissions.

Post Certification Revisit completed on September 5, 2013, by the Minnesota Department of Health and on August 20, 2013, by the Minnesota Department of Public Safety to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on July 15, 2013. Based on this visit, it was determined that the facility had corrected the deficiencies issued pursuant to the standard survey, completed on July 15, 2013, as of September 4, 2013. As a result of the revisit findings, the Minnesota Department of Health discontinued the Category 1 remedy of state monitoring effective September 4, 2013.

The Minnesota Department of Health recommended the following to the CMS RO. The CMS RO concurred with this recommendation. Therefore, the following remedy will remain in effect.

A civil money penalty for the deficiency cited at F155 (42 CFR 488.430 through 488.444)

The facility is no longer subject to NATCEP loss.

Effective September 4, 2013, the facility is certified for 95 skilled nursing facility beds.

Please refer to the CMS 2567B.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5266 February 6, 2014

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

Dear Mr. Brennan:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 4, 2013, the above facility is certified for:

95 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 95 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 7, 2014

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

RE: Project Number S5266024

Dear Mr. Brennan:

On July 30, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 4, 2013. (42 CFR 488.422)

On July 30, 2013, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- A civil money penalty for the deficiency cited at F155. (42 CFR 488.430 through 488.444)

In our letter of July 30, 2013, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 12, 2013, due to denial of payment for new admissions.

This was based on the deficiencies cited by this Department for a standard survey completed on July 15, 2013. The condition in the facility at the time of the standard survey constituted Immediate Jeopardy (IJ) to resident health or safety. The most serious deficiencies at the time of the survey were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On September 5, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 20, 2013, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on July 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 4, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 15, 2013, as of September 4, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 4, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of July 30, 2013:

- A civil money penalty for the deficiency cited at F155, remain in effect. (42 CFR 488.430 through 488.444)

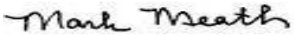
The CMS Region V Office will notify you of their determination regarding the imposed remedies.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5266r14.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245266	A. Building B. Wing	9/5/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0155** Reg. # **483.10(b)(4)** LSC	Correction Completed **08/15/2013**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **08/15/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **08/15/2013**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/14/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/15/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **08/15/2013**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/15/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **09/04/2013**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/15/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/12/2013			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245266	A. Building / B. Wing: 01 - MAIN BUILDING 01	8/20/2013

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0012	07/22/2013	ID Prefix Reg. # NFPA 101 LSC K0017	07/16/2013	ID Prefix Reg. # NFPA 101 LSC K0052	07/16/2013
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PS	01/07/2014	28120	08/20/2013
CMS RO				

Followup to Survey Completed on: 7/15/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: B8BR

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245266**

2.STATE VENDOR OR MEDICAID NO.
(L2) **196677400**

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

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/12/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **110** (L18)

13.Total Certified Beds **110** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	110			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jamie Butterfass, HFE NE II 08/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 08/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
ML Posted 8/27/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5266

A NOTC survey was completed on July 15, 2013 - deficiencies were found, the most serious at a scope and severity (S/S) level of J. The health surveyors identified an immediate jeopardy (IJ) situation on July 11, 2013 at 4:02 p.m. involving deficiency F155. The IJ was abated on July 12, 2013.

As a result, we imposed State Monitoring effective August 4, 2013 for the deficiency cited at F155. In addition, we recommended to the CMS RO imposition of the following remedy and CMS concurred:

- Civil Money Penalty effective July 12, 2013 for the deficiency cited at F155.

See attached CMS-2567 for survey results.

Also, see attached Fire Safety Evaluation System (FSES) for Life Safety Code results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3793

July 30, 2013

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

RE: Project Number S5266024

Dear Mr. Brennan:

On July 15, 2013, a standard survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 12, 2013, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3792

Fax: (651) 201-3790

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 4, 2013. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F155. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

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

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 October 12, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 12, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5266s13.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	07/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted by the Minnesota Department of Health on July 8 through July 11, 2013. The survey resulted in an Immediate Jeopardy (IJ) at F155 related to the facility's failed response to a resident's request for a change in code status from do not resuscitate/do not intubate (DNR/DNI) to full code (resuscitation) which resulted in the high potential for harm or death. The IJ began July 11, 2013, at 4:02 p.m. The IJ was removed on July 12, 2013, at 4:47 p.m. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. The facility has appealed the deficiencies and licensing violations stated herein. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance.	
F 155 SS=J	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents	F 155	It is the policy of Benedictine Health Center of Minneapolis to provide residents with information concerning resident rights and information specific to Advance Directives with the admission process. A. MD order for Full Code status was obtained on 7/11/13 for resident R34. B. On 7/11/13 audits of twenty medical	8-19-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 8-9-13

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

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F 155	Continued From page 1 concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to respond to a resident's request for a change in code status from do not resuscitate/do not intubate (DNR/DNI) to full code (resuscitation) resulting in a high potential for harm or death for 1 of 5 residents (R34) reviewed for dialysis and advanced directives. The immediate jeopardy (IJ) situation for R34 began on 6/24/13, when the facility was first made aware that the resident wanted to discuss a change in code status. The facility's administrator and director of nursing were notified of the IJ on 7/11/13, at 4:02 p.m. The IJ was removed on 7/12/13, at 4:47 p.m. but noncompliance remained at an isolated scope and severity of D (no actual harm with potential for more than minimal harm that is not an IJ). Findings include: On 7/10/13, at 11:45 a.m. R34 was interviewed through an interpreter (I)-A. I-A reported that when asked about any additional issues R34 wanted addressed with the facility, the resident had stated he wanted to be designated as a full code at the nursing home facility. I-A stated R34 reported he believed he was designated as full code at dialysis, and had asked if he could be full	F 155	records were completed with the focus of verifying current orders related to Advanced Directives were present and consistent between the physician orders and on the resident's face sheet. All were present and consistent. Just in time review/education was provided to licensed staff prior to them working their next shift related to the need to communicate with MD/NP when they have been made aware of a resident's desire to change his/her Advance Directives. The licensed staff member who is made aware of a request for change is to contact the MD/NP or the on call service for that MD/NP that shift. C. Information specific to right to formulate Advance Directives will be included with upcoming OBRA MDS 3.0 cycle for the following quarter, then with Annual or Significant Change MDS 3.0 in addition to the admission process. Resident Council Meeting on 8/16/13 will include review of the right to formulate Advance Directives. D. Random audits of resident medical records will be conducted by members	

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F 155	Continued From page 2 code at the nursing home facility a few weeks ago. R34 stated through I-A, he thought because he requested to be full code at dialysis that he would be full code at the nursing home facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home would not do anything to revive him. I-A reported R34 stated he had requested the code status change over two weeks ago, but no one had followed-up or readdressed his code status with him. R34 reported through I-A, that he had cancer of his pancreas and went to dialysis. R34's annual Minimum Data Set (MDS) dated 2/27/13, indicated a Brief Interview for Mental Status (BIMS) was not conducted. The MDS indicated R34's long term memory was intact but R34 had problems with short term memory. On 7/11/13, at 3:42 p.m. R34's designated licensed social worker (LSW)-A stated no BIMS score was completed to determine whether R34 was cognitively intact because there was a coordination issue with when the translator/interpreter was scheduled to come to the facility and when R34 would be available in the facility due to his scheduled dialysis off campus. A Nursing Progress note dated 6/24/13, at 12:48 p.m. included, "Clinical manager informed about resident's code status. Per dialysis nurse, resident would like to get an interpreter to re-evaluate and possibly change code status with facility." R34's document, My Guide for Family and Caregivers, indicated the resident had formulated a healthcare directive on 6/11/13, that indicated he did not wish for attempts at resuscitation. "I	F 155	of the interdisciplinary team specific to education provided to resident/family/legal representative in conjunction with OBRA MDS 3.0 cycle and the admission process. Audit will include review of current physician orders for code status and the process for residents to communicate their choices to ensure the residents Advance Directive wishes have been facilitated. The results of these audits will be presented to the Quality council for further discussion or action. Compliance date: 8/19/13 RECEIVED AUG - 9 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	

