



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 29, 2025

Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

RE: CCN: 245266
Cycle Start Date: January 16, 2025

Dear Administrator:

On January 16, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by April 16, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:
<https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 1/14/25 to 1/16/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS On 1/14/25 to 1/16/25, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed with no deficiency issued. H52664580C (MN00107812) H52664581C (MN00106026) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2025

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	Continued From page 1			F 000			
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced			F 553			2/26/25

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F 553	Continued From page 2 by: Based on interview and document review, the facility failed to ensure the resident and/or resident representative participated in care conferences for the planning process and development of interventions for 1 of 1 residents (R36) reviewed for participation of care planning. Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated October 2023, the RAI is used to, "assist staff with evaluating goal achievement and revising care plans accordingly by enabling the nurse home to track changes in the resident's status". The RAI, "establishes a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise". The Assessment Reference Date (ARD) refers to the specific endpoint for the observation period in the MDS assessment process and is federally mandated to be completed on admission, quarterly (every 92 days), annually, with a significant change in status (SCSA), and on discharge. R36's quarterly Minimum Data Set (MDS) dated 10/16/24 identified R36 with severe cognitive impairment, was dependent on staff for personal hygiene, toileting, showers/bathes, dressing upper and lower body and turning in bed. In addition, R36 with diagnoses of Alzheimer's, dementia, hemiplegia affecting right dominant side, and malnutrition.	F 553	R36s Care conference was completed on 02/5/25. Facility conducted audit of all residents in the facility to ensure care conferences have been completed or offered with their most recent MDS cycle or have been scheduled for completion by 2/28/25. IDT education completed regarding care conferences to be held based on MDS/ARD, including significant changes. Audit 2 residents per week for 12wks/3 months. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: MDS Coordinator		

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F 553	Continued From page 3 R36's electronic medical record (EMR) indicated the MDS assessments were documented and submitted on the following dates: - 1/3/24 - quarterly - 3/27/24- quarterly - 6/26/24- quarterly - 7/21/24 - SCSA (significant change) - 10/16/24- quarterly Care Conferences were documented on 1/17/24, 4/9/24, and 7/17/24 following discharge from hospice services. The EMR lacked evidence of a care conference being done after 7/21/24. During interview with the registered nurse/infection control preventionist (ICPC) on 1/14/25 at 12:10 p.m., ICPC stated, "we do it [care conferences] when the ARD is due or as needed. [Social Worker] takes care of the care conferences". During interview with facility's director of social services (SS)-A on 1/15/25 at 2:23 p.m., SS-A stated she was responsible for scheduling and conducting the care conferences for all residents of the facility. SS-A stated R36 "is due for one" and, "should be done every three months". In addition, SS-A stated "[R36] is one to two months late. It should be done with every MDS cycle, but it was not done." SS-A unable to state why R36's October 2024 care conference was not done. During interview with family member (FM)-A on 1/16/25 at 7:25 a.m., FM-A stated she was R36's primary emergency contact. FM-A stated she was invited to R36's care conferences and was last invited, "Last Summer [2024]" and not since then.	F 553			

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F 553	Continued From page 4 During interview with director of nursing (DON) on 1/16/25 at 10:40 a.m., DON stated expectation of care conferences to coincide with the MDS assessments. Facility policy titled Comprehensive Assessments and Care Planning dated 11/2017 state, "Residents and resident representative will be involved in the comprehensive person-centered care planning". Facility policy titled Resident/Family Participation in Care Planning dated 11/28/2017 state, "Care conference documentation includes that[sic] staff, resident and others that participate." And, "Responsible for Implementation: Social Services, Nursing".			F 553			
F 583 SS=E	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other			F 583			2/26/25

