DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 14, 2023

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: October 19, 2023

Dear Administrator:

On November 27, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 1, 2023

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: October 19, 2023

Dear Administrator:

On October 19, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Alex Warren, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55082
Email: Alex.Warren@state.mn.us
Mobile: 651-279-5375 Office: 218-302-6186

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 19, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 19, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 10/16/23 to 10/19/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 10/16/23 to 10/19/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52366495C (MN97796), H52366409C(MN97043), H52366426C (MN97341). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 11/10/2023

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

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F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely repositioning was offered for 1 of 6 residents (R74) reviewed for pressure ulcers. Findings include: R74's quarterly Minimum Data Set (MDS) dated 9/27/23, identified R74 had severe cognitive impairment and required moderate to maximum assist with activities of daily living (ADLs). Diagnoses included congestive heart failure, kidney disease, diabetes, and venous insufficiency. R74 had one stage three pressure ulcer (full thickness loss of skin) and and was at risk for further development of pressure ulcers. R74 was dependent on staff to roll side to side in bed. R74's care plan dated 9/5/23, identified R74 was at risk for alteration in skin status. Interventions	F 686	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. F686 Treatment Services to Prevent/Heal Pressure Ulcer. Resident 74 does not reside in the facility and has been discharged. All other residents who were care planned to be repositioned every 2-3 hours were reviewed and skin checks completed to	11/22/23

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F 686	Continued From page 2 included a turning and repositioning program to turn side to side and change positions every two to three hours. On 10/17/23 at 12:00 p.m., R74 was assisted to eat her lunch by nursing assistant (NA)-A while lying in bed, on her back. The head of the bed was elevated and R74 was covered with a bright green blanket. R74 was still wearing a hospital gown and stated she did normally get up in her wheelchair but had not felt like it today. During continuous observation on 10/17/23, from 12:00 p.m. to 3:15 p.m. R74's position had not changed and she continued to lie on her back with the head of her bed elevated, intermittently watching television in her room or sleeping with her chin resting on her chest. Staff did not interact or offer to reposition R74 or enter R74's room during the three hours and fifteen minute continuous observation. On 10/17/23 at 3:15 p.m., surveyor intervened NA-A stated he and NA-B assisted R74 with incontinence care before lunch and had boosted her up in her bed; however, they had not positioned her on her side at that time. NA-A and trained medication assistant (TMA)-A assisted R74 to turn on her right side and assisted to change her incontinence brief, which was soiled due to a bowel movement. R74's back and buttocks were deep red in color with deep creases and wrinkles from the bed sheets visible. R74's coccyx was excoriated with multiple surface abrasions. TMA-A completed peri care and asked R74 if she would like to lie on her side, which R74 was agreeable to. She was easily positioned on her left side, with no complaints of discomfort.	F 686	ensure appropriate interventions in place. Education provided to all nursing staff regarding prevention and treatment of skin breakdown and repositioning for dependent residents or residents with wounds. If staff are unable to attend, the staff will receive the training on, during or before their next shift. Prevention and Treatment of Skin Breakdown policy has been reviewed and remains appropriate. DON or designee will conduct weekly repositioning audits on 10 residents weekly for 2 weeks, then 5 residents weekly for 4 weeks. Findings will be presented to facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by 11/22/2023.	

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F 686	Continued From page 3 During observation of wound care treatment on 10/18/23 at 9:30 a.m., registered nurse (RN)-I changed R74's dressing to her coccyx. After removing R74's large adhesive butterfly dressing and cleaning peri area, R74's coccyx and buttocks were noted to be deep red in color with several small open areas and an excoriated appearance. RN-I stated it did appear to be more irritated and it was possible lying in the same position on her back the day before could have contributed to the increase redness and excoriated appearance. R74 was to be turned and repositioned every two hours. RN-I was not sure if that was indicated on R74's plan of care, but turning and repositioning every two hours was the usual practice for any residents who had pressure ulcers. He had noticed a decline with R74's wounds. R74 was seen by the wound clinic in September and she had another appointment with the wound clinic on 10/19/23. When interviewed on 10/19/23 at 1:30 p.m., director of nursing (DON) indicated she was informed R74 was not repositioned timely on 10/17/23. It was important to complete timely turning and repositioning to maintain skin integrity and to prevent further deterioration of her current pressure ulcer. The facility's undated policy Prevention and Treatment of Skin Breakdown identified maintenance of intact skin was integral to resident health and wellness. Care and services would be delivered to maintain skin integrity and promote skin healing if skin breakdown should occur. A resident centered care plan would be implemented for skin risk with interventions based upon areas of risk, resident assessment,	F 686		