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F 155	Continued From page 3 wish to be allowed a natural death, to be kept comfortable, and for my loved ones to be present." A Referral Form dated 7/10/13, to the dialysis facility from the nursing home, included: "Please read! [R34] recently wanted to change back to FULL CODE. Please discuss the ramifications with him." R34's electronic medical record (EMR) was reviewed on 7/11/13, at 9:23 a.m. The EMR indicated R34 had been admitted to the facility in 2002, was non-English speaking, and had primary diagnoses including: newly diagnosed pancreatic cancer, end-stage renal disease requiring dialysis, dementia, and that R34 was legally blind. The EMR also indicated R34 was his own responsible party. R34's code status, identified on the EMR Demographic Sheet, and on the care plan dated 6/12/13, indicated R34 was a DNR/DNI code status. In addition, the advanced directives identified on a red sleeve in the front of the chart, indicated a DNR/DNI code status. On 7/10/13, at 9:49 a.m. clinical manager registered nurse (RN)-B stated that last month R34 had wanted his code status to be DNR/DNI. RN-B reported the resident had since changed his mind and wanted to have further discussion about changing his code status back to full code. RN-B stated she had just sent communication to the dialysis center that day (7/10/13), asking them to have the code status addressed with the nephrologist at dialysis with an interpreter. RN-B confirmed no other staff, to her knowledge, had attempted to obtain an interpreter to discuss with R34 his wish to re-evaluate his code status.	F 155		

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F 155	Continued From page 4 On 7/11/13, at 9:23 a.m. a licensed practical nurse (LPN)-A reported R34 returned from dialysis yesterday with a change in his code status, and now was full code. LPN-A stated she'd given the consult note to the clinical manager to process. LPN-A verified the code status had not been changed yet in R34's medical record. LPN-A stated she was R34's day nurse most of the time at the facility including today, and stated if he coded she would have provided CPR (medical intervention use to restore circulatory and/or respiratory function that has ceased). On 7/11/13 at 9:40 a.m. a nursing assistant (NA) -C reported if a resident stopped breathing or went into cardiac arrest she would immediately notify the nurse on the shift. NA-C stated she was CPR certified, but would want to inform the nurse immediately. On 7/11/13, at 9:52 a.m. LPN-A reported if a NA reported to her that a resident had stopped breathing she would immediately go check on the resident. LPN-A stated that if the resident had stopped breathing, she would have the NA run and get the chart. LPN-A also reported she would then check the chart for the advanced directive placed in the front of the paper chart in a red sleeve, to determine if the resident should have CPR. LPN-A confirmed the facility had received a communication form identifying R34's code status had been changed to full code on 7/10/13, however, the advanced directive currently in the paper chart, on the EMR face sheet, and on the care plan did not reflect the change. LPN-A stated she would initiate CPR for R34 because of the clarification sent from dialysis yesterday. LPN-A stated she had given the dialysis	F 155		

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F 155	Continued From page 5 communication form to the clinical manager to process and change in the medical record. At 10:31 a.m. LPN-A approached the surveyor and clarified she would have to follow the DNR/DNI order as noted in R34's record. On 7/11/13, at 9:59 a.m. RN-E stated if a resident had a witnessed cardiac arrest staff were expected to check the resident's face sheet in the EMR, or the advanced directive in the paper chart to determine code status. RN-E confirmed R34's face sheet identified he was DNR/DNI, therefore, would not initiate CPR. On 7/11/13, at 9:49 a.m. RN-B stated that if a NA found a resident not breathing, they were to get the nurse right away. RN-B stated the nurse would assess the resident and initiate CPR as appropriate. RN-B also reported the code status could be found in a residents' paper chart under physician orders. At 10:13 a.m. RN-B stated she sent a Referral Form (communication form) to dialysis the previous day to ask them to address R34's request that he wanted to "possibly" change his code status to full code. RN-B explained that the dialysis staff had not addressed the information sent, so the resident's code status remained DNR/DNI. RN-B stated she first became aware of R34's request to change his code status on 6/24/13, however verified no one at the facility had contacted R34's primary physician regarding the request, but they should have done so. RN-B reported she felt the dialysis staff and the nephrologist would have been a better means to have this addressed because R34 considered the dialysis staff family. RN-B confirmed dialysis staff had contacted the facility asking that they address the resident's code status on 6/24/13. RN-B stated due to the	F 155		

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F 155	Continued From page 6 language barrier, it was difficult to identify if R34 fully understood his cancer prognosis, and whether that would affect his code status decision. RN-B also confirmed the facility had not had the social worker address this with R34, had not contacted the physician, nor obtained an interpreter to clarify R34's request. RN-B stated they would expect that staff to follow residents' advanced directives in the front of their charts, or look on the face sheet in the EMR to determine the resident's code status. RN-B verified the facility had failed to address the issue for R34 earlier and should have. During this interview, the surveyor requested any additional information regarding how the facility had addressed R34's request to change his code status on 6/24/13. On 7/11/13, at 10:58 a.m. the DON stated she was aware of the resident's request to go back to full code, as that had been an issue R34 had wavered about over the past one and a half year. The DON confirmed she would have expected the primary physician to be contacted in a timely manner if a resident requested to have their code status changed. The DON also confirmed R34 considered the dialysis staff to be family, and stated that was why the facility's nursing staff had sent the clarification form regarding his code status back to dialysis staff. The DON stated she did not know the dialysis staff had initially reported R34's request to the facility staff. The DON stated the expectation was for nurses to check the EMR or the advance directive in the paper chart to determine a resident's code status prior to initiating CPR. The DON also stated R34's code status was currently DNR/DNI, but a clarification was sent to R34's primary physician (MD)-A today (7/11/13).	F 155		

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F 155	Continued From page 7 Attempts to reach the dialysis center's clinical manager on 7/11/13, at 12:29 p.m. were unsuccessful. On 7/11/13, at 2:00 p.m. the DON confirmed the facility had not contacted the MD until that day. The surveyor apprised the DON of serious concerns regarding the lack of follow up to the resident's request to change his code status, and requested the DON provide the surveyor with any additional clarifying information. On 7/11/13, at 3:31 p.m. MD-A was interviewed and stated she had not been notified prior to today of R34's request to change his code status to full code, but should have been. MD-A stated she was not happy about R34's request, but would address his wishes with him at an upcoming appointment on 7/22/13. On 7/12/13, at 9:52 a.m. LSW-A reported she had not been notified of the need for an interpreter regarding R34's request to discuss his code status. LSW-A stated she would have expected to be notified of the resident's wishes and to have been involved in the situation, but was not. LSW-A added that R34 was his own responsible party. LSW-A stated the facility had attempted to obtain a court appointed guardian in the past, however the judge had deemed R34 competent through psychological and mental testing. On 7/12/13 at 11:35 a.m., a phone interview was conducted with MD-B who stated he was aware R34's request for an interpreter to discuss code status changes had not been acted upon; and thought the request had come through an unconventional channel (a contracted	F 155		

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F 155	Continued From page 8 service-dialysis). MD-B also stated the resident "may not be cognitive to make his choices." However, MD-B also stated he believed the facility should have notified the provider. MD-B added, "Sometimes [the] provider would say don't change it yet; I'd like to discuss it with the resident; but I would expect the facility to notify the provider. And that is what I would educate the nurses on." MD-B verified it would be his expectation that the facility notify providers of resident concerns or choices for clinical care. On 7/15/13, at 12:46 p.m. MD-A reported she saw R34 today regarding his code status. MD-A stated R34 reported talking with, "a lady from Phoenix," about his code status and wanting to live. MD-A believed R34 was given false hope regarding the circumstances surrounding being revived by CPR in his condition. MD-A stated she discussed with R34 the ramifications of CPR, and believed his expectations were, "unrealistic." MD-A stated the facility should have contacted her when this issue was first brought up, because now he convinced himself to be full code without properly being informed of his condition. MD-A verified that R34 was cognitively intact and at his baseline, but did have a diagnosis of dementia. The facility's Advanced Directive Policy and Procedure dated 7/03, did not identify how the facility should address a resident's request to change their code status outside of the initial admission. R34 lacked follow up to his Advance Directive after he had requested a change in code status. The IJ that began on 6/24/13 was removed on 7/12/13 at 4:47 p.m., after the facility had reassessed the Advance Directive for R34 and	F 155		

