DEPARTMENT OF HEALT	TH AND HUMAN	SERVICES			CENTERS FOR MI	EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: B8BR
MEDICARE/MEDICAID PROVID     (L1) 245266		3. NAME AND AI	DDRESS OF FACILI	TY	TE SURVEY AGENCY	Facility ID: 00960           4. TYPE OF ACTION: <u>7</u> (L8)
2.STATE VENDOR OR MEDICAID N (L2) 196677400	10.	(L4) 618 EAST 17 (L5) MINNEAPO			(L6) <b>55404</b>	1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	PPLIER CATEGOR 05 HHA	Y 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY Septemb 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of Th	ne Following Requirements:
To (b) :			Requirements nee Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit
12.Total Facility Beds	<b>95</b> (L18)	-	Acceptable POC		5. 24 Hour KN 4. 7-Day RN (Rural SNF 5. Life Safety Code	<ul> <li>7. Medical Director</li> <li>7) 8. Patient Room Size</li> <li>9. Beds/Room</li> </ul>
13.Total Certified Beds	<b>95</b> (L17)		mpliance with Progra ents and/or Applied V		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS	
18 SNF 18/19 SN 95	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):	I		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Angela Richey, HF	E NEII 01/07,	/2014		(L19)	Colleen B. Leach, Pro	ogram Specialist 02/06/2014
	PART II - TO BE	COMPLETED	BY HCFA RE	GIONA	L OFFICE OR SINGLE ST.	
<ol> <li>DETERMINATION OF ELIGIBII</li> <li>_X_ 1. Facility is Eligible to</li> <li> 2. Facility is not Eligible</li> </ol>	o Participate		MPLIANCE WITH C GHTS ACT:	TVIL		ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :
	(L21)				1	
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEME	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>02/24/1984</b>	BEGINNING	DATE	ENDING DATE	1	VOLUNTARY         00           01-Merger, Closure         00	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	5
25. LTC EXTENSION DATE:	27. ALTERNATI				04-Other Reason for Withdrawal	OTHER 07-Provider Status Change
	A. Suspension	of Admissions:	(L44)			00-Active
(L27)	B. Rescind Sus	pension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	UARRIER NO.		30. REMARKS	
	(L28)	03001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL DA	TE		
		08/27/2013				

(L33)

DETERMINATION APPROVAL

(L32)

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

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

ID: B8BR Facility ID: 00960

### 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.



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 Jeach

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



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.

Benedictine Health Center Of Minneapolis January 7, 2014 Page 2

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

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

### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245266	<b>(Y2) Multiple Construction</b> A. Building B. Wing		(Y3) Date of Revisit 9/5/2013
Name of Facility			Street Address, City, State, Zip Code	
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS		IINNEAPOLIS	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	(Y	(5) E	Date
	F0155 483.10(b)(4)	Correction Completed 08/15/2013		F0250 483.15(g)(1)	Correction Completed 08/15/2013	ID Prefix Reg. # LSC	F0280 483.20(d)(3), 48	3.10(k)	Correction Completed 08/15/2013 2)
ID Prefix Reg. # LSC	483.20(k)(3)(ii)	Correction Completed 08/14/2013	ID Prefix Reg. # LSC	F0309 483.25	Correction Completed 08/15/2013		F0312 483.25(a)(3)		Correction Completed 08/15/2013
ID Prefix Reg. # LSC	483.25(c)	Correction Completed 08/15/2013	ID Prefix Reg. # LSC	F0315 483.25(d)	Correction Completed 09/04/2013	ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 08/15/2013
ID Prefix Reg. # LSC									Correction Completed
Reg. #			Reg. #			D //			
		ewed By	Date:	Signature	of Surveyor:		ſ	Date:	
State Agen Reviewed I CMS RO	-	ewed By	Date:	Signature	of Surveyor:			Date:	
Followup 1	o Survey Complet 7/12/2013				v Uncorrected Defic d Deficiencies (CM			YES	NO

### **Post-Certification Revisit Report**

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245266	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN		IN BUILDING 01	(Y3) Date of Revisit 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	i) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5	5)	Date
		Correction			Correction				Correction
ID Prefix		Completed 07/22/2013	ID Prefix		Completed 07/16/2013	ID Prefix			Completed 07/16/2013
	NFPA 101		Reg. #	NFPA 101		Reg. #	NFPA 101		
LSC	K0012	-	LSC	K0017		LSC	K0052		_
		Correction			Correction				Correction
		Completed			Completed				Completed
		_							_
Reg. #		=	Reg. #			Reg. #			
		_	130						
		Correction			Correction				Correction
		Completed			Completed				Completed
ID Prefix		-							_
Reg. #		_	Reg. #			Reg. #			_
		=							
		Correction			Correction				Correction
ID Profix		Completed	ID Brofiv		Completed	ID Profix			Completed
		-							_
Reg. # LSC		-	Reg. # LSC			Reg. # LSC			_
		0							
		Correction Completed			Correction Completed				Correction Completed
ID Prefix			ID Prefix			ID Prefix			
Reg. #			Reg. #			Reg. #			
LSC		-	LSC			LSC			_
Reviewed B	By Reviewed	d By	Date:	Signature of Sur	veyor:		D	ate:	
State Agen	cy MM/I	PS	01/07/20	14 28120			30	8/20/	2013
Reviewed B	By Reviewed	d By	Date:	Signature of Sur	veyor:		D	ate:	
CMS RO									
Followup t	o Survey Completed o 7/15/2013	n:		Check for any Uncor Uncorrected Defic			AL . E	(ES	NO
	7,10,2010						-	5	

DEPARTMENT OF HEALTH	I AND HUMAN	SERVICES			CE	NTERS FOR ME	EDICARE &	MEDIC	AID SERVICES
		CARE/MEDICA						ID	B8BR
	PART I	- TO BE COMP	LETED BY T	'HE STA'	TE SURVE	Y AGENCY		Fa	cility ID: 00960
1. MEDICARE/MEDICAID PROVIDER (L1) 245266 2.STATE VENDOR OR MEDICAID NO.		<ol> <li>NAME AND AI</li> <li>(L3) BENEDICT</li> <li>(L4) 618 EAST 12</li> </ol>	INE HEALTH (				<ol> <li>TYPE O</li> <li>Initial</li> <li>Termin</li> </ol>		<u>2</u> (L8) 2. Recertification 4. CHOW
(L2) <b>196677400</b>		(L5) MINNEAPO	DLIS, MN		(1	L6) <b>55404</b>	5. Validat		6. Complaint
<ol> <li>EFFECTIVE DATE CHANGE OF OW (L9)</li> </ol>	VNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	RY 09 ESRD	<u>02</u> 13 PTIP	(L7) 22 CLIA	7. On-Site 8. Full Su	e Visit rvey After Cor	9. Other nplaint
6.     DATE OF SURVEY     07/12       8.     ACCREDITATION STATUS:       0     Unaccredited     1       2     AOA     3	/2013 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF		FISCAL YEA	R ENDING 1	DATE: (L35)
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED AS	S:					
From (a):		X A. In Complia	nce With		And/Or Ap	pproved Waivers Of Th	e Following Requ	uirements:	
To (b) :			Requirements ace Based On:			Technical Personnel	6. Sc	cope of Servic	ces Limit
12.Total Facility Beds	<b>110</b> (L18)		Acceptable POC		4.	24 Hour RN 7-Day RN (Rural SNF) Life Safety Code	)8. Pa	ledical Direct atient Room S Beds/Room	
13.Total Certified Beds	<b>110</b> (L17)		mpliance with Prog ents and/or Applied			В	(L12)		
14. LTC CERTIFIED BED BREAKDOW	VN	1			15. FACILII	TY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1	) or 1861 (j) (1):	(1	.15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMAI	RKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE	):					
See Attached Remarks				,-					
17. SURVEYOR SIGNATURE		Date :			18. STATE	SURVEY AGENCY A	APPROVAL		Date:
<u>Jamie Butterfass, HF</u>	E NE II		08/16/2013	(L19)	Shell	ae Dietrich, l	Program (	Speciali	<u>st</u> 08/26/2013 (L20)
Р	ART II - TO BI	E COMPLETED	BY HCFA RI	EGIONA	L OFFICE	OR SINGLE ST	ATE AGEN	CY	
<ol> <li>DETERMINATION OF ELIGIBILIT</li> <li>1. Facility is Eligible to P.</li> </ol>			MPLIANCE WITH GHTS ACT:	CIVIL		<ol> <li>Statement of Finan</li> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	Interest Disclosu		FA-1513)
2. Facility is not Eligible	(L21)								
22. ORIGINAL DATE	23. LTC AGREEM	IENT 2	4. LTC AGREEM	IENT	26. TERM	INATION ACTION:		(L.	30)
OF PARTICIPATION <b>02/24/1984</b>	BEGINNING	DATE	ENDING DAT	Έ	VOLUNTAF 01-Merger, C		-	NVOLUNTA	<u>ARY</u> et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfa	ction W/ Reimburseme	nt (	06-Fail to Me	et Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS				voluntary Termination	<u>(</u>	OTHER	
	A. Suspension	n of Admissions:			04-Other Rea	ason for Withdrawal			tatus Change
(L27)	B. Rescind Sus	spension Date:	(L44)				(	00-Active	
			(L45)						
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMAR	KS			
		03001			1.0	<b>D</b>			
	(L28)			(L31)	ML	Posted 8/2	27/2013	ML	
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL D	ATE					
	(L32)			(L33)	DETERM	INATION APPR	OVAL		

DETERMINATION APPROVAL

# 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: 00900

### 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.



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:

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

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

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

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

### <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - 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)

Benedictine Health Center Of Minneapolis July 30, 2013 Page 3

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

Benedictine Health Center Of Minneapolis July 30, 2013 Page 4

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 Benedictine Health Center Of Minneapolis July 30, 2013 Page 5

> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

		AND HUMAN SERVICES				FORM	: 07/29/2013 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245266	B. WING	;		07/	12/2013
NAME OF F	ROVIDER OR SUPPLIER	I,	r	s	TREET ADDRESS, CITY, STATE, ZIP CODE	011	12/2013
DENEOLO					18 EAST 17TH STREET		
RENEDIC	TINE HEALTH CENT	ER OF MINNEAPOLIS		N	MNEAPOLIS, MN 55404		
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F 000	INITIAL COMMENT	rs .	F(	000			
F 155 SS=J	Minnesota Departm through July 11, 20 Immediate Jeopard facility's failed respo a change in code s resuscitate/do not i (resuscitation) whice for harm or death. 4:02 p.m. The IJ wa at 4:47 p.m. The facility's plan o as your allegation of Department's accept bottom of the first p be used as verificat Upon receipt of an revisit of your facilit validate that substat regulations has beet your verification.	ntubate (DNR/DNI) to full code h resulted in the high potential The IJ began July 11, 2013, at as removed on July 12, 2013, f correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will tion of compliance. acceptable POC an on-site y may be conducted to ntial compliance with the en attained in accordance with T TO REFUSE; FORMULATE	accept rysus		Preparation, submission and impler this Plan of Correction does not con admission of or agreement with the conclusions set forth in the stateme deficiencies. The facility has appea deficiencies and licensing violations herein. This Plan of Correction is pr and/or executed as a means to con improve the quality of care, to com applicable state and federal regulat requirements and constitutes the f allegation of compliance.	stitute a facts ar ent of led the stated repared tinuousl ply with	in id Y
	refuse to participate and to formulate an specified in paragra The facility must co specified in subpart related to maintaini procedures regardia requirements include	e right to refuse treatment, to e in experimental research, advance directive as aph (8) of this section. mply with the requirements to f part 489 of this chapter ng written policies and ng advance directives. These le provisions to inform and	- - - - -	N ir ir	is the policy of Benedictine Health Inneapolis to provide residents with Information concerning resident right formation specific to Advance Dire the admission process. A. MD order for Full Code statu obtained on 7/11/13 for resident to the statu B. On 7/11/13 audits of twenty	h its and ctives wi is was ident R3-	ith 4.
LABORATORY		mation to all adult residents	NATURE	;	Admin.stator		(X6) DATE 9-13

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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.