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F 686	Continued From page 4 Braden evaluation score of 15 or less, clinician assessment, and evaluation and resident preferences. If a resident was admitted with impaired skin integrity or a new pressure injury or wound developed, the licensed nurse would evaluate current pressure reduction interventions and revise the resident centered care plan.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a restorative range of motion program for 1 of 4 residents (R14) reviewed for range of motion and who was assessed as needing a range of motion program to promote mobility. Findings include:	F 688	F688 Increase/Prevent Decrease in ROM/Mobility An Occupational Therapy evaluation has been completed for R14 to identify an appropriate restorative program on 10/23/23, care plan and group sheet will be updated to reflect restorative program.	11/22/23

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F 688	Continued From page 5 R14's significant change Minimum Data Set (MDS) dated 9/22/23, identified R14 had severe cognitive impairment. R14 required extensive assistance with activities of daily living (ADLs), was dependent on staff to transfer, and was unable to ambulate. R14's care plan dated 8/23/23, identified R14 required extensive assist of two for bed mobility, a ceiling lift was used for transfers and R14 was unable to ambulate. R14 was at risk for decline in her range of motion (ROM) related to diagnoses of hemiplegia (paralysis of one side of the body) and gait abnormality. A goal was identified to maintain or improve R14's ROM for three months. Interventions included to complete bilateral exercises two times per day, six days a week. Monitor and document participation in exercises and a quarterly review by a registered nurse. R14's Occupational therapy (OT) note dated 8/16/23, identified OT provided right upper extremity passive range of motion (PROM) to R14 and were unable to range R14's right elbow as it was in hyperextension. OT discussed a restorative program for PROM and R14 agreed. R14's Therapy Communication to Nursing Form dated 8/18/23, identified R14 was to be followed by restorative nursing to complete supine PROM exercises six time per week. R14's Physical Therapy Discharge Summary dated 8/22/23, identified skilled physical therapy (PT) services were provided with a focus to improve safety with functional mobility tasks and to setup up a restorative nursing program. R14	F 688	R14 has been tolerating the restorative program well and will continue to be followed by the restorative RN. All other residents on a restorative program will be reviewed for appropriateness of their restorative program, care plans and group sheets will be updated to reflect changes. Education provided to all nursing, therapy and wellness staff regarding residents on a restorative programs and program completion. If staff are unable to attend, the staff will receive the training on, during or before their next shift. Restorative Nursing policy has been reviewed and remains appropriate. DON or designee will conduct weekly audits on 10 residents receiving a restorative program for 2 weeks, then 5 residents weekly for 4 weeks regarding the appropriateness and completion of the program. Findings will be presented to facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by 11/22/2023.	

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F 688	Continued From page 6 was discharged with a restorative nursing program established for bilateral lower extremity PROM. Prognosis to maintain her current level of function was good with strong family support and consistent staff follow through. OT Discharge Summary dated 9/21/23, identified a PROM to R14's right upper extremity had been established. Prognosis to maintain her current level of function was good with consistent staff follow through. On 10/16/23 at 6:40 p.m. R14 was seated in her wheelchair in the dining room. R14's right arm was lying limply, wedged tightly between her body and the wheelchair arm rest. R14 had no positioning devices, and no visible contractures were noted. On 10/17/23 at 9:30 a.m., nursing assistant (NA)-A was assisting R14 with her morning cares and transfer out of bed. After providing assistance with dressing, NA-A assisted R14 to her wheelchair using a ceiling lift. No PROM or ROM was provided to R14 during completion of morning cares. During interview on 10/18/23 at 1:50 p.m., registered nurse (RN)-I stated they added a restorative nursing program to R14's care plan after RN-I received a communication note from therapy to start ROM exercises in August. Review of restorative nursing flow sheets revealed no exercises had been documented as completed in the months of September or October for R14. R14's last quarterly review was 9/22/23, and RN-I would have reviewed the restorative aides documentation at that time, as well as have recorded how often R14 had	F 688		

