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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JOZS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00861

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245236**

2.STATE VENDOR OR MEDICAID NO.
(L2) **819240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER**
(L4) **935 KENWOOD AVENUE**
(L5) **DULUTH, MN** (L6) **55811**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/21/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 08/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
11/17/1980
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/22/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245236

September 14, 2017

Mr. Brian Pattock, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Dear Mr. Pattock:

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 August 11, 2017 the above facility is recommended for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 22, 2017

Mr. Brian Pattock, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: Project Number S5236029

Dear Mr. Pattock:

On July 14, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 29, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction. Also, the Minnesota Department of Public Safety completed a PCR on August 21, 2017 to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 29, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 11, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 29, 2017, effective August 11, 2017 and therefore remedies outlined in our letter to you dated July 14, 2017, will not be imposed.

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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 22, 2017

Mr. Brian Pattock, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: Reinspection Results - Project Number S5236029

Dear Mr. Pattock:

On August 21, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 29, 2017, with orders received by you on July 24, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JOZS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00861

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245236**

2. STATE VENDOR OR MEDICAID NO. (L2) **819240500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER**
(L4) **935 KENWOOD AVENUE**
(L5) **DULUTH, MN** (L6) **55811**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/29/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE II 08/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **11/17/1980** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
08/22/2017 (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 14, 2017

Mr. Brian Pattock, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: Project Number S5236029

Dear Mr. Pattock:

On June 29, 2017, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 8, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 8, 2017 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC 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 ePoC 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. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 September 29, 2017 (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 December 29, 2017 (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
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	06/29/2017

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to resolve grievances expressed in resident council regarding slow call light response times. This had the potential to affect 10 of 17	F 244	F244 The Director of Social Services or designee will meet with R2, R116, R67, R149, R216, R54, R95, R22, R33 and R113 to discuss with them the grievance	8/11/17

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

Electronically Signed | 07/24/2017

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 _____	06/29/2017

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 244	Continued From page 1 residents (R2, R116, R67, R149, R216, R54, R95, R22, R33, and R113) reviewed for resident council concerns. Findings include: Resident Council Meeting Minutes were reviewed from January 2016, through June 2016. - 1/9/17; Residents stated call lights are taking a long time to be answered. The meeting minutes did not contain any follow up to the concern. - 2/13/17; The director of nursing (DON) said that all nursing staff should be wearing walkie talkies. They are working on getting a new call light system. - 3/13/17; Residents stated call lights are slow to be answered. The meeting minutes did not contain any follow up to the concern. - 4/10/17; Residents stated call lights are slow to be answered. The DON stated she will do a call light check. - 5/8/17; Residents stated call lights are slow to be answered. The meeting minutes did not contain any follow up to the concern. - 6/2/17; Residents stated call lights are slow to be answered. The meeting minutes did not contain any follow up to the concern. On 6/29/17, at 10:35 p.m. R2, who regularly attends resident council meetings, was interviewed and stated long call lights have been brought up every month. R2 further stated the staff never get back to the residents on what they were doing to reduce the call light response times. On 6/29/17, at 10:52 a.m. R116, who also regularly attends resident council meetings, stated the facility stated they are working on the	F 244	procedure and review the new tracking tool which has been developed to track group concerns at resident council meetings. The Director of Social Services or designee will hold another resident council meeting to discuss with all the residents who attend, the grievance process and how concerns will be followed up on. The meeting has been set for August 1, 2017. The Activity Director has been educated on the grievance process. A new tracking tool has been developed to log any concerns the group may have. The concerns will be addressed at the resident council meeting with feedback on how the facility is correcting the concerns. Individual concerns will be entered into the concern data base and assigned to the responsible person for follow up. Audits have been developed to assure resident concerns/grievances have been addressed. Audits will be conducted after each resident council meeting until the Quality Assurance (QA) committee deems 100% compliance. The grievance policy has been reviewed and remains appropriate. The Director of Social Services or designee is responsible. Date of compliance is 8/11/17.	

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 _____	06/29/2017

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
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call lights be answered more timely, but nothing ever changes. R116 stated she was frequently left in the bathroom, staff say they will be back, and they don't come back. R116 stated it takes a long time for someone to answer the call light.

On 6/29/17, at 11:04 a.m. the activity director (AD)-A stated department heads attend every resident council meeting, and address concerns that are related to their department. AD-A stated she does not include staff response to concerns in the meeting minutes. AD-A further stated every month there are concerns about long response times to call lights, and stated the DON follows up individually with residents.

On 6/29/17, at 12:24 p.m. the DON stated she individually meets with residents that complain of call light response times and then checks the call light logs. The DON stated the facility had adjusted staffing groups and times staff were in the dining rooms. The DON further stated resident concerns were an area the facility could improve on, as there is no documentation to track what the facility did in response to concerns.

The facility policy Concern, Grievances dated 2016, directed when a resident, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards it to the Social Services department/designee in a confidential manner. The staff person responsible investigates, resolves the issue, and responds back to the customer within five business days and documents action. Resident satisfaction with the resolution and handling of the concerns is obtained.

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R67's Face Sheet printed 6/29/17, indicated R67's diagnoses included hemiplegia and hemiparesis (weakness or paralysis of one side of the body) following cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD-breathing problems), pain, difficulty walking, acute and chronic respiratory failure, and dysphagia (swallowing problems).

R67's care plan edited 4/17/17, and 4/28/16, indicated R67 was able to communicate his needs, was cognitively intact, and required assistance of two staff for toileting every two hours. R67's care plan edited 6/26/17, indicated R67 had the potential for falls, and was non-ambulatory. Interventions included keeping the call light in reach, and assistance with bed mobility. R67's care plan further indicated R67 had the potential for pain, was to be repositioned for comfort and monitored for increased pain, was to be monitored for signs and symptoms of respiratory distress, and was at risk for skin breakdown.

On 6/26/16, at 1:35 p.m. R67 stated he had to wait a long time for call light to be answered.

R67's Device Activity Report dated 6/1/17, to 6/29/17, indicated R67's call light response time was over 20 minutes on 12 occasions, including the following:
-30 to 40 minutes, 2 times
-40 to 60 minutes, 1 time
-60-80 minutes, 2 times

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F 244	Continued From page 4 -greater than 100 minutes (139 minutes), 1 time R149's Face Sheet printed 6/29/17, indicated R149's diagnoses included compression fractures of the spine, dysphagia, weakness, repeated falls, and heart disease. R149's care plan dated 4/25/17, indicated R149 was cognitively intact, was able to communicate needs appropriately, and required assistance with all mobility related to compression fracture, pain, and weakness. Interventions included call light to be kept in reach, and extensive assist of one staff for transfers. R149's care plan further indicated R149 was at risk for pressure ulcers, was frequently incontinent of bowel and bladder and required staff assistance for toilet use every two hours. The care plan further indicated R149 was to be monitored for increased pain, repositioned for comfort, and was at risk for falls requiring the call light to be kept in reach. On 6/27/17, at 1:08 p.m. R149 stated she has had to wait over an hour for her call light to be answered at times. R149's Device Activity Report dated 6/1/17, to 6/29/17, indicated R149's call light response time was over 20 minutes, 88 times, including the following: -30 to 40 minutes, 17 times -40 to 60 minutes, 14 times -60 to 80 minutes, 4 times -80 to 100 minutes, 3 times -greater than 100 minutes (104 minutes, and 111 minutes) 2 times R216's Face Sheet printed 6/29/17, indicated R216's diagnoses included pain, epilepsy	F 244		

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(seizures), dysphagia, cerebral infarction, muscle weakness, heart disease, and abnormality of gait and mobility.

R216's care plan 4/27/17, indicated R216 was cognitively intact, was at risk for pressure ulcers, and had pain which was to be monitored. The care plan further indicated R216 was independent with bed mobility, required limited assistance of staff for ambulation and transfers, and was to reposition every two hours. R216's care plan also indicated R216 was at risk for falls, and the call light was to be kept in reach. R216 had occasional incontinence of bladder and frequent incontinence of bowel, and was to be asked every two hours and taken to the bathroom per her request.

On 6/27/17, at 2:14 p.m. R216 stated she sometimes waited a half hour or one hour to have call lights answered. R216 stated she had been incontinent when she has had to wait. R216 stated being incontinent didn't feel good, and was uncomfortable.

R216's Device Activity Report is combined with R54's Device Activity Report below (they are roommates).

R54's Face Sheet printed 6/29/17, indicated R54's diagnoses included heart arrhythmia, weakness, hemiplegia and hemiparesis following stroke, anxiety disorder, difficulty in walking, and pain.

R54's care plan dated 4/13/17, indicated R54 was cognitively intact, occasionally incontinent of bladder and was to be asked every two hours for toileting needs or per her request. The care plan

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also indicated R54 required staff assistance for toilet or bedpan use, was at risk for pressure ulcers, and was to be turned and repositioned every two hours with staff assistance. The care plan further indicated R54 had pain that was to be monitored for increased symptoms, was at risk for falls, and the call light was to be kept within reach.