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/29/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245266	B. WING			07/	12/2013
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BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS			8 EAST 17TH STREET		
				MI	NNEAPOLIS, MN 55404		
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F 155	or surgical treatment	t to accept or refuse medical nt and, at the individual's	F 1	55	records were completed with the of verifying current orders related		
	includes a written d	an advance directive. This description of the facility's nent advance directives and			Advanced Directives were present consistent between the physician	t and	
	This STANDARD i Based on interview facility failed to resp a change in code st resuscitate/do not in (resuscitation) resu harm or death for 1 for dialysis and adv The immediate jeop began on 6/24/13, v made aware that th change in code stat and director of nurs 7/11/13, at 4:02 p.n 7/12/13, at 4:47 p.n remained at an isol (no actual harm wit minimal harm that i Findings include: On 7/10/13, at 11:4	s not met as evidenced by: and document review, the bond to a resident's request for tatus from do not ntubate (DNR/DNI) to full code lting in a high potential for of 5 residents (R34) reviewed anced directives. bardy (IJ) situation for R34 when the facility was first e resident wanted to discuss a tus. The facility's administrator ing were notified of the IJ on n. The IJ was removed on n. but noncompliance ated scope and severity of D h potential for more than s not an IJ). 5 a.m. R34 was interviewed		; C.	orders and on the resident's face All were present and consistent. time review/education was provid licensed staff prior to them working their next shift related to the need communicate with MD/NP when have been made aware of a reside desire to change his/her Advance Directives. The licensed staff men who is made aware of a request for change is to contact the MD/NP of on call service for that MD/NP that shift.	sheet. Just in ded to ng d to they ent's nber or r the at be DS 3.0 en	
	when asked about a wanted addressed had stated he want code at the nursing reported he believe	ter (I)-A. I-A reported that any additional issues R34 with the facility, the resident ed to be designated as a full home facility. I-A stated R34 d he was designated as full d had asked if he could be full		D.	process. Resident Council Meeting 8/16/13 will include review of the to formulate Advance Directives. Random audits of resident medica records will be conducted by men	e right al	

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

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Facility ID: 00960

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         AND PLAN OF CORRECTION       245266       B. WING       07/12/2013         NAME OF PROVIDER OR SUPPLIER       B. WING       07/12/2013         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       618 EAST 17TH STREET         BENEDICTINE HEALTH CENTER OF MINNEAPOLIS       ID       PROVIDER'S PLAN OF CORRECTION       (x5)         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION BE PRECEDED BY FULL       PREFIX         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED       COMPLETED         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 facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home would       F 156       of the interdisciplinary team specific to education provided to resident/family/legal representative in conjunction with OBRA MDS 3.0 cycle			I AND HUMAN SERVICES				FORM	: 07/29/2013 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BENEDICTINE HEALTH CENTER OF MINNEAPOLIS       618 EAST 17TH STREET         MINNEAPOLIS, MN 55404       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 REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       (X5) COMPLETI DATE         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 on white to moving home to the provided D24       F 155						ECONSTRUCTION	(X3) DAT	E SURVEY
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         BENEDICTINE HEALTH CENTER OF MINNEAPOLIS       618 EAST 17TH STREET         MINNEAPOLIS, MN 55404       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) COMPLETI DATE         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 can this to review him to a continue to review the to a continue to review the to a continue to review to a staff at the nursing home would not do can this to review to be a staff at the nursing home would to the accentering home to accenter of D24       F 155			245266	B. WING	;		07/	12/2013
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS       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) COMPLETI DATE         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 net dia gavithing to review this to A constraint for the stopped breathing now, staff at the nursing home would       F 154	NAME OF I	PROVIDER OR SUPPLIER	· ·······		1			
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)ID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)(X5) COMPLETI DATEF 155Continued 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 facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home facility as well, however R34 indicated that if he stopped breathing now, staff at the nursing home would conjunction with OBRA MDS 3.0 cycleID PREFIX COMPLETI TAG	BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS					
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 conjunction with OBRA MDS 3.0 cycle	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
<ul> <li>and the admission process. Addit will and the admission process. Addit will are protect through I-A, that he had cancer of his pancreas and went to dialysis.</li> <li>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 324 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 available in the facility due to his scheduled to available in</li></ul>	F 155	code at the nursing ago. R34 stated thr he requested to be would be full code a well, however R34 i breathing now, staff not do anything to r stated he had reque over two weeks ago or readdressed his reported through I-/ pancreas and went R34's annual Minim 2/27/13, indicated a Status (BIMS) was indicated R34's long R34 had problems 7/11/13, at 3:42 p.m social worker (LSW completed to deterr cognitively intact be coordination issue v translator/interprete the facility and whe the facility due to hi campus. A Nursing Progress p.m. included, "Clin resident's code stat resident would like re-evaluate and pos facility."	home facility a few weeks ough I-A, he thought because full code at dialysis that he at the nursing home facility as indicated that if he stopped f at the nursing home would evive him. I-A reported R34 ested the code status change b, but no one had followed-up code status with him. R34 A, that he had cancer of his to dialysis. hum Data Set (MDS) dated a Brief Interview for Mental not conducted. The MDS g term memory was intact but with short term memory. On h. R34's designated licensed I)-A stated no BIMS score was mine whether R34 was because there was a with when the er was scheduled to come to n R34 would be available in s scheduled dialysis off a note dated 6/24/13, at 12:48 ical manager informed about tus. Per dialysis nurse, to get an interpreter to ssibly change code status with y Guide for Family and ed the resident had formulated			of the interdisciplinary team spece education provided to resident/family/legal representat conjunction with OBRA MDS 3.0 of and the admission process. Audit include review of current physicial orders for code status and the pro- for residents to communicate the choices to ensure the residents Advance Directive wishes have be facilitated. The results of these a will be presented to the Quality of for further discussion or action. liance date: 8/19/13 <b>RECEIVED</b> AUG – 9 2013 COMPLIANCE MONITORING DIV	ive in cycle t will an ocess eir een udits counci!	
he did not wish for attempts at resuscitation. "I         FORM CMS-2567(02-99) Previous Versions Obsolete       Event ID:B8BR11	EORM CMS 24	he did not wish for a	attempts at resuscitation. "I	1	Facil			

		HAND HUMAN SERVICES				FORM	): 07/29/2013 1 APPROVED ): 0938-0391
TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '		CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245266	B. WING			07	/12/2013
NAME OF 1	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CEN	TER OF MINNEAPOLIS			EAST 17TH STREET INEAPOLIS, MN 55404		
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F 155	wish to be allowed comfortable, and fi present." A Referral Form da facility from the nu read! [R34] recent FULL CODE. Plea with him." R34's electronic m reviewed on 7/11/ indicated R34 had 2002, was non-En primary diagnoses pancreatic cancer,	age 3 a natural death, to be kept or my loved ones to be ated 7/10/13, to the dialysis rsing home, included: "Please ly wanted to change back to se discuss the ramifications hedical record (EMR) was 13, at 9:23 a.m. The EMR been admitted to the facility in glish speaking, and had including: newly diagnosed , end-stage renal disease dementia, and that R34 was	F1	55			
	own responsible p identified on the E on the care plan d was a DNR/DNI co advanced directive the front of the cha status. On 7/10/13, at 9:4 registered nurse (I R34 had wanted h RN-B reported the his mind and want about changing his RN-B stated she h the dialysis center to have the code s nephrologist at dia	EMR also indicated R34 was his arty. R34's code status, MR Demographic Sheet, and ated 6/12/13, indicated R34 ode status. In addition, the es identified on a red sleeve in art, indicated a DNR/DNI code 9 a.m. clinical manager RN)-B stated that last month is code status to be DNR/DNI. e resident had since changed red to have further discussion s code status back to full code. had just sent communication to that day (7/10/13), asking them status addressed with the alysis with an interpreter. RN-B r staff, to her knowledge, had					

		H AND HUMAN SERVICES			-	FORM	: 07/29/2013 APPROVED . 0938-0391
TATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			(X3) DAT	E SURVEY
		245266	B. WING			07/	12/2013
NAME OF	PROVIDER OR SUPPLIER		1 1	STI	REET ADDRESS, CITY, STATE, ZIP COD		1212010
BENEDI	CTINE HEALTH CEN	TER OF MINNEAPOLIS			8 EAST 17TH STREET NNEAPOLIS, MN 55404		·
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F 155	Continued From pa	age 4	F 1	55			
	nurse (LPN)-A rep dialysis yesterday status, and now was she'd given the col- manager to process status had not beer record. LPN-A state most of the time at stated if he coded (medical interventiand/or respiratory) On 7/11/13 at 9:40 -C reported if a resist went into cardiac at notify the nurse of CPR certified, but immediately.	3 a.m. a licensed practical orted R34 returned from with a change in his code as full code. LPN-A stated nsult note to the clinical ss. LPN-A verified the code en changed yet in R34's medical ted she was R34's day nurse t the facility including today, and she would have provided CPR ion use to restore circulatory function that has ceased). 0 a.m. a nursing assistant (NA) sident stopped breathing or arrest she would immediately n the shift. NA-C stated she was would want to inform the nurse 2 a.m. LPN-A reported if a NA					
	reported to her that breathing she would resident. LPN-A st stopped breathing and get the chart. then check the chart placed in the front sleeve, to determin CPR. LPN-A confit communication for had been changed however, the advar paper chart, on the care plan did not r stated she would it the clarification set	2 a.m. LPN-A reported in a NA at a resident had stopped ald immediately go check on the tated that if the resident had b, she would have the NA run LPN-A also reported she would art for the advanced directive of the paper chart in a red ne if the resident should have irmed the facility had received a rm identifying R34's code status d to full code on 7/10/13, anced directive currently in the e EMR face sheet, and on the reflect the change. LPN-A initiate CPR for R34 because of ent from dialysis yesterday. had given the dialysis	5		· · ·		

	MENT OF HEALTH							RINTED: FORM MB NO.	APPR	OVED
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/S IDENTIFICAT	UPPLIER/CLIA ION NUMBER:			E CONSTRUCTION		(X3) DAT		EY
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	PROVIDER OR SUPPLIER	ER OF MINNEA	POLIS		61	TREET ADDRESS, CITY, STATE, ZIP CO 18 EAST 17TH STREET IINNEAPOLIS, MN 55404	DE			
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F 155	Continued From par communication form process and chang 10:31 a.m. LPN-A a clarified she would order as noted in R On 7/11/13, at 9:59 had a witnessed ca expected to check EMR, or the advant to determine code a face sheet identifier would not initiate C On 7/11/13, at 9:49 found a resident not the nurse right awa would assess the re appropriate. RN-B could be found in a physician orders. A sent a Referral For dialysis the previou R34's request that change his code st explained that the c addressed the infor code status remain first became aware his code status on one at the facility he physician regarding have done so. RN- staff and the nephr better means to ha R34 considered the confirmed dialysis a asking that they ad status on 6/24/13. I	m to the clinical e in the medica approached the have to follow f 34's record. a.m. RN-E sta ardiac arrest sta the resident's fa ced directive in status. RN-E sta d he was DNR/ PR. a.m. RN-B stated d he was DNR/ PR. a.m. RN-B stated esident and init also reported the residents' pap t 10:13 a.m. RI m (communical is day to ask the he wanted to "p atus to full code dialysis staff har mation sent, se ed DNR/DNI. F e of R34's reque 6/24/13, howev ad contacted R g the request, b B reported she ologist would h ve this address e dialysis staff f staff had contact dress the resid RN-B stated du	al record. At a surveyor and the DNR/DNI ated if a resident aff were ace sheet in the the paper chart onfirmed R34's (DNI, therefore, ated that if a NA ey were to get d the nurse iate CPR as ne code status er chart under N-B stated she tion form) to em to address possibly" e. RN-B d not o the resident's RN-B stated she est to change ver verified no 34's primary out they should felt the dialysis ave been a sed because amily. RN-B cted the facility ent's code le to the	F1						
FORM CMS-2	567(02-99) Previous Versions	s Obsolete	Event ID: B8BR1	1	Fac	cility ID: 00960 If co	ontinuaf	ion sheet	Page 6	5 of 44

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IAME OF F	PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE HEALTH CENT	FER OF MINNEAPOLIS			AST 17TH STREET EAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 155	language barrier, it fully understood his whether that would decision. RN-B als had the social worl not contacted the p interpreter to clarift they would expect advanced directive look on the face sh the resident's code facility had failed to earlier and should surveyor requester regarding how the request to change On 7/11/13, at 10: was aware of the r full code, as that h wavered about ove The DON confirmed the primary physic manner if a reside status changed. T considered the dia stated that was wh sent the clarification status back to dial did not know the op reported R34's red DON stated the ex check the EMR or paper chart to det prior to initiating O R34's code status	was difficult to identify if R34 s cancer prognosis, and l affect his code status o confirmed the facility had not ker address this with R34, had obysician, nor obtained an y R34's request. RN-B stated that staff to follow residents' es in the front of their charts, or neet in the EMR to determine e status. RN-B verified the o address the issue for R34 have. During this interview, the d any additional information facility had addressed R34's his code status on 6/24/13. 58 a.m. the DON stated she resident's request to go back to ad been an issue R34 had er the past one and a half year. ed she would have expected ian to be contacted in a timely nt requested to have their code he DON also confirmed R34 alysis staff to be family, and by the facility's nursing staff had on form regarding his code ysis staff. The DON stated she lialysis staff had initially quest to the facility staff. The cpectation was for nurses to the advance directive in the ermine a resident's code status iPR. The DON also stated was currently DNR/DNI, but a ent to R34's primary physician		55			