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F 688	Continued From page 7 completed her exercise program. RN-I thought maybe the restorative NA was having difficulty completing his documentation of exercises. During interview on 10/18/23 at 2:45 p.m., NA-E stated ROM exercises were not recorded for R14 because NA-E never assisted R14 with exercises. When NA-E came on shift R14 was always up in her wheelchair and she needed to be lying down to do the ordered ROM. NA-E received the Therapy Communication form for R14 on 8/18/23, but had not added her to his daily restorative schedule. NA-E notified RN-I several times that NA-E had not started R14's exercise program yet and RN-I was aware of this issue. NA-E always notified RN-I when NA-E was unable to see a resident for exercises. During interview on 10/19/23 at 1:30 p.m., director of nursing (DON) stated they identified R14 was not getting restorative nursing and her care planned exercises were not being done. DON was aware NA-E was not able to get to all of his assigned patients for restorative exercises and leadership was working to resolve the issue. Nursing assistants did not perform ROM exercise for residents during care, but that was something the DON was considering. The facility could be doing a better job at providing restorative nursing program to their residents. When it was assessed a resident needed assistance with ROM it was important it was provided to maintain the resident's current level of function and to avoid contractures and decline in condition. The facility policy Restorative Nursing Program dated 6/9/20, identified its purpose was to promote an optimal level of physical, mental, and psychosocial functioning in alignment with a	F 688		

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F 688	Continued From page 8 resident's individual goals. The RN would document the individualized restorative nursing program including initiation of nursing assistant documentation and care plan problem, goals and approaches in the medical record. Associates administering the restorative interventions would be trained on the interventions assigned to them. An RN would provide oversight to the program to ensure the restorative interventions were being implemented as planned. The RN would document at minimum quarterly the program evaluation, including the progress, lack of progress and changes to the restorative care plan.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F 692		11/22/23

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	245236	A. BUILDING _____ B. WING _____	C 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce/prevent continued weight loss for 1 of 4 residents (R7) reviewed for weight loss. Findings include: R7's quarterly Minimum Data Set (MDS) dated 9/1/23, identified R7 had no cognitive impairment, required setup and clean up assistance with eating, and did not have a weight loss of 5% or greater in the past month. R7's Mini-Nutritional Assessment dated 8/31/23, identified R7 consumed a regular, heart healthy, low carbohydrate diet with fair intake of 50 to 75% of meals. A weight loss was identified of 2.2 to 6.6 pounds in the past three months. R7's weights varied greatly and would continue to monitor his weight and intakes per facility protocol. R7's care plan dated 9/27/23, identified R7 had a nutritional deficit related to R7's progressive weight loss and variable weight pattern. A goal for R7's nutrition was to have a stable weight pattern. Interventions identified R7 would like to use a select menu to choose his daily food choices and he would be provided three meals per day and snacks. On 10/17/23, at 4:00 p.m. R7 was seated in his wheel chair in his room, watching television with a bedside table in front of him. An unopened candy bar rested on the table. R7 stated he did not like the meals he was served at the facility. A couple	F 692	F692 Nutrition/Hydration Status Maintenance On 11/6/23 the registered dietician (RD) reviewed R7, observed R7 to accept chocolate ensure well, reviewed selective menu with the resident and was in agreement with alternative options. A weight review and reassessment has been completed for R7 to identify percentage of weight loss and interventions for weight loss prevention by the RD with a net loss of 6lbs/2.7% in the past months. Overall is down 36.4 lbs/14.5% in the past 6 months. On 11/3/23 3x/wk weights were implemented to monitor weights. The pharmacy consultant completed a review on 10/23/23 of medications with no recommendations. R7 was seen by the NP on 11/3/23 and ordered a chocolate ensure BID with meals. A discussion was held with R7□s family on 11/3/23 who will be bringing in extra snacks for R7. A weekly menu has been provided to R7 and was able to choose alternatives on 11/10/23. On 11/3/23 the resident□s weight was 213.6 lbs. and on 11/8/23 the resident□s weight was 216.4 lbs. for a gain of 3lbs in 5 days. All other resident□s weights have been reviewed to determine if they have experienced a >5% in one month, or >7.5% in 3 months, or >10% over the past six months, interventions reviewed, care plans and group sheets will be updated to	