On 6/27/17, at 1:39 p.m. R54 stated she recently had to wait one and one-half hours for her call light to be answered, and has had to wait a long time intermittently. R54 stated the time of day when she has to wait has varied. R54 stated she has been incontinent, and has needed to have her bed changed at times when she has had to wait. R54 stated she was self-conscious about it.

R54's and R216's Device Activity Report dated 6/1/17, to 6/29/17, indicated the room call light response times were over 20 minutes, 104 times, including the following:
-30 to 40 minutes, 30 times
-40 to 60 minutes, 18 times
-60 to 80 minutes, 5 times
-greater than 100 minutes (103 minutes) 1 time

R95's Face Sheet printed 6/29/17, indicated R95's diagnoses included a heart arrhythmia, congestive heart failure, difficulty in walking, pain, and asthma.

R95's care plan dated 6/26/17, indicated R95 was cognitively intact, was able to communicate her needs, and was independent with toilet use and mobility. The care plan further indicated R95 was at risk for falls and pain, and the call light was to be kept in reach.

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On 6/26/17, at 2:36 p.m. R95 stated she had kidney and bladder problems with urinary urgency, had problems with incontinence, and staff do not answer the call lights timely, especially in the evening and night shifts. R95 stated it takes up to 40 minutes to get the call light answered. R95 stated it seemed staff only answered call lights of residents who are on their list to care for, and walk by the room of those residents they aren't caring for.

R95's Device Activity Report dated 6/1/17 to 6/29/17, indicated the call light response times were over 20 minutes, 44 times, including the following:
-30 to 40 minutes, 10 times
-40 to 60 minutes, 3 times
-greater than 100 minutes (109 minutes), 1 time

R22's Face Sheet printed 6/29/17, indicated R22's diagnoses included COPD, asthma, heart arrhythmia, dysphagia, and backache.

R22's care plan edited 12/20/16, indicated R22 was cognitively intact and was able to communicate her needs. The care plan also indicated R22 was at risk for falls, pain, and respiratory distress. The care plan also indicated R22 was at risk for skin breakdown, and staff were to ensure she was repositioned every two hours, was independent with toilet use, was independent with transfers and bed mobility, and her call light was to be kept in reach.

On 6/27/17, at 4:14 p.m. R22 stated she has had to wait up to an hour or two for staff to answer call lights. R22 stated she sometimes misses the toilet when she has to wait so long. R22 stated she has to go in the hall and yell at the nurse and

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that makes her look bad. R22 stated it is degrading. R22 stated morning was the worst time for call lights to go unanswered. R22 stated there was another resident who hollers for a long time, and the staff ignores her light also.

R22's Device Activity Report dated 6/1/17 to 6/29/17, indicated the call light response times were over 20 minutes, 27 times, including the following:
-30 to 40 minutes, 4 times
-40 to 60 minutes, 4 times
-60 to 80 minutes, 5 times

R33's Face Sheet dated 5/23/16, indicated R33's diagnoses included acute respiratory distress, anxiety disorder, dysphagia, low back pain, and respiratory failure.

R33's care plan edited 4/28/17, indicated R33 was cognitively intact, and was able to communicate her needs. R33's care plan indicated R33 was at risk for pressure ulcers, required extensive assist of two for repositioning, and was to be repositioned every two hours. The care plan also indicated R33 was at risk for respiratory distress and falls, had a history of severe pain, and directed staff to keep call light in reach. R33's care plan further indicated R33 was to be asked every two hours and per her request for toileting needs.

On 6/26/17, at 1:16 p.m. R33 stated it can take one to two hours for staff to come in response to call lights.

R33's Device Activity Report dated 6/1/17, to 6/29/17, indicated the call light response times were over 20 minutes, 76 times, including the

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F 244	Continued From page 9 following: -30 to 40 minutes, 14 times -40 to 60 minutes, 16 times -60 to 80 minutes, 3 times -greater than 100 minutes (107 minutes and 118 minutes), 2 times R113's Face Sheet printed 6/29/17, indicated R113's diagnoses included difficulty in walking, muscle weakness, dysphagia, acute and chronic respiratory failure, heart arrhythmia, epistaxis (nose bleeds), history of falls, and chronic pain. R113's care plan edited 6/18/17, indicated R113 was cognitively intact, able to use his call light and could communicate his needs. R113's care plan indicated he required assistance with bed mobility and transfers, was at risk for skin breakdown, and required repositioning every two hours. The care plan also indicated R113 was at risk for pain and respiratory distress, and was at risk for falls. R113's care plan further indicated R113 was occasionally incontinent of bowel and bladder, required staff assist to the toilet, was to be asked every two hours if he had toileting needs, and the call light was to be kept in reach. On 6/27/17, at 1:18 p.m. R113 stated it takes up to one and one half hours for staff to respond to call lights. R113 stated he hollers for help and then staff come. R113 stated he has had bloody noses and has had to wait for an hour for help, then he gets upset and all worked up. R113's Device Activity Report dated 6/1/17 to 6/29/17, indicated the call light response times were over 20 minutes, 23 times, including the following: -30 to 40 minutes, 7 times	F 244		

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F 244	Continued From page 10 -40 to 60 minutes, 3 times -60 to 80 minutes, 1 time -80 to 100 minutes, 1 time -greater than 100 minutes (127 minutes) 1 time On 6/29/17, at 4:52 p.m. the administrator was interviewed and stated the facility is working on a new call light system that will allow the staff to communicate with the resident prior to entering the resident room. The administrator also stated walkie talkies will be smaller for the staff to carry, and there will be routine announcements over the walkie talkies with an escalating announcement that will go up the line to the nurse, nurse manager, and then director of nursing (DON). The administrator stated when the residents voice a concern the facility will act on it. The administrator and DON both verified they had extended call light response times, and both stated at that time that the new call light system should help with call light response times.	F 244		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 309		8/11/17

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F 309	Continued From page 11 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ongoing assessment for changes in skin conditions for 1 of 3 residents (R26) reviewed for non-pressure related skin. Findings include: R26's Face Sheet undated, indicated diagnoses of chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), and osteoporosis. R26's quarterly Minimum Data Set (MDS) dated 3/28/17, indicated R26 was cognitively intact and required extensive assist with activities of daily living (ADLs). R26's care plan dated 6/23/17,	F 309	F309 R26 has had a comprehensive skin assessment including the Nurse Practioner□s (NP) documented assessment. A list of residents with the potential for non pressure related skin issues has been developed. Those residents have been assessed and new interventions implemented if identified with skin related concerns. Audits have been developed to assure weekly skin checks are being completed with bath days. 5 Audits will be completed weekly. Staff have been re-educated on reporting any skin changes to the licensed	

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F 309	Continued From page 12 indicated licensed staff were to conduct a systematic skin inspection weekly. The care plan also directed the nursing assistants to inspect R26's skin daily with cares. R26's weekly skin documentation dated 6/8/17, through 6/26/17, lacked documentation related to R26's forearm bruising. A nursing progress note dated 6/27/17, indicated R26 was at risk for skin breakdown. A nursing progress note dated 6/23/17, indicated a bath observation with no new skin issues. On 6/26/17, at 1:55 p.m. R26 was observed sitting in a recliner with large bruised area on right forearm and a quarter sized bruise on the left forearm. On 6/28/17, at 8:22 a.m. licensed practical nurse (LPN)-A was interviewed and stated nurses document skin concerns weekly on the bath sheet. LPN-A stated R26 had no documentation on the bath sheet related to the bruising on R26's forearms. LPN-A stated she was unaware R26 had bruising on the forearms. On 6/28/17, nursing assistant (NA)-D was interviewed and stated if there was a skin issue with R26, she would report to the nurse immediately. On 6/28/17, at 4:07 p.m. registered nurse (RN)-A stated staff were to observe and report any skin changes to the nurse immediately. RN-A stated the skin sheets are completed weekly by the nursing staff. On 6/29/17, at 10:34 a.m. trained medication assistant (TMA)-A stated R26's arm bruising	F 309	nurse. The skin policy has been reviewed with the staff. Audits will be conducted weekly until the QA committee deems a 100% compliance. The DON or designee is responsible. Date of compliance is 8/11/17.	

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should be documented on the bath sheet. TMA-A stated R26's right forearm bruising was approximately three inches by three inches with brown and purple coloring. TMA-A stated R26's left forearm had three dime size areas that were pink in color. TMA-A state the bruising on the right forearm might be from the night stand drawer and R26 digging in her drawer, and the left forearm might be from hitting the stand lift. TMA-A stated no one had reported the bruising on R26's forearms to TMA-A. TMA-A stated, "They should tell me about this, and I would get the nurse manager to do the skin assessment."

On 6/29/17, at 11:18 a.m. RN-A stated the nurse passing medications documents on the bath sheets if there are skin issues with residents, then they are to tell the nurse manager.