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

If continuation sheet Page 7 of 44

TATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _	AND	CON	IPLETED
,		245266	B. WING			07/	12/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE <b>8 EAST 17TH STREET</b>		
BENEDIC	CTINE HEALTH CENT	TER OF MINNEAPOLIS			INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 155	Attempts to reach manager on 7/11/1 unsuccessful. On 7/11/13, at 2:00 facility had not con The surveyor appri- concerns regarding resident's request requested the DOI additional clarifying On 7/11/13, at 3:3 and stated she had today of R34's req to full code, but sh she was not happy would address his upcoming appointr On 7/12/13, at 9:55 had not been notifi interpreter regardin code status. LSW- expected to be not and to have been was not. LSW-A a responsible party. attempted to obtai the past, however competent through testing. On 7/12/13 at 11:3	the dialysis center's clinical 3, at 12:29 p.m. were 0 p.m. the DON confirmed the tacted the MD until that day. ised the DON of serious g the lack of follow up to the to change his code status, and N provide the surveyor with any g information. 1 p.m. MD-A was interviewed d not been notified prior to uest to change his code status ould have been. MD-A stated v about R34's request, but wishes with him at an	F	55			
	R34's request for a status changes ha thought the request	an interpreter to discuss code ad not been acted upon; and st had come through an annel (a contracted					

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

Event ID: 888R11 Facility ID: 00960

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		I AND HUMAN SERVICES			FORM	): 07/29/201 1 APPROVE 0. 0938-039	
ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245266	B. WING _			/12/2013	
	PROVIDER OR SUPPLIER	FER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP C 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 155	"may not be cognit However, MD-B als facility should have added, "Sometime change it yet; I'd lik resident; but I wou the provider. And t nurses on." MD-B expectation that th resident concerns On 7/15/13, at 12:4 saw R34 today reg stated R34 reporte Phoenix," about hi live. MD-A believer regarding the circu revived by CPR in discussed with R3 believed his expect MD-A stated the fa her when this issue now he convinced properly being info verified that R34 w baseline, but did h The facility's Adva Procedure dated 7 facility should add change their code admission. R34 lacked follow after he had reque The IJ that began 7/12/13 at 4:47 p.1	AD-B also stated the resident ive to make his choices." so stated he believed the e notified the provider. MD-B s [the] provider would say don't ac to discuss it with the ld expect the facility to notify hat is what I would educate the verified it would be his e facility notify providers of or choices for clinical care. 46 p.m. MD-A reported she parding his code status. MD-A ed talking with, "a lady from s code status and wanting to d R34 was given false hope umstances surrounding being his condition. MD-A stated she 4 the ramifications of CPR, and stations were, "unrealistic." acility should have contacted e was first brought up, because himself to be full code without ormed of his condition. MD-A vas cognitively intact and at his ave a diagnosis of dementia. nced Directive Policy and 7/03, did not identify how the ress a resident's request to status outside of the initial up to his Advance Directive ested a change in code status. on 6/24/13 was removed on m., after the facility had dvance Directive for R34 and		55			

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		AND HUMAN SERVICES			FORM	07/29/2013 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245266	B. WING		07/	12/2013
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS		18 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 155 F 250 SS=D	had received order resident's desire to facility had conduct records to verify the consistent with thei code status docum facility policy, and h licensed staff to en respond to a reside code status. The re- through resident re- interviews of licens shifts in the facility, education that had administrator. 483.15(g)(1) PROV RELATED SOCIAL The facility must pr services to attain o	s that recognized the be full code. In addition, the red audits of other resident eir Advance Directives were r choices, had verified that entation was consistent with had conducted training for sure they knew how to ent's request to modify their emoval plan was verified cord review, through ed staff that worked on various and through reviewing staff taken place by the DON and /ISION OF MEDICALLY _ SERVICE rovide medically-related social r maintain the highest al, mental, and psychosocial	F 155 F 250		y related e highest	social
	by: Based on interview facility failed to pro services related to changes to end of (R34) reviewed for Findings include: On 7/10/13, at 11:4 through an interpret	NT is not met as evidenced v and document review, the vide medically-related social a resident's right to make life wishes for 1 of 5 residents dialysis. 45 a.m. R34 was interviewed eter (I)-A. I-A reported that any additional issues R34		<ul> <li>well-being of each resident.</li> <li>A. Interpreter services were a R34 on 7/10/13.</li> <li>B. Plans for care of current reservices require interpreter services reviewed for presence of in specific to communication.</li> <li>C. Reviewed facility policy reginterpreter services with lice and interdisciplinary team of D. Random audit/interview of the service of the servi</li></ul>	rranged for sidents wi were terventio arding ensed sta members.	ho ns

		AND HUMAN SERVICES				FORM	07/29/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
: - -		245266	B. WING			07/	12/2013
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS			18 EAST 17TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 250	had stated he want code at the nursing reported he believe code at dialysis, an code at the nursing ago. R34 stated thr he requested to be would be full code a well, however R34 breathing now, staf not do anything to r stated he had reque over two weeks ago or readdressed his reported through 1-/ pancreas and went R34's electronic me reviewed on 7/11/1 the record, R34 wa 2002, was non-Eng primary diagnoses pancreatic cancer, requiring dialysis, d The EMR also indic responsible party. R34's annual Minim 2/27/13, identified a Status (BIMS) was noted his long term	with the facility, the resident ed to be designated as a full home facility. I-A stated R34 d he was designated as full d had asked if he could be full home facility a few weeks ough I-A, he thought because full code at dialysis that he at the nursing home facility as indicated that if he stopped f at the nursing home would revive him. I-A reported R34 ested the code status change b, but no one had followed-up code status with him. R34 A, that he had cancer of his		250 Co	DEFICIENCY) staff by Director of Nursing/SS/Designee specific knowledge of how to obtain services. Results of audits/int communicated to Quality Co- input. mpliance date: 8/19/13	interpreto erviews	er
EOPM CMS-2	3:42 p.m. R34's de worker (LSW)-A sta completed to deter issues because the with when the inter	signated licensed social ated no BIMS score was mine if R34 had any cognitive are was a coordination issue preter/translator would be to the facility and when R34		Fai	cility ID: 00960		Page 11 of 44

TATEMEN	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION		E SURVEY	
		245266	B. WING			07	07/12/2013	
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		618	EET ADDRESS, CITY, STATE, ZIP CODE EAST 17TH STREET INEAPOLIS, MN 55404	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLET DATE	
F 250	was in the building did not have a syst R34 when an intern to explain slowing i "knows more Engli A Nursing Progress p.m. revealed, "Cliir residents code stat would like to get an possibly change co R34's My Guide foi indicated the resid healthcare directive did not wish for att to be allowed a nat comfortable, and co A Referral Form da facility from the nu read! [R34] recent FULL CODE. Pleat with him." R34's electronic m on 7/11/13, at 9:23 R34's code status on the care plan d do not resuscitate/ code status. On 7/12/13, at 9:5 was not notified of regarding R34's re status. LSW-A stat to be notified of th been involved in th	age 11 . LSW-A confirmed the facility em in place to communicate to oreter was coming other than in English because R34 sh than he lets on." s note dated 6/24/13, at 12:48 nical manager informed about tus. Per dialysis nurse, resident interpreter to re-evaluate and ode status with facility." r Family and Caregivers ent had formulated a e on 6/11/13, that indicted he empts at resuscitation. "I wish tural death, to be kept of my loved ones to be present." ated 7/10/13, to the dialysis rsing home noted "Please ly wanted to change back to se discuss the ramifications nedical record (EMR) showed a.m. the resident identified on the demographic sheet and ated 6/12/13, both indicated a 'do not intubate (DNR/DNI) 2 a.m. LSW-A reported she is a need for an interpreter equest to discuss his code ted she would have expected e resident's wishes and to have ne situation, but was not. Provision of Social Services		50				

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If continuation sheet Page 12 of 44

		AND HUMAN SERVICES	1			FORM	07/29/2013 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245266	B. WING	;		07/	12/2013
NAME OF F	PROVIDER OR SUPPLIER			l	TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE HEALTH CENT	TER OF MINNEAPOLIS			I8 EAST 17TH STREET INNEAPOLIS, MN 55404		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	I	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE
F 250	dated 7/03, indicate medically-related s maintain the highes and psychosocial w Assisting staff to in designate; about th health care choices Making referral and outside entities [wh services]. K) Assis they would like to r health care, and w anyone else to be Meet the needs of The types of condi should respond wit referral included: in	ed the facility must provide ocial services to attain or st practicable physical, mental vellbeing which included: "C) form residents and those they he resident's health status and s and their ramifications. D) d obtaining services from hich include interpreter ting residents to determine how make decisions about their hether or not they would like involved in those decisions. N) residents who are grieving. tions for which the facility th social services by staff or hability to cope with loss of		250			
F 280 SS=D	residents condition chronic disabling n effective family/soc Neither the social v assisted the reside were met to modifive resident requested 483.20(d)(3), 483. PARTICIPATE PL The resident has to incompetent or oth incapacitated under participate in plant changes in care and A comprehensive within 7 days after	10(k)(2) RIGHT TO ANNING CARE-REVISE CP the right, unless adjudged therwise found to be er the laws of the State, to ning care and treatment or	F	280	It is the practice of Benedictine H Minneapolis Interdisciplinary Tea and re-evaluate interventions and care plan based upon resident ne A. Plan of care for R44 has b and revised. B. Care Plans for those reside	im to de d revise eeds. Deen rev	velop the iewed

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Facility ID: 00960

		AND HUMAN SERVICES			FORM	07/29/2013 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
- - - -		245266	B. WING		07/	12/2013
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE HEALTH CENT	ER OF MINNEAPOLIS		618 EAST 17TH STREET		
				MINNEAPOLIS, MN 55404		
(X4) lD PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		JLD BE	(X5) COMPLETION DATE
F 280	interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent p the resident, the resilegal representative and revised by a te each assessment. This REQUIREMENT by: Based on interview facility failed to re-er revise the care plan prevent further skin residents (R44) rev R44 developed a D or maroon area of o damage of underlyit Findings include: The care plan for R reflect new open ar 6/19/13. The care p revisions to the inter skin breakdown an record review indica the hospital on 7/9/ fracture. A physician progree indicated R44 was buttocks, measurin	ge 13 m, that includes the attending red nurse with responsibility d other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's e; and periodically reviewed am of qualified persons after NT is not met as evidenced v and document review, the evaluate interventions and to promote healing and breakdown for 1 of 4 iewed for pressure ulcers and reep Tissue Injury (DTI- purple discolored intact skin due to ng soft tissue) at the facility. At had not been revised to ea which was identified on blan did not include any erventions to prevent further d to promote healing. Closed ated R44 was discharged to 13, with left distal tibia/ fibular ss note dated 6/19/13, diagnosed with DTI on both ng 2 x 2 centimeter (cm) on 1 x 3 cm on the left buttocks	F 2	<ul> <li>alterations in skin integrity I reviewed for presence of in consistent with their individ factors.</li> <li>C. Review of expectations relaplan review and revision winterdisciplinary team.</li> <li>D. Random audit of care plans the inclusion of resident spintegrity risk factors by Direc Nursing or designee. Audit findings to be communicated members of the interdiscip and then to Quality Councitation.</li> <li>Compliance date: 8/19/13</li> </ul>	tervention ual risk ted to care th specific to ecific skin ector of results or ed to linary tean	
FORM CMS-2	567(02-99) Previous Versions	···· · · · ·	1	Facility ID: 00960 If contin	uation sheet I	Page 14 of 44

		AND HUMAN SERVICES				FORM	: 07/29/20 APPROVE , 0938-039	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY	
		245266	B. WING		<u>,</u>	07	/12/2013	
	ROVIDER OR SUPPLIER	TER OF MINNEAPOLIS	P	618	REET ADDRESS, CITY, STATE, ZIP CO 8 EAST 17TH STREET NNEAPOLIS, MN 55404	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 280	failed to revise can healing, and preve result the right butt unstageble pressu R44's electronic m was admitted to th diagnoses included borderline persona above the knee an osteoarthritis, and The physician prog indicated the DTI a color" with a small cm, and Calmosep moisture barrier) v Further record rev reassessment of t care plan updating 6/19/13.	o reassess rick factors, and e plan interventions to promote nt further skin breakdown. As a tock DTI developed into an re ulcer. edical record (EMR) noted R44 e facility on 9/6/12, and had d schizoaffective disorder and ality disorder, diabetes, Right nputation, depressive disorder,		280				
	following: - On 6/17/13, th noted on buttocks cream applied. W manager. Unable when touched." - On 6/22/13, th presents with an a frequently black o or devitalized tissu buttock. Scant ble slough [non-viable brown tissue; usu	ne note indicated "Black area . Tena [brand name] protective riter left a message for clinical to measure due to pain in area ne note indicated "Resident area of eschar [thick, leathery, r brown in color, necrotic (dead) ue] 5.2cmx5 cm on his right seding from edges with a thin e yellow, tan, gray, green or ally moist, can be soft, stringy rexture] also noted on the						

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

		HAND HUMAN SERVICES			FORM	): 07/29/201 I APPROVE ): 0938-039		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	ECONSTRUCTION		FE SURVEY MPLETED		
		245266	B. WING		. 07	/12/2013		
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS	61	STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 280	edges. Tena crean is also c/o [compla - On 6/26/13, the refused shower, bu assessed and note cm with slough and bleeding." The note "area to be very pa - On 7/3/13, the given, and skin ass right was "about 3. edges with scant a - There were no to skin monitoring, to the hospital on 7 The quarterly Minin indicated resident to and had no unheal The skin care plan "Alteration in skin i venous stasis, diat moisture, and liste "monitor for indicat [physician] if prese	n applied as ordered, resident int of] pain in the area." e note indicated resident at agreed to a bed bath, "Skin d coccyx wound about 4.55 d pink/red edges with small a also indicated resident stated inful." note indicated a bed bath was sessment completed, and the 5 x 3 cm with slough and red mount of bleeding." additional notes found related and resident was discharged						
	care plan also indi reposition every 2 indicate presence 6/19/13. Per the ca at times." The plan new intervention w 6/19/13, or later w unstageble pressu	ng per MD orders." The mobility cated "One staff to turn and hours." The care plan did not of acquired pressure ulcer from are plan " resident resists care of care was not revised with hen the DTI was identified on the DTI developed into an re ulcer. se (RN)-B nurse manager was	1					