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F 583	Continued From page 5 than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident identifiable personal health information (PHI) was kept secured and out of public view. This had potential to affect all 73 residents of the second, third and fourth floors whose personal information was listed on exposed care sheets. Findings include: Document titled "3rd Floor Nursing Care Work Sheet" downloaded 1/14/25, indicated, "Carry this care worksheet with you during your shift; do not leave out for others to see (HIPAA/PHI)" [Health Insurance Portability and Accountability Act - federal standards to protect PHI - Personal Health Information]. During observation on 1/15/25 at 8:37 a.m., on the third-floor transitional care unit (TCU), an alcove in the middle of the hallway across from room 315 contained two large plastic rolling containers with lids, a linen cart that was covered, and a tall office type chair. On top of the covered	F 583	Identified care sheets were removed immediately on 1/15/25. Verbal education was completed with identified nursing staff on 1/15/25 as the incident occurred. All common spaces were audited to ensure there was no further PHI visible or observed on 1/15/25. All nursing staff are educated that all Protected health information including care sheets must be kept in your pocket, turned over on your cart or behind nurse's station and not in common areas. Audit all units 3x per week for 12 wks. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: ED/DON or Designee/HIM/SD		

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F 583	Continued From page 6 linen cart was an unattended, "3rd Floor Nursing Care Work Sheet" containing twenty five resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status, and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking status, bedrail positioning, and tracheostomy and gastric tube presence. Two staff members walked past the unattended care sheet. During interview on 1/15/25 at 8:39 a.m., nursing assistant (NA)-A pointed to the third-floor unattended care sheet and stated, "Care sheets should not be left unattended." During interview on 1/15/25 at 8:42 a.m., NA-B verified the third-floor unattended care sheet was his responsibility and stated, "I forgot about it and left it there [pointing to the alcove]. There is private information on this sheet and should not be visible to anyone." During observation and interview on 1/15/25 at 9:39 a.m., on the fourth-floor of the facility, an unattended, "4th floor Nursing Care Work Sheet" containing twenty five resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking			F 583			

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F 583	Continued From page 7 status, bedrail positioning, and tracheostomy and gastric tube presence was left face up on an unattended medication cart located in the common area directly across from the nursing station. During interview with assistant director of nursing (ADON) at 9:43 a.m., the ADON verified the unattended fourth-floor care sheet contained, "patient identifying information". The ADON stated, "This could be visible to people who shouldn't see it". During interview with RN-B on 1/15/25 at 10:27 a.m., RN-B stated, "unattended care sheets [sic] should not happen. [contains] Private information that others should not see." During observation on 1/16/25 at 8:48 a.m., on second-floor across from room 208, the alcove contained an unattended care sheet titled, "2nd Floor NAR WORKSHEET". The worksheet contained twenty three resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking status, bedrail positioning, and tracheostomy and gastric tube presence. During interview with trained medication aide (TMA)-A on 1/16/25 at 8:49 a.m., TMA-A pointed to the second-floor unattended care sheet and stated, "[that] has patient information and [it is a] violation of HIPAA." During interview on 1/16/25 at 8:50 a.m., NA-D	F 583			