On 6/29/17, at 11:25 a.m. R26 was observed with RN-A. RN-A measured the bruising on R26's forearms, the right forearm bruise was 12 centimeters (cm) by 8 cm, and brown and purple color. RN-A measured the left forearm bruising to be 4.5 cm by 1.5 cm. RN-A stated the staff should report to the team lead immediately if there are skin changes on residents.

On 6/29/17, at 1:53 p.m. NA-A stated R26 did not have any bruising on the arms. NA-A went into R26's room and stated, "I did not see the bruising this morning when I assisted her." NA-A stated the marks on R26's forearms should have been reported to the nurse.

On 6/29/17, at 2:05 p.m. the director of nursing (DON) stated staff are to immediately report to the nurse if they notice any change in the skin of a resident.

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F 309	Continued From page 14 A facility policy related to skin was requested and none was provided.	F 309		
F 313 SS=D	483.25(a)(1)(2) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION (a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- (1) In making appointments, and (2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure vision services, assistive devices and adaptations were provided for 1 of 1 residents (R216) reviewed for vision problems. Findings include: R216's admission Minimum Data Set (MDS) dated 4/27/17, indicated R216 was cognitively intact, had impaired vision, had corrective lenses, and was able to read large print. R216's Face Sheet printed 6/29/17, indicated R216's diagnoses included a mood disorder with depressive features, and unspecified dementia.	F 313	F313 R216 has had a vision assessment completed and interventions implemented per assessment. A list of current residents with the potential for vision deficits has been developed. Identified residents will be reviewed for a visual assessment. Residents identified as needing or requesting a vision exam will be offered one. A list of newly admitted residents has been completed. These residents will be reviewed to assure vision assessments have been completed and vision services offered if deemed necessary. Audits have been developed to assure the vision assessments are complete and any vision concerns are brought to the clinical	8/11/17

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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 313	Continued From page 15 R216's Care Area Assessment (CAA) for visual function dated 4/27/17, indicated R216 had impaired vision at the level of newsprint without the use of corrective lenses. R216's CAA indicated R216 usually wore reading glasses, but did not have them at the facility. R216's CAA further indicated decreased vision could contribute to not having her needs met, and R216 would be referred to the physician and ophthalmologist as needed. R216's CAA for activities dated 4/27/17, indicated R216 liked to watch TV, read books, and listen to the radio. R216's CAA further indicated R216 had poor vision. R216's care plan dated 4/27/17, indicated R216 had impaired vision, and needed corrective lenses to see at a newspaper print level. R216's care plan directed nursing to assess the effect of vision loss on R216's functional status, and directed nursing assistants to assure the lenses of R216's glasses were clean and in good repair. R216's care plan further directed activity staff to provide the book cart twice a month, and assist resident to find books of interest for R216. In addition, R216's activity care plan indicated R216 liked to read books and magazines, and watch TV. R216's vision assessment progress note dated 4/25/17, indicated R216's vision was impaired at newspaper level print, and R216 usually wore reading glasses, which were not at the facility. R216's activity assessment progress note dated 4/25/17, indicated R216 expressed reading and playing Bingo were very important to her, and she liked to watch TV and listen to her radio. R216's progress note indicated R216 had poor vision.	F 313	manager for follow up. 3 audits will be conducted weekly. The individuals who complete the MDS have been educated to report any vision concerns to the clinical manager. The policy has been reviewed and revised. Audits will be completed weekly until the QA committee deems 100% compliance. The DON or designee will be responsible. Date of compliance is 8/11/17.	

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F 313	Continued From page 16 R216's nursing assistant care guide sheets lacked identification of vision deficits or glasses. R216's Physician progress notes dated 4/25/17, indicated R216 had decreased vision, could see the TV, but could not see the scroll on the bottom or the newsprint On 6/27/17, at 2:01 p.m. R216 stated she was legally blind, but liked to read. R216 stated she was unable to read now, and has not been offered books on tape, but stated she would like to try that. R216 stated she listens to the TV. R216 further indicated she did not have glasses at the facility. On 6/29/17, at 9:20 a.m. R216 was lying in bed with her head set on, watching TV. R216 had a book sitting with regular print on her table. R216 stated she was unable to read her book without her glasses, and did not know where where her glasses were. On 6/29/17, at 10:43 a.m. registered nurse (RN)-A verified no adaptations had been made for R216's vision deficits. RN-A stated R216 does not participate in activities, and declines to get out of bed. RN-A stated she would offer residents with vision deficits ophthalmology consults. On 6/29/17, at 11:00 a.m. activity director (AD)-A stated she would have offered books on tape and the book cart for R216, but did not specifically remember if she had offered. AD-A stated R216 is offered activities frequently, but usually refuses to participate. On 6/29/17, at 12:38 p.m. the director of nursing	F 313		

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F 313	Continued From page 17 (DON) stated she would expect vision services to be offered when deficits are identified. A policy and procedure for vision was not provided.	F 313		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the	F 329		8/11/17

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F 329	Continued From page 18 clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure target behaviors and interventions were identified, monitored, and communicated to staff who provided care for 2 of 5 residents (R216, R151) reviewed for unnecessary drugs. Findings include: R216's admission Minimum Data Set (MDS) dated 4/27/17, indicated R216 was cognitively intact, had symptoms of severe depression and delirium with disorganized thinking, delusions, verbal behaviors 1 to 3 days during the look-back period that significantly interfered with cares. The MDS further indicated R216 rejected cares 1 to 3 days, and wandered 1 to 3 days. R216's MDS also indicated R216 had diagnoses of dementia and depression, and received antipsychotic and antidepressant medications. R216's Face Sheet printed 6/29/17, indicated R216's diagnoses included mood disorder with depressive features, delusional disorder, major depressive disorder, restlessness and agitation, unspecified dementia without behavioral disturbance, and seizure disorder. R216's Physician Orders printed 6/29/17, included orders for mirtazapine (antidepressant)	F 329	F329 R 216 and R 151 have been assessed and target behaviors and interventions have been identified, monitoring is in place, and communicated to the staff. The front line staff was involved in identifying the target behaviors and the non-pharmacological interventions have been individualized with each resident. The target behaviors have been added to the care plan and the nursing assistants care guides. A list of residents with mood altering medications has been developed by utilizing the pharmacy consultant□s report. The nurse manager will complete target behaviors, interventions, and ongoing monitoring for 3 residents per week until all residents identified have been assessed. Audits have been developed to assure target behaviors, interventions, monitoring, and care plans have been updated. 3 audits will be done every week until the QA committee deems a 100% compliance. The DON or designee is responsible. The compliance date is 8/11/17.	

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F 329	Continued From page 19 and olanzapine (antipsychotic). R216's Care Area Assessment (CAA) for psychotropic medication use dated 4/27/17, indicated R216 was monitored for side effects of medications, and for mood and behavior changes. R216's CAA for mood state and behavioral symptoms dated 4/27/17, along with social services progress note dated 4/26/17, indicated R216 was an immediate threat to self, had signs and symptoms of severe depression, and made statements regarding thoughts of being better off dead or of hurting self. Nursing and physician were notified of mood assessment results and R216's statements. R216's social services note further indicated R216 was an elopement risk due to wandering and disorganized and delusional thinking. R216's progress notes dated 4/28/17, indicated the physician related mood assessment scores to dementia. R216's progress note further indicated R216 had improved since admission. R216's care plan dated 5/24/17, indicated R216 displayed behavioral symptoms of wandering, but did not exit-seek. R216's care plan initiated 4/26/17, indicated R216 had signs and symptoms of severe depression, and made statements of being better off dead or harming self, in line with delusional and disorganized thinking. R216's care plan further indicated R216 displayed verbal behaviors, rejection of care and wandering during the assessment period. Care plan approaches included behavioral monitoring per protocol, talk way through tasks to avoid startling R216, and medications as ordered. The care plan further directed social services to monitor for increases in mood or behavioral issues or signs and	F 329		

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F 329	Continued From page 20	F 329		

symptoms of depression, coordinate interventions with nursing, and directed nursing to use a slow calm approach. If R216 was resistive, leave and reapproach later. R216's care plan lacked identification of R216's specific target behaviors related to R216's medications. R216's care plan lacked interventions for direct care staff to manage R216's delusions or severe mood concerns.

R216's Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked identification of R216's target behaviors related to medications.

R216's nursing assistant care guides lacked identification of R216's target behaviors and severe mood concerns or interventions to manage behavioral and mood signs and symptoms.

R216's Point of Care Behavior Category Report dated 5/26/17 to 6/29/17, indicated R216 rejected care on 6/28/17, 6/23/17, and 6/22/17. Behaviors listed in the Point of Care Behavior Category Report lacked individualized target behaviors and interventions for R216. R216's progress notes lacked documentation of behaviors identified on the Behavior Category Report.