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F 155	Continued From page 9 had received orders that recognized the resident's desire to be full code. In addition, the facility had conducted audits of other resident records to verify their Advance Directives were consistent with their choices, had verified that code status documentation was consistent with facility policy, and had conducted training for licensed staff to ensure they knew how to respond to a resident's request to modify their code status. The removal plan was verified through resident record review, through interviews of licensed staff that worked on various shifts in the facility, and through reviewing staff education that had taken place by the DON and administrator.	F 155		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide medically-related social services related to a resident's right to make changes to end of life wishes for 1 of 5 residents (R34) reviewed for dialysis. Findings include: On 7/10/13, at 11:45 a.m. R34 was interviewed through an interpreter (I)-A. I-A reported that when asked about any additional issues R34	F 250	It is the practice of Benedictine Health Center of Minneapolis to provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. A. Interpreter services were arranged for R34 on 7/10/13. B. Plans for care of current residents who require interpreter services were reviewed for presence of interventions specific to communication. C. Reviewed facility policy regarding interpreter services with licensed staff and interdisciplinary team members. D. Random audit/interview of licensed	

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F 250	Continued From page 10 wanted addressed with the facility, the resident had stated he wanted to be designated as a full code at the nursing home facility. I-A stated R34 reported he believed he was designated as full code at dialysis, and had asked if he could be full code at the nursing home facility a few weeks ago. R34 stated through I-A, he thought because he requested to be full code at dialysis that he would be full code at the nursing home facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home would not do anything to revive him. I-A reported R34 stated he had requested the code status change over two weeks ago, but no one had followed-up or readdressed his code status with him. R34 reported through I-A, that he had cancer of his pancreas and went to dialysis. R34's electronic medical record (EMR) was reviewed on 7/11/13, at 9:23 a.m. According to the record, R34 was admitted to the facility in 2002, was non-English speaking, and had primary diagnoses including newly diagnosed pancreatic cancer, end-stage renal disease requiring dialysis, dementia, and was legally blind. The EMR also indicated R34 was his own responsible party. R34's annual Minimum Data Set (MDS) dated 2/27/13, identified a Brief Interview for Mental Status (BIMS) was not conducted. The MDS noted his long term memory was intact and had problems with short term memory. On 7/11/13, at 3:42 p.m. R34's designated licensed social worker (LSW)-A stated no BIMS score was completed to determine if R34 had any cognitive issues because there was a coordination issue with when the interpreter/translator would be scheduled to come to the facility and when R34	F 250	staff by Director of Nursing/SS/Designee specific to knowledge of how to obtain interpreter services. Results of audits/interviews communicated to Quality Council for input. Compliance date: 8/19/13	

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	245266	A. BUILDING _____ B. WING _____	07/12/2013

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BENEDICTINE HEALTH CENTER OF MINNEAPOLIS	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

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F 250	Continued From page 11 was in the building. LSW-A confirmed the facility did not have a system in place to communicate to R34 when an interpreter was coming other than to explain slowing in English because R34 "knows more English than he lets on." A Nursing Progress note dated 6/24/13, at 12:48 p.m. revealed, "Clinical manager informed about residents code status. Per dialysis nurse, resident would like to get an interpreter to re-evaluate and possibly change code status with facility." R34's My Guide for Family and Caregivers indicated the resident had formulated a healthcare directive on 6/11/13, that indicted he did not wish for attempts at resuscitation. "I wish to be allowed a natural death, to be kept comfortable, and of my loved ones to be present." A Referral Form dated 7/10/13, to the dialysis facility from the nursing home noted "Please read! [R34] recently wanted to change back to FULL CODE. Please discuss the ramifications with him." R34's electronic medical record (EMR) showed on 7/11/13, at 9:23 a.m. the resident identified R34's code status on the demographic sheet and on the care plan dated 6/12/13, both indicated a do not resuscitate/do not intubate (DNR/DNI) code status. On 7/12/13, at 9:52 a.m. LSW-A reported she was not notified of a need for an interpreter regarding R34's request to discuss his code status. LSW-A stated she would have expected to be notified of the resident's wishes and to have been involved in the situation, but was not. The Facility policy Provision of Social Services	F 250		

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F 250	Continued From page 12 dated 7/03, indicated the facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial wellbeing which included: "C) Assisting staff to inform residents and those they designate; about the resident's health status and health care choices and their ramifications. D) Making referral and obtaining services from outside entities [which include interpreter services]. K) Assisting residents to determine how they would like to make decisions about their health care, and whether or not they would like anyone else to be involved in those decisions. N) Meet the needs of residents who are grieving. The types of conditions for which the facility should respond with social services by staff or referral included: inability to cope with loss of function, need for emotional support, changes in residents condition/function, presence of a chronic disabling medical conditions, lack of an effective family/social support system." Neither the social worker or nursing services assisted the resident to assure social services were met to modify the advance directives as the resident requested.	F 250		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280	It is the practice of Benedictine Health Center of Minneapolis Interdisciplinary Team to develop and re-evaluate interventions and revise the care plan based upon resident needs. A. Plan of care for R44 has been reviewed and revised. B. Care Plans for those residents with	

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F 280	Continued From page 13 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to re-evaluate interventions and revise the care plan to promote healing and prevent further skin breakdown for 1 of 4 residents (R44) reviewed for pressure ulcers and R44 developed a Deep Tissue Injury (DTI- purple or maroon area of discolored intact skin due to damage of underlying soft tissue) at the facility. Findings include: The care plan for R44 had not been revised to reflect new open area which was identified on 6/19/13. The care plan did not include any revisions to the interventions to prevent further skin breakdown and to promote healing. Closed record review indicated R44 was discharged to the hospital on 7/9/13, with left distal tibia/ fibular fracture. A physician progress note dated 6/19/13, indicated R44 was diagnosed with DTI on both buttocks, measuring 2 x 2 centimeter (cm) on right buttocks, and 1 x 3 cm on the left buttocks	F 280	alterations in skin integrity have been reviewed for presence of interventions consistent with their individual risk factors. C. Review of expectations related to care plan review and revision with interdisciplinary team. D. Random audit of care plans specific to the inclusion of resident specific skin integrity risk factors by Director of Nursing or designee. Audit results or findings to be communicated to members of the interdisciplinary team and then to Quality Council for input. Compliance date: 8/19/13	

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F 280	Continued From page 14 The facility failed to reassess rick factors, and failed to revise care plan interventions to promote healing, and prevent further skin breakdown. As a result the right buttock DTI developed into an unstageble pressure ulcer. R44's electronic medical record (EMR) noted R44 was admitted to the facility on 9/6/12, and had diagnoses included schizoaffective disorder and borderline personality disorder, diabetes, Right above the knee amputation, depressive disorder, osteoarthritis, and obesity. The physician progress note dated 6/19/13, also indicated the DTI areas on R44 were "purple in color" with a small open area measuring 0.5 x 0.5 cm, and Calmoseptine ointment (a multipurpose moisture barrier) was initiated two times a day. Further record review indicated lack of reassessment of the skin risk factors, and lack of care plan updating after the DTI was identified on 6/19/13. The nurses progress notes review revealed the following: - On 6/17/13, the note indicated "Black area noted on buttocks. Tena [brand name] protective cream applied. Writer left a message for clinical manager. Unable to measure due to pain in area when touched." - On 6/22/13, the note indicated "Resident presents with an area of eschar [thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue] 5.2cmx5 cm on his right buttock. Scant bleeding from edges with a thin slough [non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture] also noted on the	F 280		

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F 280	Continued From page 15 edges. Tena cream applied as ordered, resident is also c/o [complaint of] pain in the area." - On 6/26/13, the note indicated resident refused shower, but agreed to a bed bath, "Skin assessed and noted coccyx wound about 4.55 cm with slough and pink/red edges with small bleeding." The note also indicated resident stated "area to be very painful." - On 7/3/13, the note indicated a bed bath was given, and skin assessment completed, and the right was "about 3.5 x 3 cm with slough and red edges with scant amount of bleeding." - There were no additional notes found related to skin monitoring, and resident was discharged to the hospital on 7/9/13. The quarterly Minimum Data Set dated 6/11/13, indicated resident was at risk for pressure ulcer, and had no unhealed pressure ulcers. The skin care plan dated 9/12/12, indicated "Alteration in skin integrity" related to chronic venous stasis, diabetes, maceration related moisture, and listed approaches which included: "monitor for indication of infection, contact MD [physician] if present", "Turning and Repositioning based on tolerance of tissue to pressure", and "Treatment/dressing per MD orders." The mobility care plan also indicated "One staff to turn and reposition every 2 hours." The care plan did not indicate presence of acquired pressure ulcer from 6/19/13. Per the care plan " resident resists care at times." The plan of care was not revised with new intervention when the DTI was identified on 6/19/13, or later when the DTI developed into an unstageble pressure ulcer. The registered nurse (RN)-B nurse manager was interviewed on 7/12/13 at 10:30 a.m. and stated	F 280		