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F 583	Continued From page 8 pointed to second-floor unattended care sheet and stated, "should not be left open. Violation of HIPAA. [contains] patient information. [staff] should have this in their pocket and not out in the open."	F 583			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657			2/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2025	
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F 657	Continued From page 9 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise and update a comprehensive care plan for 1 of 1 resident (R23) who had a foley catheter, psychology provider anxiety interventions, and refusals of care not identified in the care plan. Findings include: R23's annual Minimal Data Set (MDS), dated 12/4/24, indicated R23 was admitted to the care facility on 12/18/19, had moderate cognitive impairment and was dependent on staff for toileting and bathing and required "touching" assistance with personal hygiene. R23's Hospital Discharge Summary, dated 12/31/24, indicated R23 was hospitalized on 12/27/24 and discharged back to the care facility on 12/31/24. A foley catheter was placed at the hospital on 12/28/24. R23's Orders indicated a nursing order, dated 1/11/25, for staff to monitor urine output every shift. R23's Active Orders, printed 1/16/25, lacked any other order related to R23's foley catheter. R23's Associated Clinic of Psychology (ACP) note, dated 12/13/24, indicated several interventions for R23's generalized anxiety disorder and major depressive disorder including "milieu (a person's social environment) management/positive focus/socializing" by tidy up R23's space and engaging in a "blinds open" program everyday to "increase natural daylight			F 657	R23's care plan was updated to add foley catheter on 1/16/25. R23's care plan was updated to add ACP interventions on 1/30/25. R23's care worksheet was updated with foley and ACP interventions on 1/30/25. R23's orders were updated with catheter care orders on 1/16/25 DX obtained on 1/30/25. All residents with catheters have had care plans and care sheets reviewed for accuracy regarding catheter care. All residents with catheters have had orders reviewed for catheter care and indication. All residents followed by ACP have had their last visit notes reviewed and ensured recommendations are care planned (and put on care sheet) as applicable. SS/Nurse Managers review ACP visit notes weekly ongoing for interventions that need to be care planned. Nurse Managers and IDT to review Hospital DC summary upon hospital return. Education to nurse managers/IDT on updating care plans with any new ACP recommendations and medical changes as applicable. Education to nurse managers on updating new medical needs on care plans/care sheets. All staff education: All catheters must have catheter care orders, if someone		

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

PRINTED: 02/12/2025
FORM APPROVED
OMB NO. 0938-0391

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F 657	Continued From page 10 exposure." R23's ACP note, dated 1/3/25, indicated several new and similar interventions for R23's generalized anxiety disorder and major depressive disorder including ensuring important items such as the TV remote and eyeglasses were left within reach for R23's "sense of agency and control", continue to encourage staff to assist with cleaning up and organizing R23's room, use a "non-judgmental, patient centered approach" to encourage R23 to get up, out of bed with phrases such as "I've heard you say you get so tired of being this bed. I'd be happy to get you up after lunch to get you get a soda and change it up for a while", and continue to engage in an "open blinds" program every day where curtains are "opened in the morning and closed at night." R23's care plan, printed 1/16/24, indicated R23 was fully incontinent of bladder and for staff to "check and change resident every 2-3 hours and prn [as needed]. Continue to offer commode, though I decline toileting." R23's care plan further indicated R23 had a foley catheter removed 3/29/21, and to "encourage patient to void when urge is noted." The care plan lacked any updates on R23's current catheter use to ensure proper monitoring and catheter cares, and lacked any updates from R23's ACP notes to help R23 with a sense of control and to help reduce his anxiety and depression. R23's Care Work Sheet, printed 1/14/25, lacked any interventions for R23's foley catheter use and further lacked any ACP interventions for staff to use when approaching and providing cares for R23.	F 657	returns from hospital with new catheter, nursing needs to get orders. If resident has a device that is not on the care plan/care sheet alert nurse manager/DON. When residents return from hospital, any new medical equipment must have orders and be passed along to next shift. ACP provides recommended interventions at times and will be listed on the care plan. Audit 2 residents monthly x3 months to ensure accurate catheter care planning and orders. Audit 2 residents weekly x 4 weeks then 4 residents per month x 2 months that are seen by ACP to ensure recommendations are reflected in the care plan and care sheet. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: SS/SD/MDS Coordinator/DON or Designee		

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

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OMB NO. 0938-0391

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F 657	Continued From page 11 During observation on 1/14/25 at 8:58 a.m., R23 was laying in bed with the blinds closed, a foley catheter bag hooked onto the side of his bed. During an interview on 1/15/25 at 10:20 a.m., R23's nurse practitioner (NP) stated R23 had his foley catheter placed during his most recent hospitalization. The NP further stated urology, who placed the catheter, would usually remove it and she believed it would be temporary, stating she will have to make a plan for R23's catheter. During an interview on 1/15/25 at 10:35 a.m., registered nurse (RN)-C stated, as a nurse she would be expected to review the residents' care plans and orders prior to providing care to the residents to gain an understanding of what care, treatment, and medications to administer during her shift. RN-C confirmed the electronic medical record (EMR) lacked indication of and direction for R23's catheter. During an interview on 1/15/25 at 10:49 a.m., nursing assistant (NA)-B stated he worked with R23 about once a week, and this day was the first time he had noticed R23 had a catheter. NA-B stated the aides were expected to use the care work sheets to know what cares to provide a resident. During an interview on 1/16/25 at 9:33 a.m., clinical manager and RN-I stated it would be expected for the nurses and nursing assistants to use the residents care plans and care work sheets everyday while working with the residents. RN-I stated the nursing aides should report to the nurses if something was missing or different on the resident care sheets for updates. RN-I stated it was her and the MDS nurse's	F 657			