R216's progress notes dated 6/20/17, indicated R216 rejected her bath three times. R216's progress notes dated 5/22/17, indicated R22 refused her breakfast and displayed verbal behaviors, yelling at staff. R216's progress notes dated 5/13/17, indicated R216 was agitated and slightly confused, yelled at staff, and was delusional about bugs in her food. R216's progress notes dated 5/3/17, indicated R216 was

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up during the night shift going through cabinets in small dining room, looking for food, making comments about wishing to die, wanting to be out of facility, and having a shot in the head for family members. R216's documentation did not include interventions attempted or effects of interventions.

R216's physician progress notes dated 5/16/17, indicated R216 was continually dissatisfied with her care, paranoid she was being poisoned, and reported her food was laced with methane. Physical exam note addressing R216's psychiatric state indicated R216 was "cantankerous," and had paranoia, depression, and negative thought patterns.

On 6/28/17, at 9:45 a.m. R216 was sleeping in her bed, after eating most of her breakfast in bed.

On 6/29/17, at 9:20 a.m. R216 was lying in bed with her head set on, watching TV. R216 stated she doesn't like the food at the facility, the activities, and wanted to go home.

On 6/29/17, at 10:47 a.m. registered nurse (RN)-A stated nurses document behaviors, and there should be a task for them on the MAR or TAR. RN-A stated nursing assistants (NA) documented resident's behaviors in Point of Care charting. RN-A stated nursing assistants and nurses report behaviors, and it gets noted on the 24 hour report board. RN-A stated R216's target behaviors should include hallucinations, striking out with cares, and refusal of cares.

On 6/29/17, at 11:19 a.m. trained medication assistant (TMA)-A stated there was usually a task on the MAR that informed staff to document side

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effects and behaviors for residents on psychotropic (mood altering) medications, but verified she did not find one on R216's MAR. TMA-A stated R216 should have this with the medications she was receiving. TMA-A verified R216's MAR did not identify target behaviors for this resident.

On 6/29/17, at 12:38 p.m. the director of nursing (DON) verified target behaviors should have been on the MAR for R216.

On 6/29/17, at 6:47 p.m. DON verified NAs do not have access to the care plans, and stated they get reports and information from the nurses. The DON stated if the information is not included on the NA group sheets, the NAs may hear it in a report or may not. The DON verified the interventions for behaviors may not be included on the group sheets. The DON stated the NAs should ask the team leader if they have questions. The DON further stated nurse managers and nurse supervisors update the group sheets.

The facility policy and procedure for Behavioral Assessment, Intervention and Monitoring revised 12/16, directed the interdisciplinary team (IDT) to assess and evaluate the resident's behavioral symptoms, and incorporate findings on the care plan. The care plan would include a description of the behavioral symptoms, targeted and individualized interventions, rationale for interventions and approaches, specific goals for targeted behaviors and how staff would monitor effectiveness of interventions. When medications are prescribed for behavioral symptoms, the documentation should include specific target behaviors and expected outcomes. The IDT

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would monitor resident's progress until stable.

R151's Face Sheet printed 6/29/17, indicated diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, and restlessness and agitation.

R151's annual Minimum Data Set (MDS) dated 4/10/17, indicated R151's had impaired short and long term memory, and severely impaired cognitive skills for daily living.

R151's physician visit dated 5/25/17, indicated R151 received Trazadone (antidepressant) and Zyprexa (antipsychotic).

R151's care plan dated 4/13/17, directed nursing to monitor for side effects of medications (dizziness, drowsiness, difficulty urinating, sleep disturbances, headache, and anxiety). R151's care plan also included non-pharmacological interventions for behaviors of poor safety awareness and recall with impulsiveness. These interventions included position for comfort, allow to sit by nurses station, gentle range of motion, and give coconut water with pineapple.

R151's nursing assistant group sheets lacked identification of target behaviors and interventions to manage behaviors.

R151's Psychiatric Physician Progress notes dated 2/27/17, indicated facility staff have reported to him that R151 had been disimpacting herself and eating her own feces. The note also indicated R151 had verbal outbursts that were difficult to control at times.

On 6/29/17, at 11:21 a.m. nursing assistant

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(NA)-E stated R151 is generally resistive to cares, and will yell out most of the time with any cares. NA-E stated R151 is usually better at meals. NA-E stated he had not observed that behavior of eating her feces,"In quite some time."

On 6/29/17, at 11:28 a.m. licensed practical nurse (LPN)-C stated she had seen stool on R151's hands and sometimes on her mouth. LPN-C stated she has not seen it for a couple of months now. LPN-C stated staff check on R151 more frequently as a result of that target behavior.

On 6/29/17, at 2:35 p.m. NA-C stated R151 has had really good and really bad days. NA-C stated R151 is confused. NA stated she moves slow when caring for R151, and will sing with R151 during cares. NA-C stated she would report to the nurse or trained medication assistant (TMA) regarding problems or target behaviors with R151. NA-C stated she would use redirection with R151, to allow NA-C to perform cares. NA-C stated she was not sure if she has access to R151's care plan, as it was on the computer. NA-C stated she documents R151's behaviors in the computer kiosk. NA-C stated group sheets/pocket care plans carried by NAs do not have target behaviors or interventions listed. NA-C stated R151 loves ice cream, and likes music.

On 6/29/17, at 3:01 p.m. the director of nursing (DON) was interviewed and stated R151's target behaviors are reaching out for things, hollering out repeatedly, digging in her feces, and her behaviors increase with the need for a bowel movement.

On 6/29/17, at 6:38 p.m. the DON stated NAs do

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F 329	Continued From page 25 not have access to the complete care plan. The DON confirmed problem areas on the care plan are not identified on group sheets/pocket care plans carried by the NAs. The DON confirmed target behaviors and interventions are not on group sheets/pocket care plans On 6/29/17, at 6:45 p.m. the DON stated target behaviors would be passed down to the NAs in report. The DON confirmed NAs do not have access to the care plan. The DON stated NAs are supposed to report concerns or target behaviors to the team leader for that particular shift. The DON stated nurse managers or weekend supervisors update the group sheets.	F 329		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides.	F 356		8/11/17

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F 356	Continued From page 26 (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to post and or develop the nurse staff posting on a daily basis. This practice had the potential to affect all 89 residents residing in the facility. Findings include: On 6/26/17, at 6:59 a.m. during the initial tour, the nurse staff posting was posted near the front desk however, was dated 6/23/17.	F 356	F356 The posted nurse staffing policy has been reviewed and revised. It is the responsibility of the scheduler or designee to post the staffing information every morning. On the weekends the front desk receptionist will post it. The supervisor/charge nurse is responsible for changing the posting hours if adjustments are needed in the absence of the scheduler. Audits have been developed to assure	

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F 356	Continued From page 27 Review of the nurse staff posting forms from 4/17, through 6/17 indicated the following: 4/17: A staff posting was not created and posted for 4/6/17, 4/7/17, 4/8/17, 4/9/17, 4/10/17. 5/17: A staff posting was not created and posted for 5/24/17, 5/25/17, 5/26/17, 5/27/17, 5/28/17. On 6/29/17, at 8:43 a.m. the staffing coordinator (SC)-C was interviewed and stated she was responsible for completing the nurse staff posting on a daily basis. SC-C stated when she went to post the 6/26/17, form she realized it was dated 6/23/17. SC-C stated she forgot to print out the nurse staff postings for 6/24/17, and 6/25/17, and have the nursing supervisor post them. SC-C further stated she did not always complete the nurse staff posting form and get them posted on a daily basis because of distractions. SC-C was not sure how long the facility was to retain a copy of the nurse staff posting forms, but stated she thought it was three years. On 6/29/17, at 12:22 p.m. the director of nursing (DON) was interviewed and stated the nurse staff posting was expected to be completed and posted on a daily basis. A policy on nurse staff posting was requested and not received.	F 356	timely and accurate nursing hours are posted. Audits will be done daily until the QA deems 100% compliance. Staff have been re-educated. The DON or designee is responsible. The compliance date is 8/11/17.	
F 411 SS=D	483.55(a)(1)(2)(4) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS (a) Skilled Nursing Facilities A facility-	F 411		8/11/17

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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 411	Continued From page 28 (a)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; (a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; (a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dental services were offered and provided for 1 of 3 residents (R216) reviewed for dental services . Findings include: R216's Face Sheet printed 6/29/17, indicated R216's diagnoses included malnutrition, unspecified dementia, and dysphagia (swallowing problems). R216's admission Minimum Data Set (MDS) dated 4/27/17, indicated R216 was cognitively intact, required partial assistance from staff with oral hygiene, and had obvious or likely cavities or broken teeth. R216's MDS further indicated R216 had mouth or facial pain, and discomfort or difficulty chewing.	F 411	F411 R216 has had an oral cavity assessment. R216 was offered a dental visit and declined as she has no problems with her teeth, chewing or swallowing. A list of interview able residents has been developed each resident will be asked if they have any current dental concerns and offered services if any concerns are indicated. A list of non-interview able residents has been developed and each will have an oral cavity assessment and any dental concerns will be addressed. All residents will be offered a dental visit at least annually or if they are having dental concerns. A dental form has been developed which includes offering annual dental visit or if the resident declines the annual visit. The form will be brought to care conferences. A list of newly admitted	