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F 280	Continued From page 16 she was not aware that resident had DTI wounds on his bottom. The RN-B explained she did not read the physician's progress notes, since she was present during the assessment, and was under the impression that R44's wounds were "shearing" related. The RN-B also stated that as per the facility's policy a reassessment was completed each time when a new wound was noted in order to identify the risk factors by completing the Braden assessment, and new tissue perfusion test. The RN acknowledged R44 was not reassessed to identify risk factors, there was no Braden tool (used to determine risk for developing pressure ulcer) completed, or tissue perfusion test completed. Per the RN-B "pressure was a risk factor" as R44 sat in the wheel chair, and laid in the bed. The RN-B also stated she have not seen R44's wounds since the initial assessment on 6/19/13, and the wound nurse have never seen them either. The RN-B further stated after reviewing the progress notes from 6/22/13, 6/26/13 and 7/3/13, that R44's DTI turned into and unstageble pressure ulcer, which she was not "aware of." The RN-B reviewed R44's treatment record and stated the Calmoseptine ointment treatment which was initiated on 6/19/13, was not changed when the DTI developed into an unstageble pressure ulcer, and as per the progress notes, the physician was not notified either. The facility's Skin Integrity - Pressure Ulcers policy undated, indicated "Licensed Nurse will assess all residents' skin upon admission, readmission to facility, quarterly, and when at risk for development of ulcer, or when pressure ulcer is discovered." The Notification/Documentation/Interventions procedure included:	F 280		

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F 280	Continued From page 17 "a. Initial summary of a pressure area should be documented in the resident's clinical notes and on any facility specific forms. b. If more than one pressure ulcer, each area should have a separate entry/form. c. Braden score form should be completed. "The policy also indicated: "g. Initiate and implement appropriate measures in plan of care and update as treatment/intervention change." The policy also indicated physician to be notified any time there was a "significant" change, "as increasing Stage." Although the record indicated R44 resisted cares due to his borderline personality, the staff did not reassess R44 to identify risk factors, and did not re-evaluate effectiveness of the interventions to prevent R44 from further skin breakdown.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for grooming assistance for 1 of 2 residents (R77) reviewed for nail care. Also, the facility failed to ensure that services provided by the facility staff met the professional standards of quality care for 2 of 3 residents (R78, R35) observed for indwelling Foley catheter (brand name - a urine collection device) care.	F 282	It is the practice of Benedictine Health Center of Minneapolis to provide services in accord with each resident's written plan of care. A. Nail care was completed for R77 on 7/11/13. R 35 and R78, refer to education below. B. Plans of care for other current residents with urinary catheters were reviewed and revised if indicated. Reviewed policy and expectations related to urinary catheter care with RN's, LPN's and NA/R's. Education included	

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F 282	Continued From page 18 Findings include: R77 was not provided assistance with grooming (which included nail care) as directed by the care plan. The care plan dated 9/26/11, identified R77 had an alteration in ability to groom related to right ischemic brain injury, diabetes mellitus uncomplicated type 2, left hemiplegia, balance problems, inconsistent ability to follow directions and spasticity. R77's care plan focus goal directed for R77 "will be well groomed." The Nursing Care Work Sheet dated 7/10/13, directed R77 required assistance of one with activities of daily living (ADL's) and R77's bath day was Monday second shift. On 7/8/13, at 2:47 a.m. during initial interview observed finger nails (approximately one fourth inch in length). On 7/8/13, at 5:58 p.m. during interview with family member (F)-A stated there was no enough help for R77 when it comes to nails care. F-A stated occasionally was able to clip the nails but believed someone in the facility should be responsible for clipping the nails. F-A further stated sometimes when visiting R77's nails are long and had to get someone to do them when visiting. On 7/9/13, at 8:40 a.m. observed R77 in the dining room nails long having breakfast. On 7/10/13, at 7:18 a.m. to 7:40 a.m. during continuous morning cares observation, nursing assistant (NA)-A provided R77 assistance with	F 282	maintaining location of tubing and drainage bag below the level of the bladder. Review of policy and expectations related to nail care. C. Random audit of ADL cares and transfers of residents with urinary catheters with focus on catheter tubing/bag remaining below the level of the bladder. Random audit of grooming specific to nail care. Audits by facility staff as directed by Director of Nursing or designee. D. Results of audits communicated to Quality Council for input. Compliance Date: 8/19/13	

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F 282	Continued From page 19 ADLs but not nail care. On 7/10/13, from 8:23 a.m. to 9:30 p.m. R77 was observed to be assisted by various staff and was not provided assistance with nail care. On 7/10/13, at10:42 a.m. interviewed NA-A regarding R77's nail care. NA-A stated it is completed on R77's bath day on Monday evening and verified looking at the nursing care work sheet. On 7/10/13, at 3:15 p.m. observed R77 up in the TV lounge on the Broda chair (tilt and recline positioning wheelchair) tipped slightly with pillow under his head nails still long observed NA-G standing to R77's right side spoke with R77 and then left. On 7/10/13, at 3:22 p.m. interviewed NA-G stated was assigned to R77 on the second shift and had been informed by nurse that R77 was to be toilet and repositioned at 4:00 p.m. NA-G further stated when observed by R77 NA-G was checking to see if R77 required anything as this was at the beginning of the shift. On 7/11/13, at 10:15 a.m. interviewed registered nurse/clinical nurse manager (RN)-E who stated there was no charting completed that the bath had been completed but expected staff to chart if a resident refused. RN-E further stated the expectation was any staff would assist with nail care if they noticed it was a problem as needed and not just on the bath day. The RN-E acknowledged the nails were long to surveyor and stated the nails needed to be trimmed. On 7/11/13, at 3:07 p.m. interviewed director of	F 282		

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F 282	Continued From page 20 nursing (DON) stated she expects nail care to be completed with resident bath and if not able to be completed the aide was expected to let the nurse know. Resident nail care can be completed by any nursing staff who notices nail care was needed for the resident unless there were other circumstances that stated otherwise. DON further stated staff was expected to follow the resident care plan during care provision. The DON also confirmed that staff was expected to follow the resident care plan when providing care. The policy and procedure dated 5/12/11, titled Nail Care, indicated "nail care will be provided to the residents on their shower day and as needed. Licensed nurse will cut the nails of a resident with diabetes." R78's urine drainage bag was kept on the bed for over half an hour during morning cares, was raised to R78's chest level during mechanical lift transfer, and the Foley catheter was not anchored to minimize pulling and stretching of the catheter. R78's care plan dated 4/24/13, indicated R78 had alteration in urinary function, and R78 was with long term Foley catheter use. The care plan directed staff to provide, "Catheter care per policy and standard of practice." The care plan also noted R78's diagnoses included dementia with behavior disturbances, chronic kidney disease, bipolar disorder and anxiety. R78 was on hospice and had long term Foley catheter use. R78 was observed during cares on 7/10/13, from 7:35 a.m. to 8:10 a.m. The nursing assistant (NA) -E washed hands, applied a pair of gloves, and	F 282		