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

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F 657	Continued From page 12 responsibility to update the care plans. The MDS nurse would generally review the resident's hospital discharge paperwork to review for any necessary care plan changes, confirming R23's foley catheter use should be care planned. RN-I stated ACP notes should be reviewed with social services and herself and discussed at IDT to ensure any new recommendations or updates are on the residents' care plans. RN-I stated keeping care plans up to date with the residents' current status is important to ensure nurses and nursing assistants are providing accurate care to the residents. During an interview on 1/16/24 at 10:55 a.m., the MDS nurse stated she reviewed the resident's hospital discharge summaries and generally updated them during an MDS cycle, though the nurse managers also reviewed them to try to catch changes in "real time." The assistant director of nursing also confirmed that care plans should be updated in "real time" and that it was a "work in progress" to ensure care plans were updated and accurate.	F 657			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene and self-care was completed to promote a dignified appearance and reduce the risk of complication (i.e., scratches) for 3 of 4	F 677	R53's nails were cleaned and trimmed on 1/15/25 R53's ADL care plan was updated on 2/4/25. R36's nails were cleaned and trimmed on		2/26/25

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F 677	Continued From page 13 residents (R23, R36, and R53) reviewed for activities of daily living (ADLs) and whom were dependent on staff for their care. Findings include: R53 R53's quarterly Minimum Data Set (MDS), dated 11/26/24, identified R53 had severe cognitive impairment, demonstrated no speech, and was unable or rarely able to be understood. Further, the MDS identified R53 was dependent on staff for nearly all self-care. R53's care plan, dated 11/22/24, identified R53 needed assistance with dressing and personal hygiene due to a history of stroke and hemiplegia (paralysis of one side). The care plan listed a goal which read, "All my ADL needs will be anticipated and met by staff through the review date," and multiple interventions including assist of one with personal hygiene and, "Staff to trim Resident's finger and toe nails as needed following weekly bath." The care plan lacked any identified nail length preferences. On 1/14/25 at 9:15 a.m., R53 was observed lying in bed while in his room. R53's eyes were closed and adjacent ventilator equipment was present at the bedside. R53 did not open his eyes or respond verbally with interaction. However, a few moments later, R53 picked up his left hand without being asked or commanded, and he shook it several times in the air with his eyes seeming to squint down or grimace with the motion. R53's hands were visible and had no braces or splints present. R53's fingers on both hands were clenched into his palms, however,	F 677	02/03/25. R36's weekly skin check last completed on 02/03/25. R36's ADL care plan was updated on 02/03/25. R23 no longer resides at the facility. All residents have been observed for nail care (length and cleanliness) and shaving needs according to preference. All Staff Education: Nail care and skin check to be completed with bath day and all refusals to be documented (nurse and CNA). Audit 4 residents per week for 12wks for nail cleanliness and length, facial hair trimmed per preference, and weekly skin check completed on bath day. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: DON or Designee		