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F 411	Continued From page 29 R216's care plan dated 4/27/17, indicated R216 required staff assistance with set up for oral cares and teeth brushing, and directed staff to assist with completion as necessary. R216's care plan further directed to provide a referral to the dentist if R216 developed mouth or tooth pain and desired an appointment. R216's Care Area Assessment (CAA) for dental dated 4/27/17, indicated R216 had reported having pain to her oral mucosa (mouth tissue), and had trouble with chewing. R216's CAA indicated R216 had her natural teeth in poor condition, was assisted with oral cares twice daily, and was at risk for breakdown of the oral mucosa. R216's CAA indicated a referral to the dentist would be made as needed. R216's undated nursing assistant care guide sheet directed nursing assistants (NAs) to set up R216 for oral cares twice daily and as necessary. R216's progress note regarding an oral cavity assessment dated 4/25/17, indicated R216 reported having pain to oral mucosa and trouble with chewing, and her natural teeth were in poor condition. R216's progress note dated 4/18/17, indicated R216 had a couple of teeth on the top and no upper denture, and what "appeared" to be a partial on the bottom with some of her own teeth. R216's admission nutrition progress note dated 4/11/17, indicated R216 had poor dentition and refused offers of modified textures. R216's Physician Order dated 5/23/17, indicated R216 had an order for a regular liberalized diet.	F 411	residents has been completed. These residents will be reviewed to assure dental assessments have been completed and dental services offered if deemed necessary Audits have been developed and will be monitored for compliance by using the care conference schedule. Audits will be reviewed by QA and discontinued when the QA committee deems 100% compliance. Staff have been educated. The policy has been reviewed and remains appropriate. The DON or designee is responsible. Date of compliance is 8/11/17.	

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F 411	Continued From page 30 On 6/27/17, at 2:22 p.m. R216 stated she had missing teeth, cavities, and pain in her teeth and has problems chewing. R216 stated her dental appointments were canceled and new ones had not been made. R216 stated her dental problems have not been taken care of to her satisfaction. R216 was observed to have several missing teeth at that time. On 6/29/17, at 10:36 a.m. registered nurse (RN)-A stated oral assessments are done on admission, and verified R216 had an oral assessment on admission. RN-A stated the facility offers dental services and document offering of dental services in the assessment. RN-A verified R216's medical record lacked documentation to indicate if dental services had been offered to R216. RN-A verified R216 had poor dentition. On 6/29/17, at 12:38 p.m. the director of nursing (DON) stated she would expect the dental services to be offered when deficits are identified. The facility policy and procedure for Dental Services revised 12/13, directed nursing to notify social services of a need for dental services. The policy and procedure indicated residents were permitted to select dentist of their choice, or could receive dental services from the facility's consultant dentist. The facility policy and procedure for Dental Examination/Assessment revised 12/13, directed residents would be offered dental services as needed.	F 411		

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

F5236026

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	245236	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/28/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145	K 000	EPOC	

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

Electronically Signed | 07/24/2017

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Benedictine Health Center 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 smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 96 beds	K 000		

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K 000	Continued From page 2 and had a census of 89 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING 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. 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 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms 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 STANDARD is not met as evidenced by:	K 321		7/5/17

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K 321	Continued From page 3 Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 20 of 89 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 06/28/2017, observations revealed that the second floor storage room that is located by the common area has penetrations in the annular apace for four pipes that pass through the walls and the door did not positively close and latch into the frame. The storage room is greater that 50 square feet in size. This deficient condition was verified by the Maintenance Supervisor.	K 321	K321- IT store room on TCU- All gaps around pipes and other penetrations were fire caulked on 7/5/17 WITH 3M fire caulk. A spring hinge was installed to close and latch the door for the storage room on 7/5/17.	
K 346 SS=F	NFPA 101 Fire Alarm System - Out of Service Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service.	K 346		7/21/17

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K 346	Continued From page 4 9.6.1.6 This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 89 of 89 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 06/28/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire alarm system out of service policy that included the current Deputy State Fire Marshal's contact information in the event of the fire alarm being out of service and the need for a fire watch to be initiated This deficient condition was verified by the Maintenance Supervisor.	K 346	K346- Deputy Fire Marshal□s contact information was updated in the fire system out of service policy which is located in the Fire, Building and Life Safety Documentation Binder as of 7/21/17.	
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing 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	K 353		7/26/17

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K 353	Continued From page 5 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 STANDARD is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems 2010 edition, and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, 2011 edition. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 89 of 89 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 06/28/2017, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance revealed that at the time of the inspection the facility could	K 353	K353- Made arrangements with Viking Sprinkler to conduct quarterly flow test inspections-to begin July 26, 2017.	

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K 353	Continued From page 6 not provide any documentation for any of the fire sprinkler quarterly flow test verifying that it has been completed. This deficient condition was verified by the Maintenance Supervisor.	K 353		
K 354 SS=F	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for four or more hours in a 24 hour period. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of 89 of 89 residents as well as an undetermined number of staff, and visitors to the facility .	K 354	K354- Deputy Fire Marshal□s contact information was updated in the fire sprinkler system out of service policy which is located in the Fire, Building and Life Safety Documentation Binder as of 7/21/17.	7/21/17

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K 354	Continued From page 7 Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 06/28/2017, during a records review and an interview with the Maintenance Supervisor, the facility did not have an acceptable fire sprinkler system out of service policy that included the current Deputy State Fire Marshal's contact information in the event of the fire sprinkler being out of service and the need for a fire watch to be initiated. This deficient condition was verified by the Maintenance Supervisor.	K 354		
K 374 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain multiple smoke/fire barrier doors in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.7.4.	K 374	K374-Inspection of doors conducted, paint removal on tags was completed as of 7/21/17.	7/21/17

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K 374	Continued From page 8 This deficient practice could affect 20 of 89 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 06/28/2017, observation revealed that the smoke barrier double doors located in the by resident room 315 had doors that did not have a legible fire rating tag verifying the fire rating of the doors. This deficient condition was verified by the Maintenance Supervisor.	K 374		
K 712 SS=F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed	K 712	K712- A Fire drill calendar for 2017-2018 was established to include monthly drills	7/19/17

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K 712	Continued From page 9 to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 44 of 40 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 06/28/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not conduct a overnight shift fire drill in the third quarter, a second shift fire drill in the fourth quarter, and an overnight shift in the fourth quarter of the calendar year. This deficient condition was verified by the Maintenance Supervisor.	K 712	for all three shifts and was put into practice as of 7/19/17.	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 14, 2017

Mr. Brian Pattock, Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5236029

Dear Mr. Pattock:

The above facility was surveyed on June 26, 2017 through June 29, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Teresa Ament, Unit Supervisor at (218) 302-6151 or teresa.ament@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

DEPARTMENT OF HEALTH

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00861	A. BUILDING: _____ B. WING _____	06/29/2017

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 06/26/17, through 06/29/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide ongoing	2 830	Corrected.	8/11/17

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2 830	Continued From page 2 assessment for changes in skin conditions for 1 of 3 residents (R26) reviewed for non-pressure related skin. Findings include: R26's Face Sheet undated, indicated diagnoses of chronic obstructive pulmonary disease (COPD), peripheral vascular disease (PVD), and osteoporosis. R26's quarterly Minimum Data Set (MDS) dated 3/28/17, indicated R26 was cognitively intact and required extensive assist with activities of daily living (ADLs). R26's care plan dated 6/23/17, indicated licensed staff were to conduct a systematic skin inspection weekly. The care plan also directed the nursing assistants to inspect R26's skin daily with cares. R26's weekly skin documentation dated 6/8/17, through 6/26/17, lacked documentation related to R26's forearm bruising. A nursing progress note dated 6/27/17, indicated R26 was at risk for skin breakdown. A nursing progress note dated 6/23/17, indicated a bath observation with no new skin issues. On 6/26/17, at 1:55 p.m. R26 was observed sitting in a recliner with large bruised area on right forearm and a quarter sized bruise on the left forearm. On 6/28/17, at 8:22 a.m. licensed practical nurse (LPN)-A was interviewed and stated nurses document skin concerns weekly on the bath sheet. LPN-A stated R26 had no documentation on the bath sheet related to the bruising on R26's forearms. LPN-A stated she was unaware R26 had bruising on the forearms.	2 830		