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F 282	Continued From page 21 filled the sink with water. NA-B had prepared a towel and washcloths on the bed. NA-B removed the Foley catheter drainage bag from the black protector bag attached to the side of the bed and laid it on the top of the sheets in between R78's legs. The Foley catheter was observed, and was not secured to R78's thigh. After completing the morning cares R78 was transferred to the wheel chair with two staff assist and a Hoyer mechanical lift at 7:56 a.m. NA-E raised the Foley catheter drainage bag and hooked it to the sling, the urine drainage bag was at R78's chest level high during the transfer. When interviewed right after the observation on 7/10/13, at 8:10 a.m. NA-E stated they attached the catheter drainage bag to the sling to ensure safety of the catheter and bag. The NA-E also stated there was nothing special they had to do for the Foley catheter care. The infection control and staff development director/registered nurse (RN)-F was interviewed on 7/11/13, at 12:12 p.m. and stated the Foley catheter needed to be secured all the time to resident's thigh by using the multi-purpose tube holder, and presented the tube holder staff were expected to use. The RN-F verified the urine drainage bag, noted the anti-reflux was located where the drainage tube connected to the drainage bag, and confirmed the urine collected in the tube was at risk to back flow if drainage bag was raised above the bladder level. The RN-F stated staff was expected to keep/store the urine drainage bag below the bladder level at all times. R35's Foley catheter drainage bag was hanging	F 282		

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F 282	Continued From page 22 on the lift sheet above the bladder and urine collected in the tubing was observed flowing backwards on 7/11/13, at 8:44 a.m. R35 diagnoses included terminal illness, debility, legally blind, encounter with palliative care-hospice care, osteoporosis, osteoarthritis, unspecified site DJD (degenerative joint disease), and glaucoma. The care plan revised 7/9/13, identified R35 required an indwelling urinary catheter related to terminal illness which made positioning uncomfortable. R35's care plan focus goal directed R35, "Will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma." On 7/11/13, at 8:44 a.m. R35 Foley catheter drainage bag was observed lying on top of the bed in level with the resident's body. NA-F stated she had just completed getting R35's Foley catheter through the pants and was going to get help to get R35 out of bed. During the time R35 was being transferred to the Broda chair (specialized wheelchair) NA-F was observed hanging the Foley catheter drainage bag on the lift sheet between R35's legs above the bladder throughout the transfer. The urine collected in the tubing was observed flowing backwards. On 7/11/13, at 9:07 a.m. NA-F stated she usually had to pass the catheter through the pants and leaves it right there as observed early. NA-F added she usually she placed the Foley catheter drainage bag on the lower side of the lift sheet when transferring R35. NA-F stated she understands R35 could have a high likelihood of getting infections if the urine was to flow back to	F 282		

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F 282	Continued From page 23 the bladder. NA-F further stated she understood the urine has to drain downward and that the Foley catheter drainage bag needed to be positioned below the bladder when transferring R35. On 7/11/13, at 9.15 a.m. RN-D stated R35's Foley catheter drainage bag had to be kept below the bladder to prevent urine back flow. RN-D was unclear if the Foley catheter drainage bag had an anti-back flow valve but later provided a Foley catheter drainage bag from medication room that indicated the drainage bag had an anti-reflux chamber. RN-D was still unclear about urine in the tube having a back flow On 7/11/13, 10:33 a.m. RN-E stated her expectation was staff to keep the Foley catheter drainage bag below the bladder to promote urine flow when staff transferred residents with catheters. On 7/11/13, at 1:14 p.m. RN-F stated Foley catheter drainage bag should be kept below the bladder level and ideally staff could leave the bag still hanging at the side of the bed during transfers and have the wheelchair moved closed to the bed keep it below bladder level. RN-F further showed that the anti-reflux chamber valve was located on the catheter bag and not the tube. RN-F confirmed there could be the potential of urine back flow to the bladder if Foley was set above the bladder level. On 7/11/13, at 3:10 p.m. the director of nursing stated she expected staff to keep the catheter below the bladder level during transfers and she further stated the bags had a built in valve to prevent urine back flow on the drainage bag.	F 282		

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F 282	Continued From page 24 The catheter care - urinary policy dated 12/2002, indicated "Check to ensure drainage bag is lower than bladder". The Centers of Disease Control (CDC) Guideline for Prevention of Catheter-associated Urinary Tract Infections dated 2009, recommended under section 4. listed "4. Indwelling catheters should be properly secured after insertion to prevent movement and urethral traction. The recommendations under section 8. indicated "4) collecting bags should always be kept below the level of the bladder."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each resident received necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, related to dialysis access site care for 1 of 1 resident (R34) reviewed for dialysis. Findings include:	F 309	It is the practice of Benedictine Health Center of Minneapolis to provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. A. Plan of care for R34 was revised to reinstate order that had been present prior to hospitalization which directed removal of dressing at 9:00 PM on dialysis days. B. Review/revision of plan of care for other resident(s) presently receiving hemodialysis for presence of directions specific to dialysis dressing removal.	

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F 309	Continued From page 25 R34's dialysis access site dressing was not removed after dialysis to reduce the risk of access site infection. Physician orders signed on 6/17/13, did not identify specific instructions for care of the shunt site dressing. R34's care plan updated on 7/11/13, identified he received dialysis three times a week and had a left upper extremity fistula dialysis access site. The care plan instructions from 5/4/09, included:, "Shunt site dressing to be only per MD [medical doctor] orders." The plan of care identified on 12/20/11, that R34 had limited vision and required an interpreter. R34's plan of care included diagnoses not limited to: pancreatic cancer, end stage renal disease requiring dialysis, and poor vision. On 7/9/13, at 3:28 p.m. R34 was sitting up in his wheelchair wearing a long sleeved shirt. R34 spoke only Spanish. This writer pointed to his left upper arm. R34 rolled up his sleeve and showed the surveyor his dialysis access site. There were two separate dressings on the access. Both were areas were coved with soiled gauze and tape. R34 was at dialysis the prior day and the dressing over his left upper shunt dialysis access site had not been removed. The tape over the dressing was loose. On 7/9/13, at 3:30 p.m. registered nurse (RN)-A reported she frequently worked with R34. RN-A stated R34 moved the floor about a month ago. RN-A added that since R34 had been on the unit she had not removed the dressing on R34's left upper arm over his access site after dialysis. RN-A stated that to monitor for infection, she	F 309	C. Random audits by Clinical Manager or designee for removal of dressings post dialysis as per plan of care. D. Results of audits communicated to Quality Council for input. Compliance date: 8/19/13	

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F 309	Continued From page 26 moved the gauze and tape on the access site to the side, looks at the area's, then puts the same gauzes and tape over the site. RN-A reviewed R34's treatment sheet and physician orders at that time and confirmed there was no order or treatment indicating to remove the dressing on the dialysis access site after dialysis. At 3:33 p.m. RN-E stated staff do not remove the access bandage over R34's access site on off dialysis days because he wheeled himself around and did not want it to bleed. On 7/10/13, at 9:49 a.m. clinical manager, RN-B confirmed R34 had an upper arm fistula in his left arm. RN-B reviewed the treatment sheets for the last nine days and confirmed there was no order for how staff should manage R34's shunt site dressing. RN-B was not aware staff was not removing the dressing after treatment on non-dialysis days or if this was recommended. At 1:33 p.m. RN-B stated R34 had a dressing change order that was not reactivated when he came back from the hospital on 6/3/13. RN-B reported the order instructed staff to take off the dialysis dressing on dialysis days at 9:00 p.m. RN-B confirmed the dressing had not been removed since he was re-admitted from the hospital and transferred from her unit. RN-B verified staff should have been removing the dressing to reduce risk of access infection. On 7/10/13, at 11:45 a.m. through an interpreter (I)-A, R34 stated on the other unit, staff took off his dialysis dressing but since he moved to this unit and they do not. The facility policy for Care of Arteriovenous Fistulas and Arteriovenous Grafts undated, identified that care involves the primary goals of	F 309		

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F 309	Continued From page 27 preventing infection and maintaining patency of the catheter (preventing clots). The policy identified to keep the access site clean at all times.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident received grooming assistance for nail care for 1 of 2 residents (R77) reviewed for activities of daily living (ADLs). Findings include: R77's quarterly Minimum Data Set (MDS) dated 6/3/13, identified R77 was cognitively impaired with Brief Interview for Mental Status (BIMS) score of three (indicating severe cognitive loss), required total dependence with ADLs. The Care Area Assessment (CAA) for communication dated 9/12/12, identified R77 was dependent on staff for ADLs. R77's diagnoses included multiple sclerosis, hemiplegia non-dominant side, dementia, right ischemic brain injury, diabetes mellitus uncomplicated type II, and intracranial injury severe cognitive deficits. The care plan dated 9/26/11, identified R77 had	F 312	It is the practice of Benedictine Health Center of Minneapolis to ensure residents receive grooming assistance based upon their individual needs. Refer to Plan of action as noted in F 282	8-19-13