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F 692	Continued From page 10 of weeks ago, staff had told R7 they were going to give him a menu to make meal choices from, but they never did. R7 was served lasagna for his lunch and he did not eat it because he did not like it. R7 did not know what the alternative menu choice was that day but he was sure he would have liked it better than the lasagna he had been served. R7 identified he liked to eat hamburgers, hot dogs, bratwurst, cauliflower, and broccoli. R7 thought he would eat better if he received the food he liked. On 10/18/23, at 2:00 p.m. the dietary manager (DM) stated they were aware R7 was having weight loss. On the last progress note DM reviewed, R7 had lost 15 pounds. R7's meal intake ranged 25 to 50%. They tried a med pass supplement last week but it had been poorly accepted so they stopped it. DM personally talked with R7 about the menu and one time DM went in and tried to assist R7 to fill out R7's choices for the week. R7 completed one day of choices and would not complete more days. There was a weekly menu available to all residents when they requested it. Residents filled out their choices for the week and that was turned into dietary. It would be very difficult to provide a menu with choices daily, for residents. The facility did a weekly menu that was turned in on Sundays. R7's weights fluctuated and nursing was looking into determining the most accurate method to obtain R7's weight. R7's physician was notified of R7's progressive weight loss as well. R7's recorded weights from 6/20/23 to 10/16/23, identified the following: - 6/20/23, R7 weighed 242.6 pounds (lbs). - 7/24/23, R7 weighed 238.6 lbs, a 4 lbs wt loss. - 7/31/23, R7 weighed 229.6 lbs, another 9 lb wt	F 692	reflect weight loss interventions. Weight Monitoring and Documentation policy has been reviewed and remains appropriate. Culinary staff education completed regarding alternatives, weight loss and interventions. Nursing staff education regarding alternative meal options. Education to be provided to Culinary and Nursing if staff are unable to attend, the staff will receive the training on, during or before their next shift. DON or designee will complete audits for 10 residents weekly for 2 weeks, then 5 residents weekly for 4 weeks regarding weight loss and appropriate interventions. Findings will be presented to facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by 11/22/2023.	

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F 692	Continued From page 11 loss in one week. A reweigh to verify the significant weight loss in one week was not recorded. - 8/21/23, R7 weighed 239.4 lbs. - 9/20/23, R7 weighed 223 lbs, a 16 lb wt loss in one month. - 9/25/23, R7 weighed 217 lbs, another 6 lb wt loss in one week. A reweigh to verify the significant weight loss in one week was not recorded. - 10/2/23, R7 weighed 206 lbs, a 11 lb wt loss in one week. A reweigh to verify the significant weight loss in one week was not recorded. - 10/9/23, R7 weighed 219.6 lbs, a gain of 10 lbs in one week and similar to his weight recorded on 9/25/23. A weight loss of twenty-three pounds was documented for R7 in a four month period of time. R7's Physician Progress Note dated 9/29/23, identified R7 was seen by his primary physician during rounds. The physician identified nursing identified a slight decrease in R7's weight and initiated a med pass supplement to address the weight loss earlier that week. R7's medical record was reviewed and lacked any evidence R7 had been comprehensively reassessed or evaluated for his continued weight loss. After refusing med pass there was no evidence care plan interventions were implemented or screening was implemented to help prevent or slow the continued weight loss. When interviewed on 10/18/23, at 7:30 a.m. cook (CK)-A stated she never saw menu preferences menus filled out for R7. CK-A was not sure if R7 just did not want to fill out selections but the	F 692		