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

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F 677	Continued From page 14 multiple fingernails were visible and long in length with the nail being several millimeters (mm) long and, at times, pressing into the palm skin. Further, multiple nails had visible dark-colored substance underneath of them. Later on 1/14/25 at 11:38 a.m., R53's family member (FM)-B was interviewed. FM-B stated R53 getting bathed and personal hygiene care was "another gray area" of care and expressed R53, in general, wasn't being cleaned up well adding, "Not as often as we'd like them to be [doing it]." FM-B stated R53 was often found unshaven and, at times, with long fingernails adding concern, "He will just scratch himself." FM-B reiterated they wanted basic cares completed for R53 but often "It's just not happening." The following day, on 1/15/25 at 8:45 a.m., R53 was again observed lying in bed with his eyes closed. R53 remained non-verbal with interaction and was connected to an external tube feeding pump. R53's fingernails remained long with several nails having dark-colored debris present under them as had been observed the day prior. R53's progress note, dated 12/23/24, identified R53 had a brace applied to his right hand. The note continued, "Finger nails clipped. No discomfort ..." R53's subsequent Weekly Skin Check(s), dated 12/26/24 to 1/9/25, identified a total of three bed baths were completed on 12/26/24, 1/2/25, and, 1/9/25, respectively. These completed checks all listed a question to be answered by the staff which read, "Was nail care completed?[,]" which was answered, "Not Necessary," on each of the	F 677			

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

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F 677	Continued From page 15 completed evaluations. On 1/15/25 at 8:55 a.m., nursing assistant (NA)-E was interviewed. NA-E explained R53 was "total care with everything" and spent most of his time in bed due to being non-verbal and having a ventilator. NA-E stated nail care would be completed by the NA since R53 was not diabetic, and it should be completed "as often as we need to." NA-E stated R53's nails and hands were, at times, hard to clean or trim as he would pull his hands away but reiterated staff "have to make an effort." NA-E observed R53's nails at this time and expressed aloud, "They could probably use a clipping," adding further, "[They're] start digging into his skin." NA-E stated two people usually help to trim the nails due to R53's behavior but expressed it could be done. Further, NA-E stated any attempts or refusal of nail care wouldn't likely be documented by the NA as they "just tell the nurse." R53's medical record was reviewed and lacked evidence nail care had been attempted or refused since 12/24/24, despite R53 having long, soiled nails present and needing total assistance with personal hygiene. When interviewed on 1/15/25 at 9:29 a.m., registered nurse (RN)-D stated R53 was "total" help with cares but would, at times, "fight you a lot" with some of them. RN-D stated two people usually were needed to get R53's nails clip and, at times, R53's family member would help them. RN-D stated they last helped R53 with nail care "couple weeks ago" but verified they should be clipped on bath day. RN-D stated nail care was charted using the Weekly Skin Check and any attempt or refusal should be charted in the	F 677			

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

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F 677	Continued From page 16 record. On 1/15/25 at 12:49 p.m., registered nurse manager (RN)-E was interviewed. RN-E stated nail care should be address "every time they have a shower [bath]." RN-E explained R53 could be "a little difficult" to get it completed on as, at times, the left arm "goes everywhere" but acknowledged the charting reflected such care was 'not necessary' adding they were unsure why it had been marked as such. RN-E stated R53's nails should have been clipped and kept clean adding they just updated his orders to include nail care and a nurse sign-off. RN-E stated they did this order update for everyone adding, "If he's missed, who else is missed?" RN-E stated it was important to ensure nail care was completed as his nails could penetrate the skin or he could scratch himself. RN-E verified the medical record lacked evidence nail care was attempted or provided since 12/24/24 adding aloud, "no, no, no [none]." R36 R36's quarterly MDS, dated 10/16/24, identified R36 with significant cognitive impairment, did not reject care, dependent on staff for toileting, baths, upper and lower body dressing, personal hygiene, transfers, and bed mobility. In addition, R36 with diagnoses of Alzheimer's, dementia, hemiplegia (paralysis on one side of the body), stroke, and malnutrition. Review of document titled 3rd Floor Nursing Care Work Sheet scanned 1/14/25, identified all residents of third floor with column identifying 25	F 677			