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F 312	Continued From page 28 an alteration in ability to groom related to the above diagnoses. R77's care plan focus goal directed R77, "Will be well groomed." The Nursing Care Work Sheet dated 7/10/13, directed R77 required assistance of one with ADLs and R77's bath day was Monday second shift. On 7/8/13, at 2:47 a.m. during initial interview R77's finger nails on both hands were observed to be long and untrimmed (approximately one fourth [1/4] inch in length). On 7/8/13, at 5:58 p.m. R77's family member was interviewed (F)-A. F-A stated there was not enough help for R77 when it came to nail care. F-A stated they occasionally were able to clip the nails, but believed someone in the facility should be responsible for clipping the nails. F-A further stated sometimes when visiting, R77's nails were long and F-A had to get someone to cut them when visiting. On 7/9/13, at 8:40 a.m. R77 was observed to have long nails on both hands while having breakfast in the dining room. During continuous observations on 7/10/13, the following was observed: - From 7:18 a.m. to 7:40 a.m. R77's morning cares were observed. Nursing assistant (NA)-A was observed to provide R77's daily cares which included a bed bath, applying lotion, dressing, pericare, combing R77's hair and oral care. R77's nails were visible as R77 participated during cares and were untrimmed and approximately 1/4 inch long. At no time during the observation did NA-A offer nail care to R77. - At 7:42 a.m. NA-A stated the morning cares were complete except for shaving R77. NA-A	F 312		

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F 312	Continued From page 29 stated shaving would be completed after breakfast. NA-A was observed to wheel R77 out of the room and stationed R77 by the window in the dining room. - From 7:43 a.m. to 8:23 a.m. R77 was observed sitting in the dining room looking around with a side table across his lap waiting for breakfast. - From 8:23 a.m. to 8:33 a.m. NA-B was observed assisting R77 with breakfast set-up and to sit next to R77 and assist him with eating. R77 independently drank his fluids. - At 8:34 a.m. R77 completed eating his breakfast. NA-B took R77's tray back to the cart. - From 8:34 a.m. to 8:55 a.m. R77 was observed to sit in the dining room drinking a second cup of coffee. - From 8:56 a.m. to 10:02 a.m. NA-A wheeled R77 to the television room across from the dining room. R77 requested more juice and was observed to be watching television during this time. - At 10:03 a.m. R77 fell asleep in front of the television. At no time during the observation were nail cares offered. On 7/10/13, at 10:42 a.m. NA-A was interviewed regarding R77's nail care. NA-A stated nail care was completed on R77's bath day Monday evening (7/8/13) and verified this by looking at the nursing care work sheet. NA-A stated it was not always easy to clip R77's nails due to excessive movements. On 7/10/13, at 3:22 p.m. NA-G was observed standing next to R77. NA-G touched and looked at R77 then walked away. The long nails were visible. At the time of the observation NA-G confirmed she was assigned to R77 on the second shift (evening shift), and stated she was	F 312		

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F 312	Continued From page 30 checking to see if R77 needed any assistance but R77 was asleep. Nail care was not offered. On 7/11/13 at 10:15 a.m. the registered nurse/clinical nurse manager (RN)-E stated there was no charting completed that the bath had been completed but expected staff to chart if a resident refused. RN-E further stated the expectation was any staff would assist with nail care if they noticed it was a problem as needed and not just on the bath day. The RN-E observed the nails with the surveyor, acknowledged the nails were long and stated the nails needed to be trimmed On 7/11/13, at 3:07 p.m. the director of nursing (DON) stated she expected nail care to be completed with resident bath and if not able to be completed, the aide was expected to let the nurse know. DON stated resident nail care could be completed by any nursing staff who noticed nail care was needed for the resident. The DON also confirmed that staff was expected to follow the resident care plan when providing care. The Nail Care policy and procedure dated 5/12/11, titled Nail Care, identified, "Nail care will be provided to the residents on their shower day and as needed. Licensed nurse will cut the nails of a resident with diabetes."	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that	F 314	It is the philosophy of Benedictine Health Center of Minneapolis to provide a skin integrity program that includes prevention, care and treatment of pressure ulcers to promote healing.	

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F 314	Continued From page 31 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively reassess, adequately monitor and revise interventions when a Deep Tissue Injury (DTI- purple or maroon area of discolored intact skin due to damage of underlying soft tissue) was identify for 1 of 4 residents (R44) in the sample reviewed with pressure ulcers. Findings include: Closed record review indicated R44 was discharged to the hospital on 7/9/13, with left distal tibia/ fibular fracture. A physician progress note dated 6/19/13, indicated R44 was diagnosed with DTI on both buttocks, measuring 2 x 2 centimeter (cm) on right buttocks, and 1 x 3 cm on the left buttocks The facility failed to reassess rick factors, implement interventions to promote healing, and prevent further skin breakdown. As a result the right buttock DTI developed into an unstageble pressure ulcer. R44 was admitted to the facility on 9/6/12, with diagnoses that included schizoaffective disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder, osteoarthritis, and obesity. The physician progress note dated 6/19/13, also indicated the DTI areas on R44 were "purple in	F 314	A. R44 was comprehensively reassessed by the interdisciplinary team specific to skin breakdown. Per MD and Wound Nurse, appropriate interventions were in place for resident. As of 8/2/13, areas identified were healed per wound nurse. Of note: R44's multiple comorbid conditions and well established historical pattern of noncompliance have been more clearly delineated in plan of care. B. Review of medical records of other residents with alteration in skin integrity for presence of comprehensive skin risk assessment, monitoring and revisions if indicated. C. Review/reeducation of licensed staff specific to expectations related to actions to be taken if skin breakdown is identified. D. Random audit by Director of Nursing or designee for compliance with actions to be taken. Results of audits communicated to Quality Council for input. Compliance date 8/19/13	

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F 314	Continued From page 32 color" with a small open area measuring 0.5 x 0.5 cm, and Calmoseptine ointment (moisture barrier cream) was initiated two times a day. Further record review indicated lack of reassessment of the skin risk factors after the DTI was identified on 6/19/13. The nurses progress notes review revealed the following: - On 6/17/13, the note indicated, "Black area noted on buttocks. Tena (brand name) protective cream applied. Writer left a message for clinical manager. Unable to measure due to pain in area when touched." - On 6/22/13, the note indicated, "Resident presents with an area of eschar [thick, leathery, frequently black or brown in color, necrotic (dead) or devitalized tissue] 5.2 cm x 5 cm on his right buttock. Scant bleeding from edges with a thin slough [non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture] also noted on the edges. Tena cream applied as ordered, resident is also c/o [complaint of] pain in the area." - On 6/26/13, the note indicated resident refused shower, but agreed to a bed bath, "Skin assessed and noted coccyx wound about 4.5 x 5 cm with slough and pink/red edges with small bleeding." The note also indicated resident stated "area to be very painful." - On 7/3/13, the note indicated a bed bath was given, and skin assessment completed, and the right was "about 3.5 x 3 cm with slough and red edges with scant amount of bleeding." - There were no additional notes found related to skin monitoring, and resident was discharged to the hospital on 7/9/13.	F 314		

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F 314	Continued From page 33 The quarterly Minimum Data Set dated 6/11/13, indicated resident was at risk for pressure ulcer, and had no unhealed pressure ulcers. The skin care plan dated 9/12/12, indicated "Alteration in skin integrity" related to chronic venous stasis, diabetes, maceration related moisture, and listed approaches which included: "monitor for indication of infection, contact MD if present", "Turning and Repositioning based on tolerance of tissue to pressure", and "Treatment/dressing per MD orders." The mobility care plan also indicated "One staff to turn and reposition every 2 hours." The care plan did not indicate presence of acquired pressure ulcer from 6/19/13. Per the care plan "resident resists care at times." The registered nurse (RN)-B nurse manager was interviewed on 7/12/13 at 10:30 a.m. and stated she was not aware that resident had DTI wounds on his bottom. The RN-B explained she did not read the physician's progress notes, since she was present during the assessment, and was under the impression that R44's wounds were " shearing " related. The RN-B also stated that as per the facility's policy a reassessment was completed each time when a new wound was noted in order to identify the risk factors by completing the Braden assessment, and new tissue perfusion test. The RN acknowledged R44 was not reassessed to identify risk factors, there was no Braden tool (used to determine risk for developing pressure ulcer) completed, or tissue perfusion test completed. Per the RN-B "pressure was a risk factor " as R44 sat in the wheel chair, and laid in the bed. The RN-B also stated she had not seen R44's wounds since the initial assessment on 6/19/13, and the wound nurse	F 314		