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F 692	Continued From page 12 kitchen never received a preference menu for R7. When interviewed on 10/18/23, at 10:20 a.m., nursing assistant (NA)-C stated she never asked a resident if they needed assistance to make meal preferences for their weekly meals. When interviewed on 10/18/23, at 11:55 a.m. NA-F stated she helped residents to fill out their menu choices if they asked, but it was usually family who helped the residents with their menu. NA-F thought it was dietary staff that passed out menus to each resident, as NA-F did not. During telephone interview on 10/19/23, at 1:00 p.m. registered dietician (RD)-A stated they were following R7 during their weekly weight tracking meetings. The nurse manager would know more about what was being done with the variable weights, in assuring accuracy of the weight. RD-A knew the dietary manager tried to assist R7 with making choices on a weekly menu but that did not work. R7 refused supplements. RD-A made the recommendation to get R7's provider involved to rule out a medical reason for R7's weight loss. They noted the variable weights and kept hoping the weight loss was not accurate and the next obtained weight would not indicate a loss. It would be an important first step to verify the accuracy of R7's weights as they varied so dramatically from week to week. When interviewed on 10/19/23, at 2:30 p.m. the director of nursing (DON) stated the facility had weekly weight tracking meetings and R7's weights were discussed weekly. The DON verified there was no consistent follow up being done to ensure interventions were implemented consistently.	F 692		

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F 692	Continued From page 13 The facility policy Weight Monitoring and Documentation dated 8/19, indicated the facility must ensure a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that it was not possible. Each resident's weight would be monitored and fluctuations of 5% or greater in one month or 10% or greater in six months would be assessed and appropriate individualized dietary interventions and documentation would be implemented. Licensed nursing staff were to verify the accuracy if there were weight changes. Re-weighs were recommended for residents with a five pound or greater weight change.	F 692		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		11/22/23

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F 880	Continued From page 14 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 15 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct ongoing surveillance for the infection control program to ensure tracking and trending of infections and illnesses in the facility. This deficient practice had the potential to affect all 87 residents currently residing in the facility. Findings include: A line list regarding resident infection and symptom surveillance was requested from 9/1/23 through 10/18/23, but was not provided. During an interview on 10/19/23 at 10:14 a.m., infection preventionist (IP) stated the only thing the IP kept track of were the residents on antibiotics. IP did not keep track signs and symptoms of infection, labs completed. The IP did not keep track of staff or residents that had symptoms of illnesses to look at trending or symptom analysis to prevent a potential outbreak. The IP relied on the nurses to let her know when more people were getting sick and if an outbreak occurred. During an interview on 10/19/23 at 11:12 a.m., registered nurse (RN)-B stated they kept track of antibiotics to make sure labs were tracked. They did not keep track of illness trends or infection trends to prevent an outbreak, the IP was	F 880	F880 Infection Prevention and Control Program All residents currently residing in the facility have been reviewed and assessed for signs and symptoms of infections and have been logged. All staff currently out with an illness have been logged. Infection Prevention and Control Program policy has been reviewed and remains appropriate. The Infection Preventionist has been educated on the procedure and expectations of tracking and trending of all staff and resident illness. All department Leaders have been educated on reporting and tracking of illness during staff call ins. All nursing staff educated on reporting of signs and symptoms of illness. Education to be provided to all nursing staff, if staff are unable to attend, the nursing staff will receive the training on, during or before their next shift. DON or designee will complete review resident infection tracker 5x/week for 2 weeks and then 3x/wk for 4 weeks. DON or designee will complete staff infection trackers 5x/week for 2 weeks and	

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F 880	Continued From page 16 suppose to do that. During an interview on 10/19/23, at 1:45 p.m., director of nursing stated the IP was responsible to keep track of all infections and symptoms for trending and analysis to prevent possible outbreaks before they occurred. The facility policy Surveillance dated 6/17, identified infection control included ongoing, systematic collection, analysis, interpretation, and dissemination of data to identify infections and infection risks, to reduce morbidity and mortality and to improve resident health status. It is a necessary component of effective infection prevention and control in any healthcare setting.	F 880	3x/week for 4 weeks. Findings will be presented to facility□s Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by 11/22/2023.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883		11/22/23

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F 883	Continued From page 17 was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide pneumococcal conjugate vaccine 20 variant (PVC20) education as directed by the Centers for Disease Control (CDC) for 4 of	F 883	F883 Influenza and Pneumococcal Immunizations Education about the risks and benefits of	