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2 830	Continued From page 3 On 6/28/17, nursing assistant (NA)-D was interviewed and stated if there was a skin issue with R26, she would report to the nurse immediately. On 6/28/17, at 4:07 p.m. registered nurse (RN)-A stated staff were to observe and report any skin changes to the nurse immediately. RN-A stated the skin sheets are completed weekly by the nursing staff. On 6/29/17, at 10:34 a.m. trained medication assistant (TMA)-A stated R26's arm bruising should be documented on the bath sheet. TMA-A stated R26's right forearm bruising was approximately three inches by three inches with brown and purple coloring. TMA-A stated R26's left forearm had three dime size areas that were pink in color. TMA-A state the bruising on the right forearm might be from the night stand drawer and R26 digging in her drawer, and the left forearm might be from hitting the stand lift. TMA-A stated no one had reported the bruising on R26's forearms to TMA-A. TMA-A stated, "They should tell me about this, and I would get the nurse manager to do the skin assessment." On 6/29/17, at 11:18 a.m. RN-A stated the nurse passing medications documents on the bath sheets if there are skin issues with residents, then they are to tell the nurse manager. On 6/29/17, at 11:25 a.m. R26 was observed with RN-A. RN-A measured the bruising on R26's forearms, the right forearm bruise was 12 centimeters (cm) by 8 cm, and brown and purple color. RN-A measured the left forearm bruising to be 4.5 cm by 1.5 cm. RN-A stated the staff should report to the team lead immediately if	2 830		

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2 830	Continued From page 4 there are skin changes on residents. On 6/29/17, at 1:53 p.m. NA-A stated R26 did not have any bruising on the arms. NA-A went into R26's room and stated, "I did not see the bruising this morning when I assisted her." NA-A stated the marks on R26's forearms should have been reported to the nurse. On 6/29/17, at 2:05 p.m. the director of nursing (DON) stated staff are to immediately report to the nurse if they notice any change in the skin of a resident. A facility policy related to skin was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure non-pressure related skin conditions are identified and interventions to prevent recurrence are initiated. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the	21325		8/11/17

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21325	Continued From page 5 needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dental services were offered and provided for 1 of 3 residents (R216) reviewed for dental services . Findings include: R216's Face Sheet printed 6/29/17, indicated R216's diagnoses included malnutrition, unspecified dementia, and dysphagia (swallowing problems). R216's admission Minimum Data Set (MDS) dated 4/27/17, indicated R216 was cognitively intact, required partial assistance from staff with oral hygiene, and had obvious or likely cavities or broken teeth. R216's MDS further indicated R216 had mouth or facial pain, and discomfort or difficulty chewing. R216's care plan dated 4/27/17, indicated R216 required staff assistance with set up for oral cares and teeth brushing, and directed staff to assist with completion as necessary. R216's care plan further directed to provide a referral to the dentist if R216 developed mouth or tooth pain and desired an appointment. R216's Care Area Assessment (CAA) for dental	21325	Corrected.	

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21325	Continued From page 6 dated 4/27/17, indicated R216 had reported having pain to her oral mucosa (mouth tissue), and had trouble with chewing. R216's CAA indicated R216 had her natural teeth in poor condition, was assisted with oral cares twice daily, and was at risk for breakdown of the oral mucosa. R216's CAA indicated a referral to the dentist would be made as needed. R216's undated nursing assistant care guide sheet directed nursing assistants (NAs) to set up R216 for oral cares twice daily and as necessary. R216's progress note regarding an oral cavity assessment dated 4/25/17, indicated R216 reported having pain to oral mucosa and trouble with chewing, and her natural teeth were in poor condition. R216's progress note dated 4/18/17, indicated R216 had a couple of teeth on the top and no upper denture, and what "appeared" to be a partial on the bottom with some of her own teeth. R216's admission nutrition progress note dated 4/11/17, indicated R216 had poor dentition and refused offers of modified textures. R216's Physician Order dated 5/23/17, indicated R216 had an order for a regular liberalized diet. On 6/27/17, at 2:22 p.m. R216 stated she had missing teeth, cavities, and pain in her teeth and has problems chewing. R216 stated her dental appointments were canceled and new ones had not been made. R216 stated her dental problems have not been taken care of to her satisfaction. R216 was observed to have several missing teeth at that time.	21325		

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21325	Continued From page 7 On 6/29/17, at 10:36 a.m. registered nurse (RN)-A stated oral assessments are done on admission, and verified R216 had an oral assessment on admission. RN-A stated the facility offers dental services and document offering of dental services in the assessment. RN-A verified R216's medical record lacked documentation to indicate if dental services had been offered to R216. RN-A verified R216 had poor dentition. On 6/29/17, at 12:38 p.m. the director of nursing (DON) stated she would expect the dental services to be offered when deficits are identified. The facility policy and procedure for Dental Services revised 12/13, directed nursing to notify social services of a need for dental services. The policy and procedure indicated residents were permitted to select dentist of their choice, or could receive dental services from the facility's consultant dentist. The facility policy and procedure for Dental Examination/Assessment revised 12/13, directed residents would be offered dental services as needed. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure dental services are offered when appropriate for residents with impaired dental status. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	21325		

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21325	Continued From page 8 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure target behaviors and interventions were identified, monitored, and communicated to staff who provided care for 2 of 5 residents (R216, R151)	21535	Corrected.	8/11/17

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21535	Continued From page 9 reviewed for unnecessary drugs. Findings include: R216's admission Minimum Data Set (MDS) dated 4/27/17, indicated R216 was cognitively intact, had symptoms of severe depression and delirium with disorganized thinking, delusions, verbal behaviors 1 to 3 days during the look-back period that significantly interfered with cares. The MDS further indicated R216 rejected cares 1 to 3 days, and wandered 1 to 3 days. R216's MDS also indicated R216 had diagnoses of dementia and depression, and received antipsychotic and antidepressant medications. R216's Face Sheet printed 6/29/17, indicated R216's diagnoses included mood disorder with depressive features, delusional disorder, major depressive disorder, restlessness and agitation, unspecified dementia without behavioral disturbance, and seizure disorder. R216's Physician Orders printed 6/29/17, included orders for mirtazapine (antidepressant) and olanzapine (antipsychotic). R216's Care Area Assessment (CAA) for psychotropic medication use dated 4/27/17, indicated R216 was monitored for side effects of medications, and for mood and behavior changes. R216's CAA for mood state and behavioral symptoms dated 4/27/17, along with social services progress note dated 4/26/17, indicated R216 was an immediate threat to self, had signs and symptoms of severe depression, and made statements regarding thoughts of being better off dead or of hurting self. Nursing and physician were notified of mood assessment results and R216's statements. R216's social	21535		

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21535	Continued From page 10	21535		

services note further indicated R216 was an elopement risk due to wandering and disorganized and delusional thinking.

R216's progress notes dated 4/28/17, indicated the physician related mood assessment scores to dementia. R216's progress note further indicated R216 had improved since admission.

R216's care plan dated 5/24/17, indicated R216 displayed behavioral symptoms of wandering, but did not exit-seek. R216's care plan initiated 4/26/17, indicated R216 had signs and symptoms of severe depression, and made statements of being better off dead or harming self, in line with delusional and disorganized thinking. R216's care plan further indicated R216 displayed verbal behaviors, rejection of care and wandering during the assessment period. Care plan approaches included behavioral monitoring per protocol, talk way through tasks to avoid startling R216, and medications as ordered. The care plan further directed social services to monitor for increases in mood or behavioral issues or signs and symptoms of depression, coordinate interventions with nursing, and directed nursing to use a slow calm approach. If R216 was resistive, leave and reapproach later. R216's care plan lacked identification of R216's specific target behaviors related to R216's medications. R216's care plan lacked interventions for direct care staff to manage R216's delusions or severe mood concerns.

R216's Medication Administration Record (MAR) and Treatment Administration Record (TAR) lacked identification of R216's target behaviors related to medications.

R216's nursing assistant care guides lacked

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21535	Continued From page 11 identification of R216's target behaviors and severe mood concerns or interventions to manage behavioral and mood signs and symptoms. R216's Point of Care Behavior Category Report dated 5/26/17 to 6/29/17, indicated R216 rejected care on 6/28/17, 6/23/17, and 6/22/17. Behaviors listed in the Point of Care Behavior Category Report lacked individualized target behaviors and interventions for R216. R216's progress notes lacked documentation of behaviors identified on the Behavior Category Report. R216's progress notes dated 6/20/17, indicated R216 rejected her bath three times. R216's progress notes dated 5/22/17, indicated R22 refused her breakfast and displayed verbal behaviors, yelling at staff. R216's progress notes dated 5/13/17, indicated R216 was agitated and slightly confused, yelled at staff, and was delusional about bugs in her food. R216's progress notes dated 5/3/17, indicated R216 was up during the night shift going through cabinets in small dining room, looking for food, making comments about wishing to die, wanting to be out of facility, and having a shot in the head for family members. R216's documentation did not include interventions attempted or effects of interventions. R216's physician progress notes dated 5/16/17, indicated R216 was continually dissatisfied with her care, paranoid she was being poisoned, and reported her food was laced with methane. Physical exam note addressing R216's psychiatric state indicated R216 was "cantankerous," and had paranoia, depression, and negative thought patterns.	21535		