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F 314	Continued From page 34 had never seen them either. The RN-B further stated after reviewing the progress notes from 6/22/13, 6/26/13 and 7/3/13, that R44's DTI turned into and unstageble pressure ulcer, which she was not "aware of.". The RN-B reviewed R44's treatment record and stated the Calmoseptine ointment treatment which was initiated on 6/19/13, was not changed when the DTI developed into an unstageble pressure ulcer, and as per the progress notes, the physician was not notified either. The facilities wound nurse (WN) was interviewed on 7/12/13, at 11:10 a.m. and stated she was informed in June 2013 that R44 had a shearing caused wound on the bottom, however she haven't seen R44's wounds, since the one time she was on the floor R44 refused to lay down, and since that she have not received an update from staff. The WN stated she did not want to "speculate," or give her opinion since she have not seen the wound, but based on what kind the wound was she wound recommend the usage of hydrogel to help liquefy the slough or eschar. The medical director (MD) was interviewed on 7/12/13, at 11:45 a.m. and stated he was on vacation for two weeks from 6/21/13, and the other two covering physicians were not updated by staff when R44's DTI on the right buttocks developed into an unstageble pressure ulcer. The physician explained R44 was explained the risks and benefits of his refusals with care, and that R44 " was aware of the consequences of his action." The director of nursing (DON) was interviewed on 7/12/13, at 12:25 p.m. and stated she was not aware of R44 had DTI on the bottom, and was	F 314		

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	245266	A. BUILDING _____ B. WING _____	07/12/2013

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

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F 314	Continued From page 35 not updated when it turned into unstageble pressure ulcer. The DON also stated staff was expected to reassess residents with newly acquired wounds to identify risk factors such as shearing, pressure, and complete at least the Braden and discuss all the risk factors included in the Braden assessment (sensory perception, moisture, activity, mobility, nutrition, friction and shear). The facility's Skin Integrity- Pressure Ulcers policy undated, indicated "Licensed Nurse will assess all residents' skin upon admission, readmission to facility, quarterly, and when at risk for development of ulcer, or when pressure ulcer is discovered." The Notification/Documentation/Interventions procedure included: "a. Initial summary of a pressure area should be documented in the resident's clinical notes and on any facility specific forms. b. If more than one pressure ulcer, each area should have a separate entry/form. c. Braden score form should be completed." The policy also indicated: "g. Initiate and implement appropriate measures in plan of care and update as treatment/intervention change." The policy also indicated physician to be notified any time there was a "significant" change, "as increasing Stage." Although the record indicated R44 resisted cares due to his borderline personality the staff did not reassess R44 to identify risk factors, and did not re-evaluate effectiveness of the interventions to prevent R44 from further skin breakdown.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315	It is the practice of Benedictine Health Center of Minneapolis to ensure that residents receive	

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F 315	Continued From page 36 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Base on observation, interview and document review, the facility failed to ensure indwelling Foley catheter tubing and drainage bags were handled in a manner to prevent urine back flow and reduce the potential risk of bladder infection for 2 of 3 residents (R35, R78) reviewed for urinary catheter use. In addition, the facility failed to ensure the Foley catheter was anchored to prevent excessive tension on the catheter for 1 of 3 residents (R78). Findings include: R78's urine drainage bag was kept on the bed for over half an hour during morning cares, was raised to R78's chest level during mechanical lift transfer, and the Foley catheter was not anchored to minimize pulling, stretching of the catheter. R78's diagnosis included dementia with behavior disturbances, chronic kidney disease, bipolar disorder and anxiety. R78 was on hospice and had long term Foley catheter use.	F 315	nursing cares in a manner that does not allow urine to flow back into the bladder from indwelling catheter tubing. Refer to plan of action as noted in F 282 9-9-13	

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F 315	Continued From page 37 The care plan dated 4/24/13, indicated R78 had alteration in urinary function, and R78 was with long term Foley catheter use. The care plan directed staff to provide "Catheter care per policy and standard of practice." R78 was observed during cares on 7/10/13, from 7:35 a.m. to 8:10 a.m. The nursing assistant (NA) -E washed hands, applied a pair of gloves, and filled the sink with water. NA-B had prepared a towel and washcloths on the bed. NA-B removed the Foley catheter drainage bag from the black protector bag attached to the side of the bed and laid it on the top of the sheets in between R78's legs. The Foley catheter was observed, and was not secured to R78's thigh. After completing the morning cares R78 was transferred to the wheel chair with two staff assist and a Hoyer mechanical lift at 7:56 a.m. NA-E raised the Foley catheter drainage bag and hooked it to the sling, the urine drainage bag was at R78's chest level high during the transfer. When interviewed NA-E stated they attached the catheter drainage bag to the sling to ensure safety of the catheter and bag. The NA-E also stated there was nothing special they had to do for the Foley catheter care. The infection control & staff development director registered nurse (RN)-F was interviewed on 7/11/13, at 12:12 p.m. and stated the Foley catheter needed to be secured all the time to resident's thigh by using the multi-purpose tube holder, and presented the tube holder staff were expected to use. RN-F verified the urine drainage bag, noted the anti-reflux was located where the drainage tube connected to the drainage bag, and confirmed the urine collected in the tube was	F 315		

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F 315	Continued From page 38 at risk to back flow if drainage bag was raised above the bladder level. RN-F stated staff were expected to keep/store the urine drainage bag below the bladder level at all times. On 7/11/13, at 8:44 a.m. R35's Foley catheter drainage bag was obseved hanging on the lift sheet above the bladder and urine collected in the tubing was observed flowing backwards. R35 diagnoses included terminal illness, debility, legally blind, encounter with palliative care-hospice care, macular degeneration, bilateral hearing loss, bilateral hip replacement, anemia, osteoporosis, osteoarthritis, unspecified site degenerative joint disease, and glaucoma. The quarterly Minimum Data Set (MDS) dated 6/03/13, identified R35 required total dependence with activities of daily living (ADL's) including toileting. The Care Area Assessment (CAA) for urinary incontinence and indwelling catheter dated 9/14/12, identified R35 was dependent on staff for toileting assistance. The care plan dated revised 7/9/13, identified R35 required an indwelling urinary catheter related to terminal illness which made positioning uncomfortable. R35's care plan focus goal directed R35, "Will have catheter care managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma." On 7/11/13, at 8:44 a.m. R35's Foley catheter drainage bag was observed lying on top of the bed in level with resident body to resident lower	F 315		

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F 315	Continued From page 39 feet. NA-F stated she had just completed getting resident Foley catheter through pants and was going to get help to get R35 out of bed. During the time R35 was being transferred to the broda chair (specialized wheelchair) NA-F was observed hanging the Foley catheter drainage bag on the lift sheet between R35's legs above bladder throughout the transfer. The urine collected in the tubing was observed flowing backwards. On 7/11/13, at 9:07 a.m. NA-F stated she usually had to pass the catheter through the pants and usually puts it on the lower side of the lift sheet when transferring R35. NA-F stated she understood R35 could have a high likelihood of getting infections if the urine were to flow back to the bladder. NA-F further stated she understood the urine has to drain downward the Foley catheter drainage bag and needed to be positioned below the bladder when transferring R35. On 7/11/13, at 9:15 a.m. RN-D stated R35 's Foley catheter drainage bag had to be kept below the bladder to prevent urine back flow. RN-D was unclear if the Foley catheter drainage bag had an anti-back flow valve but later provided a Foley catheter drainage bag from the medication room that indicated the drainage bag had an anti-reflux chamber. RN-D was still unclear if the anti-reflux chamber valve in the bag could prevent urine back flow in the tubing. On 7/11/13, 10:33 a.m. the Registered Nurse/Clinical Nurse Manager (RN)-E stated her expectation was staff to keep the Foley catheter drainage bag below the bladder to promote urine flow when staff are transferring the residents with	F 315		