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F 883	Continued From page 18 5 residents (R30, R49, R71, R73) reviewed for immunizations. Findings include: R30's quarterly Minimum Data Set (MDS) dated 9/8/23, identified diagnoses of diabetes mellitus and hyperlipidemia. R30's undated immunization record, identified R30 received pneumococcal polysaccharide (PPSV23) on 5/18/07, and the pneumococcal conjugate vaccine (PCV13) on 10/13/00. R30's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R30 or 30's representative. R49's quarterly MDS dated 9/28/23, identified a diagnosis of dementia. R49's undated immunization record, identified R49 received the PPSV23 on 1/10/17 and the PCV13 on 5/4/19. R49's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R49 or R49's representative. R71's quarterly MDS dated 8/21/23, identified diagnoses of dementia and diabetes. R71's undated immunization record, identified R71 received PPSV23 on 12/19/03. R71's medical record failed to provide evidence the PCV20 was offered and/or education was provided in conjunction with the provider to R71 or R71's representative. R73's quarterly MDS dated 8/21/23, identified diagnoses of dementia and diabetes. R73's undated immunization record, identified R18 received PPSV23 on 6/14/17. R73's medical record failed to provide evidence the PCV20 was	F 883	the PVC20 will be provided to R30, R49, R71, R73 and will be offered the PVC20 by 11/10/23. Vaccines will be administered if agreed, declinations will be recorded if residents refuse. All resident pneumococcal vaccine records will be reviewed by 11/10/23. If it is determined that any resident is eligible for a PVC20, it will be offered and administrated. Vaccines will be administered to any who accept and declinations will be documented for any refusal. Education provided to all Nursing staff about process for completing pneumococcal vaccines for residents. Any new residents will have their pneumococcal vaccines reviewed upon admission and will determine if eligible for a vaccine or a booster and offered. Vaccines will be administered if agreed, education will be provided, declinations will be recorded if residents refuse. All pneumococcal vaccine dates will be reviewed annually to check for eligibility and will be offered if appropriate. DON or designee will audit all new admissions for 2 weeks and then audit 5 new admissions for 4 weeks. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Any additional ongoing audits would be conducted by the Infection Preventionist	

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F 883	Continued From page 19 offered and/or education was provided in conjunction with the provider to R73 or R73's representative. During an interview on 10/19/23 at 10:18 a.m., infection preventionist (IP) stated she just began to talk with the medical director about the new PCV20 immunization and had not started to immunize residents. During an interview on 10/19/23, at 1:18 p.m., corporate registered nurse stated all facilities were given clearance and should have began offering the PCV20 vaccine. During an interview on 10/19/23 at 1:24 p.m., director of nursing (DON) stated the IP was responsible for verifying all residents were up to date with their vaccinations, which include the PCV20. The facility policy Pneumococcal Vaccine for Residents dated 3/18/22, identified PCV20 pneumococcal vaccines would be offered to each resident according to the current recommendations from the CDC. The CDC guidance dated 2/9/23, identified, "adults 65 and older have the option to get PCV20."	F 883	and/or Designee. Baseline compliance to be achieved by 11/22/2023.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245236	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/19/2023

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BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE DULUTH, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245236	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE DULUTH, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the long-term care ombudsman was notified of resident transfers to the hospital for 2 of 2 residents (R30, R49) reviewed for hospitalization.

Findings include:

R30's electronic medical record (EMR) identified R30 was sent to the emergency room on 4/26/23, and returned to the facility on 4/27/23 R30's EMR did not identify the long term care ombudsman (LTCO)-A was notified of the hospital transfer.

An untitled, facility form dated 4/23, identified a list of names of residents discharged or transferred from the facility sent to the LTCO-A. The form lacked R30's name.

R49's EMR identified R49 was hospitalized on 8/24/23, and returned to the facility on 8/29/23. R49's medical record did not identify LTCO-A was notified of the hospital transfer.

An untitled, facility form dated 8/23, identified a list of names of residents discharged or transferred from the facility sent to the LTCO-A. The form lacked R49's name.

A message received via Microsoft Teams on 10/19/23 at 1:42 p.m., identified LTCO-A rarely received notification of any facility-initiated transfers or discharges from the facility. LTCO-A had not received notification of transfers in April or August of 2023.

During an interview on 10/19/23 at 10:41 a.m., licensed social worker (LSW)-A stated LSW-B was responsible to report to the ombudsman when residents were transferred or discharged from the third floor. LSW-A was unsure why the LTCO-A was not notified of R30's or R49's transfer to the hospital.