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		AND HUMAN SERVICES				FORM	): 07/29/20 1 Approve ). 0938-031
ATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245266	B, WING			07	/12/2013
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		618 I	ET ADDRESS, CITY, STATE, ZIP EAST 17TH STREET NEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 280	she was not aware on his bottom. The read the physician's was present during under the impression "shearing" related. per the facility's pol completed each tim noted in order to id completing the Bra tissue perfusion tes was not reassessed was no Braden too developing pressur perfusion test comp was a risk factor" a and laid in the bed. have not seen R44 assessment on 6/1 have never seen the stated after reviewi 6/22/13, 6/26/13 ar turned into and unsishe was not "aware R44's treatment ree Calmoseptine ointri initiated on 6/19/13 DTI developed into and as per the prog not notified either. The facility's Skin I policy undated, ind assess all resident readmission to faci	age 16 that resident had DTI wounds RN-B explained she did not is progress notes, since she the assessment, and was on that R44's wounds were The RN-B also stated that as icy a reassessment was ne when a new wound was entify the risk factors by den assessment, and new st. The RN acknowledged R44 d to identify risk factors, there I (used to determine risk for re ulcer) completed, or tissue pleted. Per the RN-B "pressure is R44 sat in the wheel chair, The RN-B also stated she 's wounds since the initial 9/13, and the wound nurse nem either. The RN-B further ing the progress notes from nd 7/3/13, that R44's DTI stageble pressure ulcer, which e of." The RN-B reviewed cord and stated the ment treatment which was is, was not changed when the an unstageble pressure ulcer, gress notes, the physician was integrity - Pressure Ulcers icated "Licensed Nurse will s' skin upon admission, lity, quarterly, and when at risk ulcer, or when pressure ulcer	F2	280		· · ·	

		I AND HUMAN SERVICES			RINTED: 07/29/2013 FORM APPROVED MB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>v j</b>		(X3) DATE SURVEY COMPLETED
		245266	B. WING		07/12/2013
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS	6	TREET ADDRESS, CITY, STATE, ZIP CODE 18 EAST 17TH STREET //INNEAPOLIS, MN 55404	<u>.</u>
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 280	<ul> <li>"a. Initial summa documented in the on any facility spects</li> <li>b. If more than of should have a sepace.</li> <li>b. Braden score for "The policy also ind implement appropriand update as treat The policy also ind any time there was increasing Stage."</li> <li>Although the record due to his borderling reassess R44 to ide re-evaluate effecting prevent R44 from 483.20(k)(3)(ii) SE PERSONS/PER CO The services provi- must be provided accordance with end care.</li> <li>This REQUIREME by: Based on observa- review, the facility was followed for garesidents (R77) re- facility failed to en- the facility staff mo- quality care for 2 observed for indw</li> </ul>	ry of a pressure area should be resident's clinical notes and clific forms. ne pressure ulcer, each area arate entry/form. form should be completed. dicated: "g. Initiate and riate measures in plan of care atment/intervention change." licated physician to be notified as a "significant" change, "as d indicated R44 resisted cares ne personality, the staff did not lentify risk factors, and did not veness of the interventions to further skin breakdown. RVICES BY QUALIFIED	F 280		n accord with re. for R77 on efer to rrent residents ere reviewed Reviewed elated to h RN's, LPN's

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/29/2013 APPROVED			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED				
		B. WING	12/2013							
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE					
BENEDIC	TINE HEALTH CENT	ER OF MINNEAPOLIS			18 EAST 17TH STREET IINNEAPOLIS, MN 55404					
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPT DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 282	Continued From pa	ge 18	F 2	282		. :				
	Findings include:			]	maintaining location of tubing	and				
					drainage bag below the level	of the				
	R77 was not provided assistance with grooming (which included nail care) as directed by the care				bladder. Review of policy and					
	plan.				expectations related to nail ca					
	The care plan date	d 0/26/11 identified P77 had			C. Random audit of ADL cares ar					
		care plan dated 9/26/11, identified R77 had Iteration in ability to groom related to right	transfers of residents with uri		:					
	ischemic brain injury, diabetes mellitus			catheters with focus on catheter						
	uncomplicated type 2, left hemiplegia, balance problems, inconsistent ability to follow directions		tubing/bag remaining below the level of							
	and spasticity. R77	's care plan focus goal			the bladder. Random audit of	-	• .			
		ill be well groomed." The Sheet dated 7/10/13, directed			specific to nail care. Audits by	•				
	R77 required assist	staff as directed by Director of Nursing or designee.								
		and R77's bath day was			D. Results of audits communicat	od to				
	Monday second shi				Quality Council for input.					
		a.m. during initial interview			duality coulier for input.		1			
	observed finger nails (approximately one fourth inch in length).			C	ompliance Date: 8/19/13		; ;			
	family member (F)- help for R77 when stated occasionally believed someone responsible for clip stated sometimes v long and had to get visiting. On 7/9/13, at 8:40 a dining room nails lo On 7/10/13, at 7:18 continuous morning	o.m. during interview with A stated there was no enough it comes to nails care. F-A was able to clip the nails but in the facility should be ping the nails. F-A further when visiting R77's nails are t someone to do them when a.m. observed R77 in the ong having breakfast. a.m. to 7:40 a.m. during g cares observation, nursing								
FORM CMS-2	567(02-99) Previous Versions	ovided R77 assistance with Obsolete Event ID: B8BR1	1	Fac	lility ID: 00960 If continuati	on sheet F	Page 19 of 44			

		H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 07/29/20 APPROV . 0938-03
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		245266	B. WING		07/12/2013	
	PROVIDER OR SUPPLIEF	ITER OF MINNEAPOLIS	61	REET ADDRESS, CITY, STATE, ZIP COI 8 EAST 17TH STREET NNEAPOLIS, MN 55404	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
F 282	ADLs but not nail On 7/10/13, from observed to be as not provided assis On 7/10/13, at10: regarding R77's n completed on R7' and verified lookin sheet. On 7/10/13, at 3:' TV lounge on the positioning wheel under his head na standing to R77's then left. On 7/10/13, at 3:' was assigned to I been informed by and repositioned when observed b see if R77 require beginning of the s On 7/11/13, at 10 nurse/clinical nur who stated there the bath had bee to chart if a resid the expectation w nail care if they n	care. 8:23 a.m. to 9:30 p.m. R77 was sisted by various staff and was stance with nail care. 42 a.m. interviewed NA-A nail care. NA-A stated it is 7's bath day on Monday evening ng at the nursing care work 15 p.m. observed R77 up in the Broda chair (tilt and recline chair) tipped slightly with pillow ails still long observed NA-G right side spoke with R77 and 22 p.m. interviewed NA-G stated R77 on the second shift and had o nurse that R77 was to be toilet at 4:00 p.m. NA-G further stated y R77 NA-G was checking to ed anything as this was at the	F 282			

그는 가는 것이 잘 하는 것이 같아요. 이 것이 같은 것은 것은 것은 것은 것이 있는 것이 가지 않는 것이 가지 않는 것이 같이 있는 것이 같이 있는 것이 없다.

ENTERS FOR I	<u>MEDICARE</u>	AND HUMAN SERVICES	(X2) MUL	TIPLE CONSTRUCTION	FORM OMB NO (X3) DA	D: .07/29/2013 M APPROVED D. 0938-0391 ITE SURVEY	
ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266			1 ' '	ING		07/12/2013	
		245266	B. WING				
ENEDICTINE HE		ER OF MINNEAPOLIS	-	STREET ADDRESS, CITY, STATE, Z 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	IP CODE		
REFIX (EAC	H DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE	(X5) COMPLETION DATE	
F 282 Continu	ed From pa	age 20	F 2	282			
complet complet know. R any nur needed circums stated s care pla confirm residen The pol Nail Ca the resi	ed with res ed the aide esident nai sing staff w for the resi tances that taff was ex n during ca ed that staf care plan icy and pro re, indicate dents on th d nurse wil	ed she expects nail care to be ident bath and if not able to be was expected to let the nurse care can be completed by ho notices nail care was dent unless there were other stated otherwise. DON further pected to follow the resident are provision. The DON also f was expected to follow the when providing care. cedure dated 5/12/11, titled d "nail care will be provided to eir shower day and as needed. I cut the nails of a resident with					
over ha raised t transfer to minin R78's c alteratio long ter directed and sta noted F behavio bipolar and ha	If an hour c o R78's che , and the F nize pulling are plan da on in urinan m Foley ca I staff to pr ndard of pr t78's diagn or disturban disorder ar d long term	ge bag was kept on the bed for luring morning cares, was est level during mechanical lift oley catheter was not anchored and stretching of the catheter. Ated 4/24/13, indicated R78 had y function, and R78 was with theter use. The care plan ovide, "Catheter care per policy actice." The care plan also oses included dementia with ces, chronic kidney disease, and anxiety. R78 was on hospice Foley catheter use.					

רפ⊿פז	MENT OF HEALT	HAND HUMAN SERVICES					: 07/29/201 I APPROVE	
		E & MEDICAID SERVICES					. 0938-039	
TATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED 07/12/2013	
		245266	B. WING	B. WING				
	ROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		618 EA	T ADDRESS, CITY, STATE, ZIP C AST 17TH STREET EAPOLIS, MN 55404	CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE	
F 282	Continued From p		F	282				
	towel and washcle the Foley catheter protector bag atta- laid it on the top of legs. The Foley ca not secured to R7 morning cares R7 chair with two staf mechanical lift at catheter drainage	water. NA-B had prepared a oths on the bed. NA-B removed drainage bag from the black ched to the side of the bed and f the sheets in between R78's atheter was observed, and was 8's thigh. After completing the 8 was transferred to the wheel f assist and a Hoyer 7:56 a.m. NA-E raised the Foley bag and hooked it to the sling, a bag was at R78's chest level ansfer.	/			J		
	7/10/13, at 8:10 a the catheter drain safety of the cath	I right after the observation on .m. NA-E stated they attached age bag to the sling to ensure eter and bag. The NA-E also nothing special they had to do eter care.						
	director/registered on 7/11/13, at 12: catheter needed to resident's thigh by holder, and prese expected to use. drainage bag, not where the drainage drainage bag, and in the tube was a bag was raised a RN-F stated staff	trol and staff development d nurse (RN)-F was interviewed 12 p.m. and stated the Foley to be secured all the time to y using the multi-purpose tube ented the tube holder staff were The RN-F verified the urine ted the anti-reflux was located ge tube connected to the d confirmed the urine collected t risk to back flow if drainage bove the bladder level. The was expected to keep/store the ag below the bladder level at all	Ð					

	MENT OF HEALTH					FC	TED: 07/2 DRM APPF NO: 0938	ROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION I	LIER/CLIA (X	-		(X3	) DATE SUR' COMPLETE	
		245266	в.	. WING			07/12/20	)13
NAME OF F	ROVIDER OR SUPPLIER		, , , , , , , , , , , , , , , , ,		REET ADDRESS, CITY, STATE,	ZIP CODE		
BENEDIC	CTINE HEALTH CENT	TER OF MINNEAPO	LIS	1	8 EAST 17TH STREET INNEAPOLIS, MN 55404	. <u></u>		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED _SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE	COM	(X5) PLETION DATE
F 282	drainage bag was bed in level with th she had just comp catheter through t help to get R35 ou was being transfe	ove the bladder an bing was observed 1/13, at 8:44 a.m. cluded terminal illne unter with palliative , osteoporosis, oste JD (degenerative jo sed 7/9/13, identified ling urinary catheter bich made positioni 35's care plan focus 1 have catheter car videnced by not ex	flowing ess, debility, eoarthritis, bint disease), ed R35 er related to ng s goal e managed hibiting signs eatheter top of the NA-F stated s Foley going to get e time R35 hair	F 282				
	hanging the Foley lift sheet between throughout the tra tubing was observ On 7/11/13, at 9:0 had to pass the ca leaves it right ther added she usually drainage bag on t when transferring understands R35	catheter drainage R35's legs above insfer. The urine co ved flowing backwa of a.m. NA-F stated atheter through the re as observed ear y she placed the Fo the lower side of the R35. NA-F stated could have a high if the urine was to	bag on the the bladder ollected in the ards. d she usually pants and ly. NA-F oley catheter e lift sheet she likelihood of					
EORM CMS-	2567(02-99) Previous Versio		Event ID: B8BR11	Fa	cility ID: 00960	If continuation	sheet Page	23 of 44