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F 315	Continued From page 40 catheters. On 7/11/13, at 1:14 p.m. RN-F stated Foley catheter drainage bag should be kept below the bladder level and ideally staff could leave the bag still hanging at the side of the bed during transfers and kept the wheelchair moved closed to the bed to keep the Foley below bladder level. RN-F further showed that the anti-reflux chamber valve was located on the catheter bag and not the tube. RN-F confirmed there could be the potential of urine back flow to the bladder if Foley was set above the bladder level. On 7/11/13, at 3:10 p.m. the director of nursing stated she expected staff to keep the catheter below the bladder level during transfers and she further stated the bags had a built in valve to prevent urine back flow on the drainage bag. The associate product manager of the Foley catheter manufacturer company in an e-mail on 7/19/13, at 11:05 a.m. (central standard time) stated, "It is always recommended to keep the urine bag 18 inches below the bladder, even during a transfer. Clinicians [facility staff] should not put the collection bag flat on the bed during transfers either. If there was urine back flow and urine was to enter back up in the bladder the risk for catheter associated urinary tract infection would be very high." The facility's Catheter Care -Urinary policy dated 12/2002, included: "Check to ensure drainage bag is lower than bladder."	F 315		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465	The dish machine was cleaned and delimed by Ecolab personnel on 7-10-2013. On a daily	

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F 465	Continued From page 41 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure kitchen equipment (including dishwasher and ceiling vent over dishwasher) were maintained in a clean manner free from debris which could potentially contaminate clean dishes. This had the potential to affect 64 of 89 residents that ate in the facility. Findings include: On 7/8/13, at 11:54 a.m. licensed dietician (D)-B gave a brief tour of the kitchen. The dishwasher was observed to have a buildup of a greenish whitish colored substance along the seams of both sides of the dishwasher. The substance appeared to be thick, porous and loose; it flaked away easily with a fingernail. D-B verified the buildup was on the clean side of the dishwasher, was unclear when the dishwasher was cleaned and unclear what the substance was. Also, the exhaust vent in the ceiling above the dishwasher was observed to have a visibly thick buildup of dark, greyish brown colored, fuzzy textured debris. The exhaust cover grate appeared obstructed by the debris and was observed to be pulled partially to the side. On 7/9/13, at 9:38 a.m. the dietary manager (D)-A stated the inside of dishwasher was de-limed every week and had cleaning logs. D-A and surveyor observed the dishwasher at the time.	F 465	schedule dietary staff will delime and clean the outside dish machine surface. This cleaning will be documented daily on the weekly cleaning duties. On 7-9-2013 the exhaust vent above the dish machine was removed and cleaned. On a monthly basis the exhaust vent above the dish machine will be removed and cleaned. This will be documented by dietary staff on the Dish Machine Care Log. Also on a monthly basis the Ecolab personnel will delime the inside and the outside of the dish machine. This will be documented on the Dish Machine Care Log. These cleaning procedures will be monitored by the Dietary Manager. Compliance date: 8/13/2013	

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F 465	Continued From page 42 D-A open the middle of the dishwasher door. The greenish whitish flaking substance was observed to be on the edges and in the track for the door. D-A confirmed pieces of the substance flaked off when the door was open and the white substance could contaminate clean dishes. D-A stated she expected staff to wipe the outside of the dishwasher door and the edges around the door daily after completing the dishwashing task. D-A was unclear what the built up substance was and thought it was leakage of the cleaning chemical on top of the dishwasher. D-A verified there was a build up above the exhaust vent above the dishwasher and clean dish area. D-A stated the exhaust vent was not on the kitchen cleaning list and thought it was a maintenance/house-keeping duty. D-A stated the vent was high up and hard to reach. D-A was unclear when it was cleaned last. On 7/9/13, at 12:30 p.m. D-A stated the housekeeping department was responsible for cleaning the exhaust vent over the dishwasher. D-A stated it was on the maintenance cleaning schedule. A copy of the maintenance schedule was requested at that time but was not provided. On 7/9/13, at 12: 36 p.m. the Ecolab specialist (O)-G was interviewed with D-A present. O-G stated monthly de-liming was completed by Ecolab staff, however was not sure when it had last been completed. O-G thought it had been cleaned in March 2013. O-G stated the built up substance was magnesium calcium (lime) and the surface was only cleanable after lime was removed. O-G stated the lime could potentially contaminate the cleaned dishes. O-G clarified the substance was not from any chemical leakage. O-G also stated the facility should have notified Ecolab the outside of dishwasher needed to be	F 465		

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F 465	Continued From page 43 de-limed. The undated Equipment Operations And Cleaning Procedures policy indicated, "Equipment is washed, rinsed and sanitize after each use to ensure the safety of food served." The procedure directed, "4) Wash, rinse and sanitize all food contact surfaces of the equipment that are stationary." The policy further directed, "The Food Service Director will: 1) Develop operation procedures and cleaning procedures for all equipment. 3) Conduct a visual inspection of all equipment to be certain that it is being cleaned properly." The policy lacked direction to report cleaning and maintenance needs of the dishwasher. The ECOLAB Lime-A-Way policy dated 10/15/10, directed staff to scrape off heavy lime build-up and de-lime as necessary to prevent reoccurrence of lime scale. The ECOLAB Routine Preventative Maintenance Service Detail Report dated 3/26/13, Warewashing form indicated the last time the dishwasher was de-limed by Ecolab staff was on 3/26/13. The facility AM Staff Weekly Cleaning Duties dated 7/1/13 through 7/7/13, directed staff to de-lime inside of dishwasher weekly but lacked direction to address de-liming the outside surfaces and seams of the machine.	F 465		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F5266022

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	245266	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/15/2013

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Heatlh Center of Mpls was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok w/ FSES 8-16-13 PB RECEIVED AUG 12 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Dc: 8-21-13

EXIT: 7-18-13

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

TITLE: Administrator

(X6) DATE: 8-9-13

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

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 5-story building was determined to be of Type II(000) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 110 beds and had a census of 89 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by:	K 012	Correction not needed. Benedictine Health Center of Minneapolis has achieved a passing FSES score (see enclosed FSES/HC and floor plans). Completion 07/22/2013	

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K 012	Continued From page 2 Based on observation and interview, this building does not meet the requirement for construction type and height. This deficient practice could affect all residents. Findings include: On facility tour between 9:00 AM and 11:45 AM on 07/15/2013, observation revealed that this 5-story, non-combustible facility of Type II(000) construction does not meet the minimum construction requirements for a building of this height. The roof of the facility does not have a fire rating. This deficient practice was verified by the administrator at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017	The cited penetrations in the corridor walls above the ceiling were properly firestopped 07/16/2013. The maintenance director will be responsible for monitoring any open penetrations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2013**

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

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K 017	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has not maintained the corridors in accordance with NFPA 101 (2000 edition), Chapter 19, Section 19.3.6.1. This could affect the residents. Findings include: On facility tour between 9:00 AM and 11:45 AM on 07/15/2013, observation revealed that there are several penetrations through the corridor walls above the ceiling by fire alarm wiring throughout the facility that are not properly firestopped. This deficienct practice was verified by the administrator at the time of the inspection.	K 017		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	On 07/16/2013 the smoke detector heads located within 36 inches of HVAC supply and return diffusers in the kitchen and all corridor storage rooms were determined to be heat detectors, and were labeled accordingly. On 07/16/2013 the smoke detector head located within 36 inches of HVAC supply and return diffusers in the corridor near Room 118, was relocated outside of the 36 inch perimeter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/15/2013**

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K 052	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility's fire alarm system is not maintained in conformance with NFPA 72, (99). This deficient practice could affect some residents. Findings include: On facility tour between 9:00 AM and 11:45 AM on 07/15/2013, observation revealed that smoke detector heads are located within 36 inches of HVAC supply and return diffusers in the kitchen, all corridor storage rooms and in the corridor near Room 118. Verify with the fire alarm installer that the placement of all fire alarm initiating devices meet the requirements under the 2000 Life Safety Code for "Automatic Fire Detection" and "Automatic Smoke Detection". This deficienct practice was verified by the administrator at the time of the inspection.	K 052		