When interviewed on 10/19/23 at 1:17 p.m., the director of nursing confirmed the social worker was responsible for notifications to the ombudsman.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245236	A. BUILDING: _____ B. WING _____	10/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE DULUTH, MN**

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2 A facilty policy regarding notification to the ombudsman was requested, but not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE** **DULUTH, MN 55811**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 10/16/2023. At the time of this survey, Benedictine Health Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 11/10/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2023**

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Benedictine Health Center is a three story building with no basement. The original building was constructed in 1980 with an addition in 1990. Both buildings are of type II (111) construction. Because the original building and the addition are of the same type of construction allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with	K 000		

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	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2023**

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BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE** **DULUTH, MN 55811**

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K 000	Continued From page 2 smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 95 beds and had a census of 80 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:	K 000		
K 225 SS=F	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 7.7.3.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1) On 10/16/2023 between 9:00am and 1:00pm, it was revealed by observation that storage materials had been placed to hold open emergency exit egress corridor next to door 262. 2) On 10/16/2023 between 9:00am and 1:00pm, it	K 225	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. K225 □ Stairways and Smokeproof Enclosures. Stored items in that identified stairwell	11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2023**

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K 225	Continued From page 3 was revealed that storage was found in the exit stairwell enclosure leading to Westwood (Door 1136) facility. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 225	area have been removed. Environmental and Spiritual care staff have been notified and educated that they can not store items in stairwell area. EVS Director or designee will audit all stairwells once a week for 4 weeks, then monthly to ensure the area is not used for storage. EVS Director or designee is responsible to ensure ongoing compliance. Compliance achieved 11/10/2023	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms	K 321		11/10/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2023**

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K 321	Continued From page 4 b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their smoke barrier per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.6.5 and 8.5.6.2. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 10/16/2023 between 09:00am and 1:00pm, it was revealed by observation that there was a mechanical floor cleaner holding open fire door 262. An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 321	K321 Hazardous Areas The mechanical floor cleaner has been removed that was blocking 262 fire door. Education to the EVS team on obstructing fire and smoke doors has been completed. EVS Director or designee will audit smoke and fire doors to ensure no objects are preventing closure for 4 weeks, then monthly. EVS Director or Administrator is responsible to ensure ongoing compliance. Compliance achieved 11/10/2023	
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		11/22/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2023**

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K 351	Continued From page 5 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to install fire sprinkler systems per NFPA 101 (2012 edition), Life Safety Code, section 19.3.5.1. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 10/16/2023 between 9:00am and 1:00pm, it was revealed by observation that the kitchen freezer and walk-in cooler were missing any fire sprinkler coverage. An interview with the Facility Administrator verified this deficient finding at the time of discovery.	K 351	K351 □ Sprinkler System - Installation We have requested clarification as the freezer and walk-in cooler we use is not in space that we own. However, pending confirmation, Viking Sprinkler was contacted to determine placement of sprinklers in the kitchen freezer and walk-in cooler, scheduled to assess for placement of sprinklers 11/16/23. There are no other walk in refrigerators or freezers to audit. EVS Director or Administrator is responsible for ongoing compliance. If provided clarification on project, will have the contractor complete as soon as able.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		11/10/23

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K 353	Continued From page 6 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain the automatic sprinkler system per NFPA 101 (2012 edition), Life Safety Code Section 19.7.6, and 4.6.12, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 10/16/2023, between 9:00am and 1:00pm, it was revealed by a review of available documentation that the facility failed to provide documentation of the performance of quarterly sprinkler system testing.	K 353	K353 □ Sprinkler System □ Maintenance and Testing. Viking Sprinkler quarterly inspections have been completed and have confirmed the following upcoming inspection dates with Viking Sprinkler. Confirmed Viking Sprinkler has scheduled inspection dates for the following year; 1/2/2024 (Quarterly), 4/2/2024 (Quarterly), 7/2/2024 (Annual), 10/2/2024 (Quarterly) on 11/10/23. Inspection due dates will be on EVS directors and Administrators calendar to serve as a back up to insure inspections occur timely.	

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K 353	Continued From page 7 An interview with the Facility Administrator verified these deficient findings at the time of discovery.	K 353	EVS Director or Administrator is responsible for ongoing compliance. Compliance achieved by 11/10/2023	