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

		HAND HUMAN SERVICES E & MEDICAID SERVICES				FORM	D: 07/29/2013 // APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245266	B. WING			07	//12/2013
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	·····	
BENEDIC	TINE HEALTH CENT	FER OF MINNEAPOLIS			18 EAST 17TH STREET /INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	the urine has to dra Foley catheter drain positioned below th R35. On 7/11/13, at 9.15 catheter drainage to bladder to prevent unclear if the Foley anti-back flow valve catheter drainage to indicated the draina chamber. RN-D wa the tube having a b On 7/11/13, 10:33 a expectation was sta drainage bag below flow when staff tran catheters. On 7/11/13, at 1:14 catheter drainage to bladder level and ic still hanging at the transfers and have to the bed keep it b further showed that was located on the RN-F confirmed the urine back flow to t above the bladder level on 7/11/13, at 3:10 stated she expected below the bladder level further stated the b	Further stated she understood ain downward and that the mage bag needed to be he bladder when transferring 5 a.m. RN-D stated R35's Foley bag had to be kept below the urine back flow. RN-D was reatheter drainage bag had an e but later provided a Foley bag from medication room that age bag had an anti-reflux as still unclear about urine in back flow a.m. RN-E stated her aff to keep the Foley catheter withe bladder to promote urine hsferred residents with bag should be kept below the deally staff could leave the bag side of the bed during the wheelchair moved closed below bladder level. RN-F t the anti-reflux chamber valve catheter bag and not the tube. ere could be the potential of he bladder if Foley was set level. 0 p.m. the director of nursing d staff to keep the catheter evel during transfers and she ags had a built in valve to			· · · · · · · · · · · · · · · · · · ·		
FORM CMS-25	prevent urine back 67(02-99) Previous Versions	flow on the drainage bag.	1	Fac	cility ID: 00960 If contin	ation sheet	Page 24 of 44

Facility ID: 00960

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 07/29/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
		245266	B. WING		07/	12/2013
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12/2010
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 24	F 28	32		
		urinary policy dated 12/2002, ensure drainage bag is lower				
F 309 SS=D	for Prevention of Ca Tract Infections dat section 4. listed "4. properly secured af movement and uref recommendations u collecting bags sho level of the bladder 483.25 PROVIDE C	under section 8. indicated "4) uld always be kept below the ," CARE/SERVICES FOR	F 30	99		
	provide the necess or maintain the high mental, and psycho	receive and the facility must ary care and services to attain nest practicable physical, social well-being, in e comprehensive assessment		It is the practice of Benedictine Minneapolis to provide care an attain or maintain the highest p physical, mental, and psychoso	d services practicable	to
	by: Based on observat review, the facility for received necessary maintain the highes and psychosocial w	NT is not met as evidenced ion, interview and record ailed to ensure each resident care and services to attain or at practicable physical, mental, rell-being, related to dialysis 1 of 1 resident (R34) s.		<ul> <li>A. Plan of care for R34 wareinstate order that haprior to hospitalization removal of dressing at dialysis days.</li> <li>B. Review/revision of plan other resident(s) prese hemodialysis for prese specific to dialysis dres</li> </ul>	d been pre which dire 9:00 PM or of care fo ntly receiv nce of dire	esent ected n or ing ctions

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

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Facility ID: 00960

		I AND HUMAN SERVICES				FORM	07/29/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245266	B. WING	·		07/	12/2013
BENEDIC (X4) ID	SUMMARY STA		- ID	61 MI	REET ADDRESS, CITY, STATE, ZIP CODE 8 EAST 17TH STREET INNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	N	(X5) COMPLETION
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC		CROSS-REFERENCED TO THE APPROP. DEFICIENCY)		DATE
F 309	R34's dialysis acce removed after dialy access site infection Physician orders si identify specific insiste site dressing. R34's care plan up received dialysis the left upper extremity The care plan instr "Shunt site dressin doctor] orders." The 12/20/11, that R34 an interpreter. R34 diagnoses not limit stage renal disease vision. On 7/9/13, at 3:28 wheelchair wearing spoke only Spanis upper arm. R34 ro the surveyor his dialysis over his left upper not been removed was loose. On 7/9/13, at 3:30 reported she freque stated R34 moved RN-A added that a she had not remove upper arm over his	ess site dressing was not vsis to reduce the risk of	F	309	C. Random audits by Clinica designee for removal of d dialysis as per plan of care D. Results of audits commun Quality Council for input. Compliance date: 8/19/13	ressings e.	post

and the second second

		AND HUMAN SERVICES				FORM	: 07/29/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245266	B. WING	3		07/	12/2013
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP COD	E .	
BENEDIO	TINE HEALTH CEN	TER OF MINNEAPOLIS		_	18 EAST 17TH STREET IINNEAPOLIS, MN 55404		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	iD	1	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(X5) COMPLETION
PRÉFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREI		CROSS-REFERENCED TO THE API DEFICIENCY		DATE
F 309	Continued From pa	age 26	F	309			- - - - - -
	moved the gauze a	and tape on the access site to	)				
	the side, looks at t	he area's, then puts the same over the site. RN-A reviewed	e				
	R34's treatment sh	neet and physician orders at					
	that time and confi	irmed there was no order or ig to remove the dressing on					
	the dialysis access	s site after dialysis. At 3:33 p.i	n.				
	RN-E stated staff (	do not remove the access I's access site on off dialysis					
	days because he v	wheeled himself around and o	lid				
	not want it to bleed	d.					
	On 7/10/13, at 9:4	9 a.m. clinical manager, RN-I	3				
-	confirmed R34 ha	d an upper arm fistula in his le ed the treatment sheets for th	eft				
	last nine days and	I confirmed there was no orde	er				
٢	for how staff should drossing RN-B wa	ld manage R34's shunt site as not aware staff was not					
	removing the dres	sing after treatment on					
	non-dialysis days	or if this was recommended. , tated R34 had a dressing	At				N.
	change order that	was not reactivated when he					
	came back from th	he hospital on 6/3/13. RN-B r instructed staff to take off the					
	dialysis dressing c	on dialysis days at 9:00 p.m.					
	RN-B confirmed t	he dressing had not been					
	hospital and trans	was re-admitted from the ferred from her unit. RN-B	t				
	verified staff shou	Id have been removing the			:		
	dressing to reduce	e risk of access infection.					
	On 7/10/13, at 11	:45 a.m. through an interprete	er f				
	his dialvsis dressi	on the other unit, staff took of ng but since he moved to this	1 i				
	unit and they do n						
	The facility policy	for Care of Arteriovenous					
	Fistulas and Arter	riovenous Grafts undated, e involves the primary goals c	of				
EORM CMS	2567(02-99) Previous Versio			Fa	acility ID: 00960 If cor	tinuation shee	t Page 27 of 44

PREFIX TAG(EACH DEFICIENC REGULATORY ORF 309Continued From p preventing infection the catheter (prev identified to keep times.F 312483.25(a)(3) ADL DEPENDENT RE A resident who is daily living received maintain good nu and oral hygiene.	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266 TER OF MINNEAPOLIS TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	A. BUILDING	LE CONSTRUCTION STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLET
BENEDICTINE HEALTH CEN(X4) ID PREFIX TAGSUMMARY ST (EACH DEFICIENC REGULATORY ORF 309Continued From p preventing infection the catheter (prev identified to keep times.F 312483.25(a)(3) ADL DEPENDENT RE A resident who is daily living received maintain good nu and oral hygiene.	TER OF MINNEAPOLIS	ID PREFIX TAG	618 EAST 17TH STREET MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR	TION (X5) ULD BE COMPLET
BENEDICTINE HEALTH CEN(X4) ID PREFIX TAGSUMMARY ST (EACH DEFICIENC REGULATORY ORF 309Continued From p preventing infection the catheter (prev identified to keep times.F 312483.25(a)(3) ADL DEPENDENT RE A resident who is daily living received maintain good nu and oral hygiene.	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	618 EAST 17TH STREET MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR	ULD BE COMPLET
(X4) ID PREFIX TAGSUMMARY ST (EACH DEFICIENC REGULATORY ORF 309Continued From p preventing infection the catheter (prev identified to keep times.F 312483.25(a)(3) ADL DEPENDENT RE A resident who is daily living received maintain good nu and oral hygiene.	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Dage 27 on and maintaining patency of	ID PREFIX TAG	MINNEAPOLIS, MN 55404 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR	ULD BE COMPLET
F 309 Continued From p preventing infection the catheter (prev- identified to keep times. F 312 483.25(a)(3) ADL SS=D DEPENDENT RE A resident who is daily living receives maintain good nu and oral hygiene.	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Dage 27 on and maintaining patency of	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE COMPLET
preventing infection the catheter (previdentified to keep times. F 312 483.25(a)(3) ADL SS=D DEPENDENT RE A resident who is daily living receive maintain good nu and oral hygiene.	on and maintaining patency of	F 309		
preventing infection the catheter (previdentified to keep times. F 312 483.25(a)(3) ADL SS=D DEPENDENT RE A resident who is daily living receive maintain good nu and oral hygiene.	on and maintaining patency of		9	
A resident who is daily living receive maintain good nu and oral hygiene.	the access site clean at all CARE PROVIDED FOR	F 312	2	
	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.		It is the practice of Benedictine Minneapolis to ensure resident grooming assistance based upo needs.	ts receive
by: Based on observ review, the facility received groomin	ENT is not met as evidenced vation, interview and document y failed to ensure a resident ng assistance for nail care for 1 77) reviewed for activities of dail	У	Refer to Plan of action as noted	d in F 282
6/3/13, identified with Brief Intervie score of three (ir required total de Area Assessmer dated 9/12/12, id staff for ADLs. R sclerosis, hemip dementia, right i	Minimum Data Set (MDS) dated R77 was cognitively impaired ew for Mental Status (BIMS) indicating severe cognitive loss), pendence with ADLs. The Care int (CAA) for communication dentified R77 was dependent on R77's diagnoses included multiple legia non-dominant side, schemic brain injury, diabetes dicated type II, and intracranial	0		
The care plan d	ated 9/26/11, identified R77 had			

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

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
			A. BUILDING				
		245266	B. WING	•	REET ADDRESS, CITY, STATE, ZIP CODE	07/	12/2013
AME OF F	PROVIDER OR SUPPLIER				EAST 17TH STREET		
BENEDIC	CTINE HEALTH CENT	ER OF MINNEAPOLIS			NNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 312	an alteration in abil above diagnoses. I directed R77, "Will Nursing Care Work R77 required assis	age 28 ity to groom related to the R77's care plan focus goal be well groomed." The < Sheet dated 7/10/13, directed tance of one with ADLs and s Monday second shift.		312			
	R77's finger nails o	a.m. during initial interview on both hands were observed immed (approximately one length).					
	interviewed (F)-A. enough help for RT F-A stated they oc nails, but believed be responsible for stated sometimes	p.m. R77's family member was F-A stated there was not 77 when it came to nail care. casionally were able to clip the someone in the facility should clipping the nails. F-A further when visiting, R77's nails were to get someone to cut them			·		
	On 7/9/13, at 8:40 have long nails on breakfast in the dir	a.m. R77 was observed to both hands while having ning room.					
	following was obse - From 7:18 a.m. tr cares were observed was observed to p included a bed bat pericare, combing nails were visible a cares and were ur inch long. At no tir NA-A offer nail car - At 7:42 a.m. NA-	o 7:40 a.m. R77's morning yed. Nursing assistant (NA)-A provide R77's daily cares which th, applying lotion, dressing, R77's hair and oral care. R77's as R77 participated during ntrimmed and approximately 1/4 ne during the observation did	6				

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245266	B. WING		07	/12/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E.	
		ER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFU TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	breakfast. NA-A wa of the room and sta the dining room. - From 7:43 a.m. to sitting in the dining side table across h - From 8:23 a.m. to observed assisting to sit next to R77 a independently drar - At 8:34 a.m. R77 breakfast. NA-B to - From 8:34 a.m. to to sit in the dining coffee. - From 8:56 a.m. t R77 to the televisi room. R77 requess observed to be wa time. - At 10:03 a.m. R7 television. At no the nail cares offered. On 7/10/13, at 100 regarding R77's in was completed or evening (7/8/13) a nursing care work always easy to cli movements. On 7/10/13, at 3:2 standing next to F at R77 then walke visible. At the time confirmed she wa	IIII be completed after as observed to wheel R77 out ationed R77 by the window in o 8:23 a.m. R77 was observed room looking around with a his lap waiting for breakfast. o 8:33 a.m. NA-B was g R77 with breakfast set-up and and assist him with eating. R77 hk his fluids. completed eating his bok R77's tray back to the cart. o 8:55 a.m. R77 was observed room drinking a second cup of. to 10:02 a.m. NA-A wheeled on room across from the dining sted more juice and was atching television during this r7 fell asleep in front of the me during the observation were		12	•	eet Page 30 o