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21535	Continued From page 12 On 6/28/17, at 9:45 a.m. R216 was sleeping in her bed, after eating most of her breakfast in bed. On 6/29/17, at 9:20 a.m. R216 was lying in bed with her head set on, watching TV. R216 stated she doesn't like the food at the facility, the activities, and wanted to go home. On 6/29/17, at 10:47 a.m. registered nurse (RN)-A stated nurses document behaviors, and there should be a task for them on the MAR or TAR. RN-A stated nursing assistants (NA) documented resident's behaviors in Point of Care charting. RN-A stated nursing assistants and nurses report behaviors, and it gets noted on the 24 hour report board. RN-A stated R216's target behaviors should include hallucinations, striking out with cares, and refusal of cares. On 6/29/17, at 11:19 a.m. trained medication assistant (TMA)-A stated there was usually a task on the MAR that informed staff to document side effects and behaviors for residents on psychotropic (mood altering) medications, but verified she did not find one on R216's MAR. TMA-A stated R216 should have this with the medications she was receiving. TMA-A verified R216's MAR did not identify target behaviors for this resident. On 6/29/17, at 12:38 p.m. the director of nursing (DON) verified target behaviors should have been on the MAR for R216. On 6/29/17, at 6:47 p.m. DON verified NAs do not have access to the care plans, and stated they get reports and information from the nurses. The DON stated if the information is not included on the NA group sheets, the NAs may hear it in a report or may not. The DON verified the	21535		

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interventions for behaviors may not be included on the group sheets. The DON stated the NAs should ask the team leader if they have questions. The DON further stated nurse managers and nurse supervisors update the group sheets.

The facility policy and procedure for Behavioral Assessment, Intervention and Monitoring revised 12/16, directed the interdisciplinary team (IDT) to assess and evaluate the resident's behavioral symptoms, and incorporate findings on the care plan. The care plan would include a description of the behavioral symptoms, targeted and individualized interventions, rationale for interventions and approaches, specific goals for targeted behaviors and how staff would monitor effectiveness of interventions. When medications are prescribed for behavioral symptoms, the documentation should include specific target behaviors and expected outcomes. The IDT would monitor resident's progress until stable.

R151's Face Sheet printed 6/29/17, indicated diagnoses that included Alzheimer's disease, dementia with behavioral disturbance, and restlessness and agitation.

R151's annual Minimum Data Set (MDS) dated 4/10/17, indicated R151's had impaired short and long term memory, and severely impaired cognitive skills for daily living.

R151's physician visit dated 5/25/17, indicated R151 received Trazadone (antidepressant) and Zyprexa (antipsychotic).

R151's care plan dated 4/13/17, directed nursing to monitor for side effects of medications (dizziness, drowsiness, difficulty urinating, sleep

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disturbances, headache, and anxiety). R151's care plan also included non-pharmacological interventions for behaviors of poor safety awareness and recall with impulsiveness. These interventions included position for comfort, allow to sit by nurses station, gentle range of motion, and give coconut water with pineapple.

R151's nursing assistant group sheets lacked identification of target behaviors and interventions to manage behaviors.

R151's Psychiatric Physician Progress notes dated 2/27/17, indicated facility staff have reported to him that R151 had been disimpacting herself and eating her own feces. The note also indicated R151 had verbal outbursts that were difficult to control at times.

On 6/29/17, at 11:21 a.m. nursing assistant (NA)-E stated R151 is generally resistive to cares, and will yell out most of the time with any cares. NA-E stated R151 is usually better at meals. NA-E stated he had not observed that behavior of eating her feces,"In quite some time."

On 6/29/17, at 11:28 a.m. licensed practical nurse (LPN)-C stated she had seen stool on R151's hands and sometimes on her mouth. LPN-C stated she has not seen it for a couple of months now. LPN-C stated staff check on R151 more frequently as a result of that target behavior.

On 6/29/17, at 2:35 p.m. NA-C stated R151 has had really good and really bad days. NA-C stated R151 is confused. NA stated she moves slow when caring for R151, and will sing with R151 during cares. NA-C stated she would report to the nurse or trained medication assistant (TMA) regarding problems or target behaviors with

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21535	Continued From page 15 R151. NA-C stated she would use redirection with R151, to allow NA-C to perform cares. NA-C stated she was not sure if she has access to R151's care plan, as it was on the computer. NA-C stated she documents R151's behaviors in the computer kiosk. NA-C stated group sheets/pocket care plans carried by NAs do not have target behaviors or interventions listed. NA-C stated R151 loves ice cream, and likes music. On 6/29/17, at 3:01 p.m. the director of nursing (DON) was interviewed and stated R151's target behaviors are reaching out for things, hollering out repeatedly, digging in her feces, and her behaviors increase with the need for a bowel movement. On 6/29/17, at 6:38 p.m. the DON stated NAs do not have access to the complete care plan. The DON confirmed problem areas on the care plan are not identified on group sheets/pocket care plans carried by the NAs. The DON confirmed target behaviors and interventions are not on group sheets/pocket care plans On 6/29/17, at 6:45 p.m. the DON stated target behaviors would be passed down to the NAs in report. The DON confirmed NAs do not have access to the care plan. The DON stated NAs are supposed to report concerns or target behaviors to the team leader for that particular shift. The DON stated nurse managers or weekend supervisors update the group sheets. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure a comprehensive care plan	21535		

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21535	Continued From page 16 that identified target behaviors, appropriate individualized interventions and is available for direct care staff and enables monitoring of effectiveness of psychotropic medications and interventions. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to resolve grievances expressed in resident council regarding slow call light response times. This had the potential to affect 10 of 17 residents (R2, R116, R67, R149, R216, R54, R95, R22, R33, and R113) reviewed for resident council concerns. Findings include: Resident Council Meeting Minutes were reviewed from January 2016, through June 2016. - 1/9/17; Residents stated call lights are taking a	21870	Corrected.	8/11/17

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long time to be answered. The meeting minutes did not contain any follow up to the concern.
- 2/13/17; The director of nursing (DON) said that all nursing staff should be wearing walkie talkies. They are working on getting a new call light system.
- 3/13/17; Residents stated call lights are slow to be answered. The meeting minutes did not contain any follow up to the concern.
- 4/10/17; Residents stated call lights are slow to be answered. The DON stated she will do a call light check.
- 5/8/17; Residents stated call lights are slow to be answered. The meeting minutes did not contain any follow up to the concern.
- 6/2/17; Residents stated call lights are slow to be answered. The meeting minutes did not contain any follow up to the concern.

On 6/29/17, at 10:35 p.m. R2, who regularly attends resident council meetings, was interviewed and stated long call lights have been brought up every month. R2 further stated the staff never get back to the residents on what they were doing to reduce the call light response times.

On 6/29/17, at 10:52 a.m. R116, who also regularly attends resident council meetings, stated the facility stated they are working on the call lights be answered more timely, but nothing ever changes. R116 stated she was frequently left in the bathroom, staff say they will be back, and they don't come back. R116 stated it takes a long time for someone to answer the call light.

On 6/29/17, at 11:04 a.m. the activity director (AD)-A stated department heads attend every resident council meeting, and address concerns that are related to their department. AD-A stated

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she does not include staff response to concerns in the meeting minutes. AD-A further stated every month there are concerns about long response times to call lights, and stated the DON follows up individually with residents.

On 6/29/17, at 12:24 p.m. the DON stated she individually meets with residents that complain of call light response times and then checks the call light logs. The DON stated the facility had adjusted staffing groups and times staff were in the dining rooms. The DON further stated resident concerns were an area the facility could improve on, as there is no documentation to track what the facility did in response to concerns.

The facility policy Concern, Grievances dated 2016, directed when a resident, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards it to the Social Services department/designee in a confidential manner. The staff person responsible investigates, resolves the issue, and responds back to the customer within five business days and documents action. Resident satisfaction with the resolution and handling of the concerns is obtained.

R67's Face Sheet printed 6/29/17, indicated R67's diagnoses included hemiplegia and hemiparesis (weakness or paralysis of one side of the body) following cerebral infarction (stroke), chronic obstructive pulmonary disease (COPD-breathing problems), pain, difficulty walking, acute and chronic respiratory failure, and dysphagia (swallowing problems).

R67's care plan edited 4/17/17, and 4/28/16, indicated R67 was able to communicate his

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needs, was cognitively intact, and required assistance of two staff for toileting every two hours. R67's care plan edited 6/26/17, indicated R67 had the potential for falls, and was non-ambulatory. Interventions included keeping the call light in reach, and assistance with bed mobility. R67's care plan further indicated R67 had the potential for pain, was to be repositioned for comfort and monitored for increased pain, was to be monitored for signs and symptoms of respiratory distress, and was at risk for skin breakdown.

On 6/26/16, at 1:35 p.m. R67 stated he had to wait a long time for call light to be answered.