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

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F 677	Continued From page 17 resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status, and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking status, bedrail positioning, and tracheostomy and gastric tube presence. This document identified: "Facial hair and nail care (men and women) occur on bath days, Report off to your nurse; make sure you've brought any change in condition or concerns to the nurses attention, and Refusals of care/treatment or inability to complete identified cares for your residents must be reported to nurse." 3rd Floor Nursing Care Work Sheet scanned 1/14/25, identified R36 with a column titled, "Bathing" and identified, "Aide trim nails". R36 care plan (CP) revised 9/16/24 identified, "Resident is dependent on staff for grooming cares, which consists of bath/shower, shampoo, nail care shave and full skin assessment. Resident with diagnoses of CVA [cerebral vascular accident], dementia." During observation on 1/14/25 at 2:14 p.m., R36 was in bed with head of bed elevated and meal tray in front of her on rolling bedside table. R36 had both feet resting on pillow with heels positioned off mattress. The left foot middle toenail was half an inch long while rest of toenails on both feet were thick, jagged, and extending	F 677			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 18 beyond the toe rubbing against the sheet and covers. All fingernails were half an inch to three quarters of an inch long, with dark matter noted, and their left hand was clenched in a fist with nails pressing into palm of hand. During interview with nursing assistant (NA)-A on 1/15/25 at 10:13 a.m., NA-A stated she was familiar with R36 and worked with her "many times". NA-A stated, "nail care is done the activities [department], they put fingernail polish and stuff like that. No, I do not do nail care on [R36]." NA-A stated, "no nail for [R36] after showers by the [nursing] aides". NA-A stated, "if nails are long on other residents, I would tell [nurse]". NA-A looked at R36's fingernails and toenails and stated, "[R36's] fingernails are half inch to one inch long." NA-A verified dark matter under right thumbnail and, "yes, toenails are long ...half inch long". NA-A stated, "[R36] don't want them trimmed. I haven't noticed or told anyone about them because she always refuses. I let nurses deal with that." During interview with NA-C and NA-D on 1/15/25 at 10:50 a.m., NA-C stated, nail care was done by nursing assistants, "unless [resident] is diabetic". NA-D stated nail care involved "clipping and file [nails]". During interview with infection control preventionist and nurse manager (ICPC) on 1/15/25 at 10:55 a.m., ICPC stated they expected nail trimming and maintaining nails to be done on shower day and prn mainly nurses and aides. ICPC stated she was aware of R36's refusals, but facility had nothing to address the R36's refusals for nail care. ICPC stated, "[R36] has the right to refuse".	F 677			

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

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F 677	Continued From page 19 During interview with activities director (AD) on 1/15/25 at 12:04 p.m., AD stated she had worked at facility for three years and the activities department painted the nails, but did not file, clip, or trim them. R36's Weekly Skin checks documented by nurses for week of 1/9/25, 12/23/24, and 11/18/24, all indicated, "Refused nail care". The record lacked documentation for the weeks of 1/13/25, 12/30/24, 12/16/24, 12/9/24, 12/2/24, and 11/25/24. During observation and interview with RN-C on 1/16/25 at 7:59 a.m., RN-C stated she was "very familiar" with R36 and stated, "nail care[sic] cut them by nurses when needed on shower days". RN-C stated "if very long we try to talk to the nurse after refusals and go to nurse manager and let the MD [provider] know. We are to document on weekly skin check in chart." RN-C stated, "[R36] don't allow us to cut her nails. She needs a team of people to work together to go in and approach her and try to convince her to let us trim them. We should involve the family in the conversations. It takes a team to get her to allow us to cut her nails." RN-C stated she had not received report from aides regarding R36's nails and did not know of any communication or plan by facility to ensure nail care was being done for R36. RN-C looked at R36's fingernails and stated, "they definitely need [sic] to be cut. Both feet [nails] are too long." During interview with family member (FM)-A on 1/16/25 at 7:30 a.m., FM-A stated she was R36's primary emergency contact. FM-A stated R36 required help with all hygiene, "[R36] does	F 677			