CENTERS FOR MEDICARE & MEDICALD SERVICES       OVER NO. 0938-0331         VAIL GENT OF CONCERCETION       (X) PHONENERUPPUENCUE       (C) PHONENCE       (C) PHONENCES         NML CH PROVDER OR SUPPLIER       24266       5. WING       (C) PHONENCES         BENEDICTINE HEALTH CENTER OF MINNEAPOLIS       5174EET ADDRESS, CITY, STARE, ZIP CODE       (C) PROVDER OR SUPPLIER       5174EET ADDRESS, CITY, STARE, ZIP CODE         Comparing the content of the co				AND HUMAN SERVICES				FORM	07/29/2013 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER       STINEE ADDRESS, CTM, STATE, ZP GODE         BENEDICTINE HEALTH CENTER OF MINNEAPOLIS       STINEE ADDRESS, CTM, STATE, ZP GODE         MinNEAPOLIS, MN 55404       State and the state of the control of the state	ST.	ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			•		
Benedictine Health Center of MINNEAPOLIS <sup>198</sup> EASH 17TH STREET          Benedictine Health Center of MINNEAPOLIS <sup>198</sup> EASH 17TH STREET          PADE       SUMMARY STATEMENT OF DEFICIENCIES <sup>198</sup> EASH 17TH STREET          PADE       SUMMARY STATEMENT OF DEFICIENCIES <sup>198</sup> EASH 17TH STREET          PADE       SUMMARY STATEMENT OF DEFICIENCIES <sup>198</sup> EASH 17TH STREET          F 312       Continued From page 30         checking to see if R77 needed any assistance but         R77 was asleep. Nail care was not offered.           F 312          On 7/11/13 at 10.15 a.m. the registered         nurse/clinical nurse manager (RN)-E stated there         was no charing completed that the bath had         been completed but expected staff to chari if a         resident refused. RN-E further stated the         and silves to the bath day. The RN-E observed         the nalls with the surveyor, acknowledged the         nursils were long and stated the nalls needed to be         trimmed           f all care to be         completed by any nursing staff who noticed nall         care was needed to the resident. The DON also         confirmed that staff was expected to follow the         resident with diabetas:         f and as needed. Licensed norse will cut the nails         or a resident. The DON also         confirmed that staff was expected to follow the         resident two the residents. The DON also         confirmed that staff was expected to follow the         resident the residents on their shower day         and as needed. Licensed nurse will cut the nails         of a resident wit				245266	B. WING			07/	12/2013
BEREDICTINE HEALTH CENTER OF MINNEAPOLIS         MINNEAPOLIS, MN 55404           (M) D PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EXCH DEFICIENCY MUST BE PRECEDED BY FUL RECOLUTIONY OR USC IDENTIFYING INFORMATION)         PROVIDER'S PLAN OF CONRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FUL RECOLUTIONY OR USC IDENTIFYING INFORMATION)         PREFX PREFX TAG         PROVIDER'S PLAN OF CONRECTION (EACH DEFICIENCY)         COMESTION (EACH DEFICIE	N	AME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
Mail Txo       reactiverificative definition       PREFX       CEACH CORRECTIVE ACTION BHOLLD SE       CROSS-REFERENCE TO TIVE ACTION SHOLLD SE       CROSS-REFERENCE TO TIVE ACTION SHOLLD SE         F 312       Continued From page 30       F 312       F 312       F 312       F 312         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 to be trimmed       F 312         On 7/11/13, at 3:07 p.m. the director of nursing (DON) stated she expected nail care to be completed, the aide was expected to let the nurse knew. DON stated resident thail care could be completed that file bath had be completed, the aide was expected to let the nurse knew. DON stated resident that action to be completed. The resident that are could be completed to the stated staff to chart if a resident with nail care was needed for the resident that are could be completed. The resident that are could be completed. The resident that are could be completed. The resident that are could be completed to the resident staff was expected to follow the resident staff was expected to follow the resident staff was expected to an integrity program that includes prevention, care and treatment of pressure ulcers to promote         F 314       Ass.26() TREATMENTSVCS TO       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	E	BENEDIC	TINE HEALTH CENT	ER OF MINNEAPOLIS			NNEAPOLIS, MN 55404		· · · · · · · · · · · · · · · · · · ·
<ul> <li>checking to see if R77 needed any assistance but R77 was asleep. Nail care was not offered.</li> <li>On 7/11/13 at 10:15 a.m. the registered nurse/clinical nurse manager (RN)-E stated there was no charing 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</li> <li>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 with resident bath and if not able to 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.</li> <li>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."</li> <li>F 314</li> <li>F 314</li> <li>Based on the comprehensive assessment of a resident, the facility muthout pressure sores does not develop pressure sores</li> <li>Based on the comprehensive assessment of a resident, the facility muthout pressure sores</li> <li>and treatment of pressure ulcers to promote</li> </ul>		PREFIX	(FACH DEFICIENC)	( MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETION
individual's clinical condition demonstrates that healing.		F 314	checking to see if F R77 was asleep. N On 7/11/13 at 10:1 nurse/clinical nurse was no charting co been completed bu resident refused. F expectation was ar care if they noticed and not just on the the nails with the s nails were long and trimmed On 7/11/13, at 3:0 (DON) stated she completed with res completed, the aid know. DON stated completed by any care was needed confirmed that sta resident care plan The Nail Care poli 5/12/11, titled Nail be provided to the and as needed. Li of a resident with 483.25(c) TREAT PREVENT/HEAL Based on the com resident, the facili who enters the facili who enters the facili	R77 needed any assistance but ail care was not offered. 5 a.m. the registered e manager (RN)-E stated there mpleted that the bath had at expected staff to chart if a RN-E further stated the my staff would assist with nail i ti was a problem as needed bath day. The RN-E observed urveyor, acknowledged the d stated the nails needed to be 7 p.m. the director of nursing expected nail care to be sident bath and if not able to be le was expected to let the nurse resident nail care could be nursing staff who noticed nail for the resident. The DON also ff was expected to follow the when providing care. cy and procedure dated Care, identified, "Nail care will residents on their shower day censed nurse will cut the nails diabetes." MENT/SVCS TO PRESSURE SORES hprehensive assessment of a ty must ensure that a resident cility without pressure sores pressure sores unless the			Center of Minneapolis to provio integrity program that includes	de a skin preventi	on, care

Facility ID: 00960

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STATEMENT OF DEPICENCIES       (M) PERVORTERUIPLIEVUATION       (D) MULTIFUE CONSTRUCTION       (D) COMPLETED       (D) COM						4		
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, 2IP COUL       STREET ADDRESS, CITY, STATE, 2IP COUL         BENEDICTINE HEALTH CENTER OF MINNEAPOLIS       ID       STREET ADDRESS, CITY, STATE, 2IP COUL       STREET ADDRESS, CITY, STATE, 2IP COUL       STREET ADDRESS, CITY, STATE, 2IP COUL         PHETX       REGULATORY OR USE OF PROVIDER OF VALL       ID       PROVIDER OF ADDR SS, CITY, STATE, 2IP COUL       OP         PHETX       REGULATORY OR USE OF DEFICIENCES       ID       ID       PROVIDER OF ADDR SS, CITY, STATE, 2IP COUL       OP         F 314       Continued From page 31       IF       ID       PROVIDER OF ADDR SS, CITY, STATE, 2IP COUL       OP         F 314       Continued From page 31       IF       STREET ADDRESS, CITY, STATE, 2IP COUL       OP         F 314       Continued From page 31       IF       STREET ADDRESS, CITY, STATE, 2IP COUL       OP         F 314       Continued From page 31       IF       STREET ADDRESS, CITY, STATE, 2IP COUL       OP         F 314       Continued From page 31       IF       STREET ADDRESS, CITY, STATE, 2IP COUL       OP         F 314       Continued From page 31       IF       STREET ADDRESS, CITY, STATE, 2IP COUL       OP         F 314       F       STREET ADDRESS, CITY, STATE, 2IP COUL       OP       OP         F 314       F <t< td=""><td>STATEMEN</td><td>T OF DEFICIENCIES</td><td>(X1) PROVIDER/SUPPLIER/CLIA</td><td></td><td></td><td>ONSTRUCTION</td><td>(X3) DAT</td><td>E SURVEY</td></t<>	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DAT	E SURVEY
MARL OF PACYNDER OR SUPPLIER       SIMPLARE OF MINNEAPOLIS       STREET ADDRESS, CITY, STREET, 20 CODE         MARL OF PACYNDER STATEMENT OF DEFICIENCIES       ID       SIMPLAREY STATEMENT OF DEFICIENCIES       Street ADDRESS, CITY, STREET, 20 CODE         MORT DE SUMAARY STATEMENT OF DEFICIENCIES       ID       ID       PROVIDER STATE       Configure Action State Construction       Construct State Construction         F 314       Continued From page 31       IT       F 314         F 314       Continued From page 31       F 314         This REQUIREMENT is not met as evidenced       F 314         This REQUIREMENT is not met as evidenced       by the introdisciplinary 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 facility failed to comprehensively reasses, adequately monitor and revise interventions when a Deep Tissue lipit or marcon area of discolared intervent with out to damage of underlying soft itsue) was identified revert with atteration in skin pressure ulcers.         F Findings include:       Cites of record review indicated R44 was districtated. The applician progress note dated 51137, indicated R44 was adaponed with DT1 on both buttocks, measuring 2 x 2 centimeter (m) or right buttocks, and 1 x 2 cm on the left buttock Th facility failed to reassess rick Kators, implement interventions to promote healing, and prevent futher skin breakdown. As a result the right buttock Th facility failed to reassess rick kators, implement interventions to promote healing, and prevent futher skin breakd			245266	B. WING	· · · · · ·	·····	07/	12/2013
BEENDOLTINE HEALTH CENTER OF MINNEAPOLIS       MINNEAPOLIS, MN 55404         (MA) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTORY OR LSCIDENTIFY AG INFORMATICS)       ID PREFIX TAG       PROVIDERS 21A OF CORRECTION (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       OWE INFORMATICS PREFIX TAG       PROVIDERS 21A OF CORRECTION (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME INFORMATICS PREFIX TAG       PROVIDERS 21A OF CORRECTION (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME INFORMATICS (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME INFORMATICS (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       PROVIDERS 21A OF CORRECTION (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME IFOR (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME IFOR (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME IFOR (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME IFOR (EACH EPERCENCY NUS 1G LEVIESCEDED & FULL RESULTATORY OR LSCIDENTIFY AG INFORMATICS)       COME IFOR (EACH EPERCENCY INSTITUTES AGE INFORMATICS)       COME IFOR (EACH EPERCENCY INTERS INFORMATICS)       COME IFOR (EACH EPERCENCY INTER	NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAGCRACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE DEFICIENCYCONSTRUCT DATEF 314Continued 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.F 314This 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 – puptie or marcon area of discolored intact skin due to damage of underlying soft insue) was identify for 1 of 4 residents (R44) in the sample reviewed with pressure ulcers.F 314Findings include:Consed record review indicated R44 was distal tibia/ fibular fracture. A physician progress note dated 6/1913, indicated R44 was distal tibia/ fibular fracture. A physician progress rick factors, implement interventions to promote healing, and prevent further skin breakdown. As a result the right buttock ST measuring 2.2 centimeter (cm) on right buttock DT developed into a unstageble pressure ulcer.F 314 compliance tas a facture of Nursing or designee for compliance with actions to be taken. Results of audits communicated to Quality Council for input. Compliance date 8/19/13F 314Compliance date 8/19/13	BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS					
<ul> <li>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.</li> <li>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.</li> <li>Findings include:</li> <li>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 ensuring 2 x 2 centimeter (cm) on right 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.</li> <li>R44 was admitted to the facility on 9/6/12, with diagnoses that holdude schizoaffective disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder and borderline personality disorder, diabetes, right above the knee amputation, depressive disorder, ostecarthritis, and obesity.</li> <li>The physician progress note dated 6/19/13, also</li> </ul>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC	D BE	COMPLETION
	F 314	they were unavoida pressure sores reco services to promote prevent new sores This REQUIREMEN by: Based on interview facility failed to com adequately monitor a Deep Tissue Injur of discolored intact underlying soft tissue residents (R44) in t pressure ulcers. Findings include: Closed record reviet discharged to the h distal tibia/ fibular fit note dated 6/19/13 with DTI on both but centimeter (cm) on on the left buttocks rick factors, implem healing, and preven result the right butto unstageble pressun R44 was admitted diagnoses that incl and borderline pers right above the kne disorder, osteoarth The physician prog	<ul> <li>able; and a resident having eives necessary treatment and a healing, prevent infection and from developing.</li> <li>NT is not met as evidenced and revise interventions when revise interventions when reveal of use windicated R44 was a standard revise interventions when reveal was identify for 1 of 4 he sample reviewed with</li> <li>ew indicated R44 was a diagnosed attocks, measuring 2 x 2 right buttocks, and 1 x 3 cm. The facility failed to reassess the interventions to promote the further skin breakdown. As a lock DTI developed into an reveal of the facility on 9/6/12, with uded schizoaffective disorder sonality disorder, diabetes, be amputation, depressive ritis, and obesity.</li> </ul>	F 3		<ul> <li>by the interdisciplinary tersistic breakdown. Per MD Nurse, appropriate interversion place for resident. As or areas identified were heal nurse. Of note: R44's mut comorbid conditions and testablished historical patter noncompliance have beer delineated in plan of care</li> <li>B. Review of medical records residents with alteration integrity for presence of coskin risk assessment, more revisions if indicated.</li> <li>C. Review/reeducation of lice specific to expectations reactions to be taken if skin identified.</li> <li>D. Random audit by Director designee for compliance to Quality input.</li> </ul>	am specif and Wou entions w f 8/2/13, ed per w ltiple well ern of more clo s of other n skin omprehe itoring ar ensed stated to breakdor of Nursii with actic	fic to nd vere ound early ensive nd aff wn is ng or ons to