R67's Device Activity Report dated 6/1/17, to 6/29/17, indicated R67's call light response time was over 20 minutes on 12 occasions, including the following:
-30 to 40 minutes, 2 times
-40 to 60 minutes, 1 time
-60-80 minutes, 2 times
-greater than 100 minutes (139 minutes), 1 time

R149's Face Sheet printed 6/29/17, indicated R149's diagnoses included compression fractures of the spine, dysphagia, weakness, repeated falls, and heart disease.

R149's care plan dated 4/25/17, indicated R149 was cognitively intact, was able to communicate needs appropriately, and required assistance with all mobility related to compression fracture, pain, and weakness. Interventions included call light to be kept in reach, and extensive assist of one staff for transfers. R149's care plan further indicated R149 was at risk for pressure ulcers, was frequently incontinent of bowel and bladder and required staff assistance for toilet use every two

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21870	Continued From page 20 hours. The care plan further indicated R149 was to be monitored for increased pain, repositioned for comfort, and was at risk for falls requiring the call light to be kept in reach. On 6/27/17, at 1:08 p.m. R149 stated she has had to wait over an hour for her call light to be answered at times. R149's Device Activity Report dated 6/1/17, to 6/29/17, indicated R149's call light response time was over 20 minutes, 88 times, including the following: -30 to 40 minutes, 17 times -40 to 60 minutes, 14 times -60 to 80 minutes, 4 times -80 to 100 minutes, 3 times -greater than 100 minutes (104 minutes, and 111 minutes) 2 times R216's Face Sheet printed 6/29/17, indicated R216's diagnoses included pain, epilepsy (seizures), dysphagia, cerebral infarction, muscle weakness, heart disease, and abnormality of gait and mobility. R216's care plan 4/27/17, indicated R216 was cognitively intact, was at risk for pressure ulcers, and had pain which was to be monitored. The care plan further indicated R216 was independent with bed mobility, required limited assistance of staff for ambulation and transfers, and was to reposition every two hours. R216's care plan also indicated R216 was at risk for falls, and the call light was to be kept in reach. R216 had occasional incontinence of bladder and frequent incontinence of bowel, and was to be asked every two hours and taken to the bathroom per her request.	21870		

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21870	Continued From page 21 On 6/27/17, at 2:14 p.m. R216 stated she sometimes waited a half hour or one hour to have call lights answered. R216 stated she had been incontinent when she has had to wait. R216 stated being incontinent didn't feel good, and was uncomfortable. R216's Device Activity Report is combined with R54's Device Activity Report below (they are roommates). R54's Face Sheet printed 6/29/17, indicated R54's diagnoses included heart arrhythmia, weakness, hemiplegia and hemiparesis following stroke, anxiety disorder, difficulty in walking, and pain. R54's care plan dated 4/13/17, indicated R54 was cognitively intact, occasionally incontinent of bladder and was to be asked every two hours for toileting needs or per her request. The care plan also indicated R54 required staff assistance for toilet or bedpan use, was at risk for pressure ulcers, and was to be turned and repositioned every two hours with staff assistance. The care plan further indicated R54 had pain that was to be monitored for increased symptoms, was at risk for falls, and the call light was to be kept within reach. On 6/27/17, at 1:39 p.m. R54 stated she recently had to wait one and one-half hours for her call light to be answered, and has had to wait a long time intermittently. R54 stated the time of day when she has to wait has varied. R54 stated she has been incontinent, and has needed to have her bed changed at times when she has had to wait. R54 stated she was self-conscious about it. R54's and R216's Device Activity Report dated	21870		

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21870	Continued From page 22 6/1/17, to 6/29/17, indicated the room call light response times were over 20 minutes, 104 times, including the following: -30 to 40 minutes, 30 times -40 to 60 minutes, 18 times -60 to 80 minutes, 5 times -greater than 100 minutes (103 minutes) 1 time R95's Face Sheet printed 6/29/17, indicated R95's diagnoses included a heart arrhythmia, congestive heart failure, difficulty in walking, pain, and asthma. R95's care plan dated 6/26/17, indicated R95 was cognitively intact, was able to communicate her needs, and was independent with toilet use and mobility. The care plan further indicated R95 was at risk for falls and pain, and the call light was to be kept in reach. On 6/26/17, at 2:36 p.m. R95 stated she had kidney and bladder problems with urinary urgency, had problems with incontinence, and staff do not answer the call lights timely, especially in the evening and night shifts. R95 stated it takes up to 40 minutes to get the call light answered. R95 stated it seemed staff only answered call lights of residents who are on their list to care for, and walk by the room of those residents they aren't caring for. R95's Device Activity Report dated 6/1/17 to 6/29/17, indicated the call light response times were over 20 minutes, 44 times, including the following: -30 to 40 minutes, 10 times -40 to 60 minutes, 3 times -greater than 100 minutes (109 minutes), 1 time R22's Face Sheet printed 6/29/17, indicated	21870		

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21870	Continued From page 23 R22's diagnoses included COPD, asthma, heart arrhythmia, dysphagia, and backache. R22's care plan edited 12/20/16, indicated R22 was cognitively intact and was able to communicate her needs. The care plan also indicated R22 was at risk for falls, pain, and respiratory distress. The care plan also indicated R22 was at risk for skin breakdown, and staff were to ensure she was repositioned every two hours, was independent with toilet use, was independent with transfers and bed mobility, and her call light was to be kept in reach. On 6/27/17, at 4:14 p.m. R22 stated she has had to wait up to an hour or two for staff to answer call lights. R22 stated she sometimes misses the toilet when she has to wait so long. R22 stated she has to go in the hall and yell at the nurse and that makes her look bad. R22 stated it is degrading. R22 stated morning was the worst time for call lights to go unanswered. R22 stated there was another resident who hollers for a long time, and the staff ignores her light also. R22's Device Activity Report dated 6/1/17 to 6/29/17, indicated the call light response times were over 20 minutes, 27 times, including the following: -30 to 40 minutes, 4 times -40 to 60 minutes, 4 times -60 to 80 minutes, 5 times R33's Face Sheet dated 5/23/16, indicated R33's diagnoses included acute respiratory distress, anxiety disorder, dysphagia, low back pain, and respiratory failure. R33's care plan edited 4/28/17, indicated R33 was cognitively intact, and was able to	21870		

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communicate her needs. R33's care plan indicated R33 was at risk for pressure ulcers, required extensive assist of two for repositioning, and was to be repositioned every two hours. The care plan also indicated R33 was at risk for respiratory distress and falls, had a history of severe pain, and directed staff to keep call light in reach. R33's care plan further indicated R33 was to be asked every two hours and per her request for toileting needs.

On 6/26/17, at 1:16 p.m. R33 stated it can take one to two hours for staff to come in response to call lights.

R33's Device Activity Report dated 6/1/17, to 6/29/17, indicated the call light response times were over 20 minutes, 76 times, including the following:
-30 to 40 minutes, 14 times
-40 to 60 minutes, 16 times
-60 to 80 minutes, 3 times
-greater than 100 minutes (107 minutes and 118 minutes), 2 times

R113's Face Sheet printed 6/29/17, indicated R113's diagnoses included difficulty in walking, muscle weakness, dysphagia, acute and chronic respiratory failure, heart arrhythmia, epistaxis (nose bleeds), history of falls, and chronic pain.

R113's care plan edited 6/18/17, indicated R113 was cognitively intact, able to use his call light and could communicate his needs. R113's care plan indicated he required assistance with bed mobility and transfers, was at risk for skin breakdown, and required repositioning every two hours. The care plan also indicated R113 was at risk for pain and respiratory distress, and was at risk for falls. R113's care plan further indicated

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 25 R113 was occasionally incontinent of bowel and bladder, required staff assist to the toilet, was to be asked every two hours if he had toileting needs, and the call light was to be kept in reach. On 6/27/17, at 1:18 p.m. R113 stated it takes up to one and one half hours for staff to respond to call lights. R113 stated he hollers for help and then staff come. R113 stated he has had bloody noses and has had to wait for an hour for help, then he gets upset and all worked up. R113's Device Activity Report dated 6/1/17 to 6/29/17, indicated the call light response times were over 20 minutes, 23 times, including the following: -30 to 40 minutes, 7 times -40 to 60 minutes, 3 times -60 to 80 minutes, 1 time -80 to 100 minutes, 1 time -greater than 100 minutes (127 minutes) 1 time On 6/29/17, at 4:52 p.m. the administrator was interviewed and stated the facility is working on a new call light system that will allow the staff to communicate with the resident prior to entering the resident room. The administrator also stated walkie talkies will be smaller for the staff to carry, and there will be routine announcements over the walkie talkies with an escalating announcement that will go up the line to the nurse, nurse manager, and then director of nursing (DON). The administrator stated when the residents voice a concern the facility will act on it. The administrator and DON both verified they had extended call light response times, and both stated at that time that the new call light system should help with call light response times. SUGGESTED METHOD OF CORRECTION:	21870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00861	A. BUILDING: _____ B. WING _____	06/29/2017

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21870	Continued From page 26 The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure response and resolution to resident grievances. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		