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		245266	B. WING			07	/12/2013
		ER OF MINNEAPOLIS		618	EET ADDRESS, CITY, STATE, ZIP EAST 17TH STREET NEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	FACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
colo cm, crea Furt reas DTI The follo - note crea mar whe - pres freq or d butt slou brov and edg is a - refu ass cm blea - give right edg	and Calmosep m) was initiate her record revi sessment of the was identified nurses progree wing: On 6/17/13, the ed on buttocks. Im applied. Wr hager. Unable for a touched." On 6/22/13, the sents with an a uently black or evitalized tissu ock. Scant blev ock. Scant blev ock. Scant blev mucinous in the es. Tena creat lso c/o [complation On 6/26/13, the sest and note with slough an eding." The not ea to be very p On 7/3/13, the en, and skin as it was "about 3 ges with scant as there were not	open area measuring 0.5 x 0.5 tine ointment (moisture barrier d two times a day. ew indicated lack of he skin risk factors after the on 6/19/13. ss notes review revealed the e note indicated, "Black area Tena (brand name) protective iter left a message for clinical to measure due to pain in area e note indicated, "Resident rea of eschar [thick, leathery, brown in color, necrotic (dead) te] 5.2 cm x 5 cm on his right eding from edges with a thin yellow, tan, gray, green or ally moist, can be soft, stringy exture] also noted on the m applied as ordered, resident aint of] pain in the area." the note indicated resident ut agreed to a bed bath, "Skin ed coccyx wound about 4.5 x 5 d pink/red edges with small te also indicated resident stated ainful." e note indicated a bed bath was ssessment completed, and the 0.5 x 3 cm with slough and red amount of bleeding." o additional notes found related , and resident was discharged		314			

		I AND HUMAN SERVICES				(INTED: 07 FORM API <u>/IB</u> NO: 09	PROVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SU COMPLE	
		245266	B. WING			07/12/:	2013
	PROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		STREET ADDRESS, CITY, STATE, ZIP 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	CODE		
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	indicated resident v and had no unheal The skin care plan "Alteration in skin ir venous stasis, diab moisture, and listed "monitor for indicat present", "Turning tolerance of tissue "Treatment/dressin care plan also indic reposition every 2 H indicate presence of 6/19/13. Per the car at times."	dated 9/12/12, indicated ntegrity" related to chronic betes, maceration related d approaches which included: ion of infection, contact MD if and Repositioning based on to pressure", and g per MD orders." The mobility cated "One staff to turn and nours." The care plan did not of acquired pressure ulcer from re plan "resident resists care					
	interviewed on 7/12 she was not aware on his bottom. The read the physician' was present during under the impressi shearing " related. per the facility's pol completed each tin noted in order to id completing the Bra tissue perfusion tes	se (RN)-B nurse manager was 2/13 at 10:30 a.m. and stated that resident had DTI wounds RN-B explained she did not s progress notes, since she the assessment, and was on that R44's wounds were " The RN-B also stated that as licy a reassessment was entify the risk factors by den assessment, and new st. The RN acknowledged R44 d to identify risk factors, there					

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

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

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	MENT OF HEALTH	AND HUMAN SERVICES				FORM	07/29/20 APPROVI
ATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		245266	B. WING			07	/12/2013
	ROVIDER OR SUPPLIER	TER OF MINNEAPOLIS		618	EET ADDRESS, CITY, STATE, ZIP CO EAST 17TH STREET INEAPOLIS, MN 55404	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET) DATE
F 314	stated after review 6/22/13, 6/26/13 a turned into and un she was not "awar R44's treatment re Calmoseptine oint initiated on 6/19/1 DTI developed intr and as per the pro- not notified either. The facilities wour on 7/12/13, at 11: informed in June 2 caused wound on haven't seen R44 she was on the flo and since that she from staff. The W "speculate," or giv not seen the wour wound was she w hydrogel to help lit	em either. The RN-B further ing the progress notes from nd 7/3/13, that R44's DTI stageble pressure ulcer, which re of.". The RN-B reviewed ecord and stated the ment treatment which was 3, was not changed when the p an unstageble pressure ulcer, ogress notes, the physician was and nurse (WN) was interviewed 10 a.m. and stated she was 2013 that R44 had a shearing the bottom, however she is wounds, since the one time por R44 refused to lay down, a have not received an update /N stated she did not want to ve her opinion since she have nd, but based on what kind the round recommend the usage of quefy the slough or eschar.		.14			
	7/12/13, at 11:45 vacation for two v other two coverin by staff when R44 developed into ar physician explain and benefits of hi	ctor (MD) was interviewed on a.m. and stated he was on veeks from 6/21/13, and the g physicians were not updated 4's DTI on the right buttocks a unstageble pressure ulcer. The ed R44 was explained the risks s refusals with care, and that e of the consequences of his	e		· · · · · · · · · · · · · · · · · · ·		

Facility ID: 00960

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			I AND HUMAN SERVICES				FORM	07/29/2013 APPROVED 0938-0391
STAT	EMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		E SURVEY PLETED
			245266	B. WING			07/	12/2013
		ROVIDER OR SUPPLIER	ER OF MINNEAPOLIS		61	REET ADDRESS, CITY, STATE, ZIP CODE 8 EAST 17TH STREET NNEAPOLIS, MN 55404		
PF	(4) ID Réfix Fag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	F 314	pressure ulcer. The expected to reasses acquired wounds to shearing, pressure Braden and discuss the Braden assess moisture, activity, to shear). The facility's Skin H undated, indicated residents' skin upo facility, quarterly, a development of ulc discovered." The Notification/D procedure includee "a. Initial summ be documented in and on any b. If more than one should have a sep c. Braden score for policy also indicated appropriate measu as treatment/inten also indicated phy there was a "signi Stage." Although the recoil due to his borderli reassess R44 to in re-evaluate effecti prevent R44 from	it turned into unstageble e DON also stated staff was ess residents with newly o identify risk factors such as and complete at least the s all the risk factors included in ment (sensory perception, mobility, nutrition, friction and ntegrity- Pressure Ulcers policy "Licensed Nurse will assess all on admission, readmission to and when at risk for cer, or when pressure ulcer is occumentation/Interventions d: arry of a pressure area should the resident's clinical notes facility specific forms. e pressure ulcer, each area	F	315	It is the practice of Benedictine H	ealth C	enter of
1	SS=D	- TOTODE DLAD				Minneapolis to ensure that resid		

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		AND HUMAN SERVICES				FORM	07/29/2013 APPROVED 0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		245266	B. WING			07/	12/2013
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER OF MINNEAPOLIS			INNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	assessment, the far resident who entern indwelling catheter resident's clinical c catheterization was who is incontinent treatment and serv infections and to re- function as possible This REQUIREME by: Base on observation review, the facility Foley catheter tubin handled in a mannand reduce the por for 2 of 3 residents urinary catheter us to ensure the Fole prevent excessive 3 residents (R78). Findings include: R78's urine drainan over half an hour of raised to R78's cho- transfer, and the F to minimize pulling R78's diagnosis in disturbances, chro	ent's comprehensive cility must ensure that a is the facility without an is not catheterized unless the ondition demonstrates that is necessary; and a resident of bladder receives appropriate ices to prevent urinary tract estore as much normal bladder e. NT is not met as evidenced on, interview and document failed to ensure indwelling ng and drainage bags were er to prevent urine back flow tential risk of bladder infection is (R35, R78) reviewed for e. In addition, the facility failed y catheter was anchored to tension on the catheter for 1 of ge bag was kept on the bed for during morning cares, was est level during mechanical lift foley catheter was not anchored g, stretching of the catheter. cluded dementia with behavior onic kidney disease, bipolar ety. R78 was on hospice and		315	nursing cares in a manner that do urine to flow back into the bladde indwelling catheter tubing. Refer to plan of action as noted in	r from	low

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If continuation sheet Page 37 of 44

& MEDICAID SERVICES	OMB NO. 0938-0391 (X3) DATE SURVEY
(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
245266 B. WING	07/12/2013
k	CITY, STATE, ZIP CODE
TER OF MINNEAPOLIS 618 EAST 17TH MINNEAPOLIS	
Y MUST BE PRECEDED BY FULL PREFIX (EACH (	ER'S PLAN OF CORRECTION (X5) RRECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DATE DEFICIENCY)
age 37F 315ad 4/24/13, indicated R78 had y function, and R78 was with theter use. The care plan ovide "Catheter care per policy actice."F 315d during cares on 7/10/13, from a.m. The nursing assistant (NA) applied a pair of gloves, and water. NA-B had prepared a oths on the bed. NA-B removed drainage bag from the black ched to the side of the bed and f the sheets in between R78's atheter was observed, and was 8's thigh. After completing the 8 was transferred to the wheel f assist and a Hoyer 	
Ansfer. I NA-E stated they attached the bag to the sling to ensure eter and bag. The NA-E also nothing special they had to do eter care. trol & staff development director (RN)-F was interviewed on p.m. and stated the Foley to be secured all the time to y using the multi-purpose tube ented the tube holder staff were RN-F verified the urine drainage ti-reflux was located where the nnected to the drainage bag,	

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

		HAND HUMAN SERVICES			FORM	: 07/29/2013 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245266	B. WING	······································	07	12/2013
NAME OF F	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP (		
BENEDI	TINE HEALTH CEN	TER OF MINNEAPOLIS		618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 315	above the bladder	/ if drainage bag was raised level. RN-F stated staff were store the urine drainage bag	F 3'	15		
	drainage bag was sheet above the b tubing was observed R35 diagnoses inclegally blind, enco- care-hospice care bilateral hearing lo anemia, osteopor site degenerative The quarterly Min 6/03/13, identified with activities of d toileting. The Care urinary incontinent dated 9/14/12, ide staff for toileting a The care plan dat R35 required an i related to termina uncomfortable. R directed R35, "W appropriately as e of infection or ure On 7/11/13, at 8:4	ted revised 7/9/13, identified ndwelling urinary catheter al illness which made positioning 35's care plan focus goal /ill have catheter care managed evidenced by not exhibiting signs athral trauma." 44 a.m. R35's Foley catheter		· · · · · · · · · · · · · · · · · · ·		
	drainage bag was bed in level with i	s observed lying on top of the resident body to resident lower				
		Discussion Except ID: DOD	244	Eacility (D: 00960	f continuation shee	t Dage 39 of

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

Facility ID: 00960

If continuation sheet Page 39 of 44

	TH AND HUMAN SERVICES			FORM	07/29/2013 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' <i>'</i>	TIPLE CONSTRUCTION		E SURVEY IPLETED
	245266	B. WING		07/	12/2013
NAME OF PROVIDER OR SUPPLIE BENEDICTINE HEALTH CE			STREET ADDRESS, CITY, STATE, ZIF 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	• CODE	
PREEIX (FACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
resident Foley ca going to get help the time R35 was chair (specialized observed hangin bag on the lift sh bladder throughd collected in the ti backwards. On 7/11/13, at 9 had to pass the o usually puts it or when transferrin understood R35 getting infections the bladder. NA- the urine has to catheter drainag positioned below R35. On 7/11/13, at 9 Foley catheter d the bladder to pi unclear if the Fo anti-back flow va catheter drainag that indicated th chamber. RN-D chamber valve i back flow in the On 7/11/13, 10: Nurse/Clinical N expectation was drainage bag bag	<ul> <li>she had just completed getting theter through pants and was to get R35 out of bed. During is being transferred to the broda d wheelchair) NA-F was g the Foley catheter drainage eet between R35's legs above out the transfer. The urine ubing was observed flowing</li> <li>07 a.m. NA-F stated she usually catheter through the pants and the lower side of the lift sheet g R35. NA-F stated she could have a high likelihood of s if the urine were to flow back to F further stated she understood drain downward the Foley e bag and needed to be v the bladder when transferring</li> <li>:15 a.m. RN-D stated R35 's rainage bag had to be kept below event urine back flow. RN-D was ley catheter drainage bag had an anti-reflux was still unclear if the anti-reflux n the bag could prevent urine</li> </ul>			If continuation shee	

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

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		AND HUMAN SERVICES				FORM	07/29/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ′		CONSTRUCTION		E SURVEY PLETED
		245266	B. WING			07/	12/2013
NAME OF F	ROVIDER OR SUPPLIER	<u>1</u>	L	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	TINE HEALTH CENT	ER OF MINNEAPOLIS			8 EAST 17TH STREET NNEAPOLIS, MN 55404		
	CUMMADY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	<u></u>	(25)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	i	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	Continued From pa	age 40	F:	315			
	catheters.						
	catheter drainage k bladder level and id still hanging at the transfers and kept to the bed to keep RN-F further show valve was located of tube. RN-F confirm	p.m. RN-F stated Foley bag should be kept below the deally staff could leave the bag side of the bed during the wheelchair moved closed the Foley below bladder level. ed that the anti-reflux chamber on the catheter bag and not the hed there could be the potential to the bladder if Foley was set level.					
	stated she expecte below the bladder further stated the b prevent urine back	) p.m. the director of nursing ed staff to keep the catheter level during transfers and she bags had a built in valve to flow on the drainage bag.					
	catheter manufactu 7/19/13, at 11:05 a stated, "It is always urine bag 18 inche during a transfer. C not put the collection transfers either. If urine was to enter	duct manager of the Foley urer company in an e-mail on .m. (central standard time) s recommended to keep the s below the bladder, even Clinicians [facility staff] should on bag flat on the bed during there was urine back flow and back up in the bladder the risk ated urinary tract infection					
SS=E	12/2002, included: bag is lower than b 483.70(h)	AL/SANITARY/COMFORTABL	F	465	The dish machine was cleaned an Ecolab personnel on 7-10-2013.	On a dai	ed by ly Page 41 of 44

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		AND HUMAN SERVICES			1	FORM	07/29/2013 APPROVED 0938-0391
STATEMENT OF DEFI AND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		CONSTRUCTION		E SURVEY IPLETED
		245266	B. WING			07/	12/2013
NAME OF PROVIDER		ER OF MINNEAPOLIS		61	REET ADDRESS, CITY, STATE, ZIP CODE 8 EAST 17TH STREET INNEAPOLIS, MN 55404		
(X4) ID PREFIX (E/ TAG REC	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
The fa sanita reside This F by: Base review equip over of mann conta to affe Findir On 7/ gave was of whitis both s appea away buildo was of dark, debri obstr pulled On 7 state	ry, and comf nts, staff and EQUIREME d on observa , the facility ment (includi lishwasher) ver free from minate clean ect 64 of 89 r ags include: 8/13, at 11:5 a brief tour of bserved to h h colored su sides of the of ared to be the easily with a up was on the inclear when inclear what bserved to h greyish brow s. The exhau ucted by the d partially to (9/13, at 9:38 d the inside of	rovide a safe, functional, ortable environment for d the public. NT is not met as evidenced ation, interview and document failed to ensure kitchen ng dishwasher and ceiling vent were maintained in a clean debris which could potentially dishes. This had the potential esidents that ate in the facility. 4 a.m. licensed dietician (D)-B f the kitchen. The dishwasher have a buildup of a greenish bstance along the seams of dishwasher. The substance ick, porous and loose; it flaked fingernail. D-B verified the e clean side of the dishwasher, the dishwasher was cleaned the substance was. Also, the e ceiling above the dishwasher have a visibly thick buildup of vn colored, fuzzy textured ust cover grate appeared debris and was observed to be		465	schedule dietary staff will delim outside dish machine surface. T be documented daily on the we duties. On 7-9-2013 the exhaus dish machine was removed and monthly basis the exhaust vent machine will be removed and c be documented by dietary staff Machine Care Log. Also on a m Ecolab personnel will delime the outside of the dish machine. T documented on the Dish Mach These cleaning procedures will the Dietary Manager. Compliance date: 8/13/2013	his clean eckly clea st vent al cleaned above th leaned. f on the E onthly b ine inside his will b ine Care	ing will ning bove the . On a ne dish This will Dish asis the and the e Log.

DEPART		AND HUMAN SERVICES			FORM	): 07/29/2013 1 APPROVED ). 0938-0391	
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4	PLE CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		245266	B. WING		07	/12/2013	
NAME OF PF	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 618 EAST 17TH STREET	TATE, ZIP CODE		
BENEDIC	TINE HEALTH CENT	TER OF MINNEAPOLIS		MINNEAPOLIS, MN 55	404		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
	greenish whitish fla to be on the edges D-A confirmed piec when the door was could contaminate expected staff to w dishwasher door a daily after completi was unclear what t thought it was leak on top of the dishw a build up above th dishwasher and cle exhaust vent was u and thought it was duty. D-A stated th reach. D-A was u On 7/9/13, at 12:37 housekeeping dep cleaning the exhau D-A stated it was of schedule. A copy of was requested at 17 On 7/9/13, at 12:37 (O)-G was intervie stated monthly de Ecolab staff, howe last been complete cleaned in March substance was on removed. O-G sta	age 42 le of the dishwasher door. The aking substance was observed and in the track for the door. ces of the substance flaked off open and the white substance clean dishes. D-A stated she vipe the outside of the nd the edges around the door ing the dishwashing task. D-A the built up substance was and cage of the cleaning chemical vasher. D-A verified there was ne exhaust vent above the ean dish area. D-A stated the not on the kitchen cleaning list a maintenance/house-keeping ne vent was high up and hard to nclear when it was cleaned last 0 p.m. D-A stated the partment was responsible for ust vent over the dishwasher. on the maintenance cleaning of the maintenance schedule that time but was not provided. 36 p.m. the Ecolab specialist ewed with D-A present. O-G -liming was completed by ever was not sure when it had ed. O-G thought it had been 2013. O-G stated the built up agnesium calcium (lime) and nly cleanable after lime was ated the lime could potentially cleaned dishes. O-G clarified the		35			

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TEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED	
		245266	B. WING			07	/12/2013	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404				
X4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLET DATE	
F 465	Continued From pa de-limed.	ge 43	F4	165				
	Cleaning Procedure "Equipment is wash each use to ensure The procedure dire sanitize all food con equipment that are directed, "The Food Develop operation procedures for all equipment being cleaned prop direction to report of needs of the dishw	ned, rinsed and sanitize after the safety of food served." cted, "4) Wash, rinse and ntact surfaces of the stationary." The policy further d Service Director will: 1) procedures and cleaning quipment. 3) Conduct a visual uipment to be certain that it is erly." The policy lacked cleaning and maintenance asher.						
	Service Detail Rep Warewashing form dishwasher was de 3/26/13. The facility AM Sta dated 7/1/13 throug de-lime inside of di	indicated the last time the -limed by Ecolab staff was on ff Weekly Cleaning Duties gh 7/7/13, directed staff to shwasher weekly but lacked s de-liming the outside						

e on earlier that the state of the second state of the second state of the state of the state state of the second state of the second state of the state of the second state of the second state of the state of the second state of the

		I AND HUMAN SERVICES		Ŧ	(-)()	FORM	07/29/2013 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY PLETED
		245266	B. WING			07/	15/2013
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	ER OF MINNEAPOLIS			I8 EAST 17TH STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	ĸ	000	1.		
	FIRE SAFETY				Poc on		
8-21-13	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT T PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 FORM WILL BE CATION OF COMPLIANCE.			POCOK W/FSES B 8-16-23		
de:	AN ONSITE REVIS BE CONDUCTED SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, BIT OF YOUR FACILITY MAY TO VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			17		
EXIT: 7-12-13	Minnesota Departn time of this survey, Mpls was found no with the requirement Medicare/Medicaid 483.70(a), Life Safe edition of National (NFPA) Standard 1 Chapter 19 Existing PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY D: pections Divísion Suite 145			AUG 1 2 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		
LABORATOR	L Y DIRECTOR PROVID	DERISOPPLIER REPRESENTATIVE'S SIG	NATURE		Admin stratur		(X6) DATE 9-13
	all					0	1

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.

ATEMENT OF DEF D PLAN OF CORRECTINE F ENEDICTINE F (X4) ID PREFIX TAG K 000 Contin Barba Maria THE DEFIN FOLL 1. A C to con 2. Th 3. Th respon preve This Type and i has a the c that i	DEFICIENCIES PRECTION VIDER OR SUPPLIER IE HEALTH CENT SUMMARY STA	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:     245266     TER OF MINNEAPOLIS     ATEMENT OF DEFICIENCIES     Y MUST BE PRECEDED BY FULL	A. BUILDING	LE CONSTRUCTION 601 - MAIN BUILDING 01 STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404	(X3) DATE SURVEY COMPLETED 07/15/2013
ENEDICTINE H(X4) ID PREFIX TAG(E REK 000Contin Barba MariaK 000Contin Barba MariaTHE DEFIN FOLL1. A c to con 2. Th 3. Th response prever This Type and i has a the c that i notifi beds surver		TER OF MINNEAPOLIS	e	618 EAST 17TH STREET	07/15/2013
ENEDICTINE H(X4) ID PREFIX TAG(E REK 000Contin Barba MariaK 000Contin Barba MariaTHE DEFIN FOLL1. A c to con 2. Th 3. Th response prever This Type and i has a the c that i notifi beds surver		ATEMENT OF DEFICIENCIES	ł	618 EAST 17TH STREET	
(X4) ID PREFIX TAG(E REK 000Contin Barba MariaK 000Contin Barba MariaTHE DEFIN FOLL1. A c to con 2. Th 3. Th response3. Th response preve This Type and i has a the c that i notifi beds surve		ATEMENT OF DEFICIENCIES			
PRÉFIX TAG(E REK 000Contin Barba MariaTHE DEFIN FOLL1. A c to con 2. Th 3. Th response preve This Type and i has a the c that i notifi beds surve	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		WINNEAPOLIS, WIN 55464	
Barba Maria THE DEFIN FOLL 1. A c to con 2. Th 3. Th respon preven This Type and i has a the c that i notifi beds surve		SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETIC
DEFIN FOLL 1. A c to con 2. Th 3. Th response prevent This Type and i has a the c that i notifi beds surve	arian.Whitney@s	@state.mn.us and state.mn.us DRRECTION FOR EACH	K 000		
This Type and i has a the c that i notifi beds surve	EFICIENCY MUS DLLOWING INFO A description of correct the defic The actual, or p The name and/o sponsible for co	ST INCLUDE ALL OF THE ORMATION: what has been, or will be, done ciency. proposed, completion date. or title of the person rrection and monitoring to			
K 012 NFP	his 5-story buildin ype II(000) const nd is fully fire spr as a fire alarm sy the corridors and the corridors and the tification. The fa eds and had a co urvey. he requirement a IOT MET as evic IFPA 101 LIFE S	rence of the deficiency. ng was determined to be of truction. It has a full basement rinklered throughout. The facility ystem with smoke detection in spaces open to the corridors for automatic fire department acility has a capacity of 110 ensus of 89 at the time of the at 42 CFR, Subpart 483.70(a) is denced by: SAFETY CODE STANDARD tion type and height meets one		Correction not needed. Benedic	
of th 19.3	f the following. 9.3.5.1	is not met as evidenced by:		Center of Minneapolis has achie FSES score (see enclosed FSES/H plans). Completion 07/22/2013	ved a passing IC and floor

		AND HUMAN SERVICES			0		APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES				(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-0391 (X3) DATE SURVEY	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING 01 - MAIN BUILDING 01			COMPLETED		
	245266		B. WING			07/15/2013		
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE HEALTH CENTER OF MINNEAPOLIS					8 EAST 17TH STREET INNEAPOLIS, MN 55404			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			) BE	(X5) COMPLETION DATE	
K 012 K 017 SS=F	does not meet the type and height. This deficient pract Findings include: On facility tour betw on 07/15/2013, obs 5-story, non-combuc construction does a construction require height. The roof of fire rating. This deficient pract administrator at the Note: This deficient FSES can establis level of fire safety con NFPA 101 LIFE SA Corridors are separ constructed with at rating. In sprinkler required to resist th non-sprinklered but above the ceiling. at the underside of permitted by Code waiting areas, dinin may be open to the conditions specifie be separated from	tion and interview, this building requirement for construction ice could affect all residents. ween 9:00 AM and 11:45 AM servation revealed that this ustible facility of Type II(000) not meet the minimum ements for a building of this if the facility does not have a tice was verified by the e time of the inspection. hey need not be corrected if an h that the fire has an overall equivalent to that required by	ĸ	017	The cited penetrations in the cor above the ceiling were properly to 07/16/2013. The maintenance do responsible for monitoring any of penetrations.	firestopp lirector \	bed	
	19.3.6.1, 19.3.6.2.							

Facility ID: 00960

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PRINTED: 07/29/2013

					RINTED: 07/29/2013 FORM APPROVED		
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED		
		245266	B. WING		07/15/2013		
NAME OF	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		DBE COMPLETION		
K 017	Continued From page 3		КO	117			
K 052 SS=F	<ul> <li>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.</li> <li>Findings include:</li> <li>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.</li> <li>This deficienct practice was verified by the administrator at the time of the inspection. NFPA 101 LIFE SAFETY CODE STANDARD</li> <li>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</li> </ul>		KO	52 On 07/16/2013 the smoke detect located within 36 inches of HVAC return diffusers in the kitchen and storage rooms were determined t detectors, and were labeled accor 07/16/2013 the smoke detector h within 36 inches of HVAC supply a diffusers in the corridor near Roor relocated outside of the 36 inch p	supply and d all corridor to be heat rdingly. On head located and return m 118, was		

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

Event ID: B8BR21

Facility ID: 00960

If continuation sheet Page 4 of 5

DEPARTMENT OF HEALTH AND HUMAN SERVICES							2: 07/29/2013	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			X3) DATE SURVEY COMPLETED			
245266		B. WING			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					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 052	Continued From pa	ge 4	КO	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 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.							

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