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

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F 677	Continued From page 20 nothing for herself". Also, "[R36] scratches herself and cuts herself [with long nails]. But they [facility] got to keep them cut. Those nails on both [fingernails and toenails]." RM-A stated, "it is ok if they [facility] knock her out if they have to to cut them off. I want them off." FM-A stated facility never contacted her to discuss nail care approaches. R23 R23's annual Minimal Data Set (MDS), dated 12/4/24, indicated R23 had moderate cognitive impairment and was dependent on staff for toileting and bathing and required "touching" assistance with personal hygiene. R23's Care Plan, revised 9/17/24, indicated R23 was "dependent on staff for grooming cares, which consists of bath /shower, shampoo, nail care, shave, and full skin assessment. Resident with diagnosis of left side hemiplegia [inability to move] and CVA" with an intervention to bathe R23 on Monday evenings. R23's care plan also included R23 was limited in ability to maintain grooming/personal hygiene R/T [related to] hemiplegia and hemiparesis following cerebral infarction to left side, generalized muscle weakness" with an intervention to shave R23 on bath day with his electric shaver. R23's Nursing Care Work Sheet, dated 1/14/25, indicated, under the bathing category, the nursing assistants were to shave R23's facial hair. During interview and observation on 1/14/25 at 8:58 a.m., R23 was laying in bed, hair disheveled			F 677			

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F 677	Continued From page 21 with approximately half inch long facial hair. R23 stated he preferred to be clean shaven but staff did not have time to assist him. On a shelf in R23's room was an electric shaver plug into an outlet. During interview and observation on 1/15/25 at 8:42 a.m., R23 was up in his wheelchair and had not been shaved. When asked again if he would like to be shaved, R23 shook his head "yes." During an interview on 1/15/25 at 10:35 a.m., registered nurse (RN)-C stated she usually saw R23 clean shaven and that he had been readmitted to the facility on Friday, 1/10/25 after hospitalization with facial hair. RN-C was unsure why R23 had not been shaved with his bath day on Monday. During an interview on 1/15/25 at 10:49 a.m., nursing assistant (NA)-B stated the nursing assistants used the care work sheets to know how to care for each resident, including when their bath day is. NA-B further stated it was expected that all residents were offered to be shaved on bath days. During an interview on 1/16/25 at 9:33 a.m., nurse manager RN-I stated it was expected that the nursing assistants use the care work sheets every shift to know what cares to provide the resident. RN-I stated when a resident was readmitted after hospitalization it was expected they receive at least a bed bath, and residents should always be offered to be shaved during bathing. The Activities of Daily Living policy dated 2021, indicated care and services will be provided for			F 677			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 677	Continued From page 22	F 677			
F 679 SS=D	residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care). Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care-planned interventions for activities of interest were provided or offered for 1 of 2 residents (R53) reviewed for activities and whom was non-verbal and unable to be understood. Findings include: R53's quarterly Minimum Data Set (MDS), dated 11/26/24, identified R53 had severe cognitive impairment, demonstrated no speech, and was unable or rarely able to be understood. Further, the MDS identified R53 was dependent on staff for nearly all self-care. R53's most recent Activity Assessment, dated	F 679			2/26/25
			R53's care sheet was updated for nursing to have radio or TV on, on 1/31/25. Audit all resident's care plans to ensure enrichment needs are available to nursing staff. Education to wellness department on communication with nursing when enrichment needs are identified and updated. All Staff Education: Provide stimulating activities (TV/radio) for nonverbal residents or residents not attending activities if they prefer.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 679	Continued From page 23 11/25/24, identified R53 was a Christian and listed a section labeled, "Specific Leisure Interests," which marked R53 as having a preference for card games, active sports, classical and jazz music, television and movie interests, and social visits adding, "Res. will have 1:1 [one to one] visits." A section labeled, "Programming Information," outlined R53 preferred 1:1 visits and was unable to participate with passive participation marked. Further, the evaluation concluded, "Updated Care Plan on - 11/25/2024." R53's activities care plan, dated 11/25/24, identified a problem statement which read, "Per family, res. enjoyment is listening to music, TV/movie shows and social visits with staff/family." The care plan outlined a goal which read, "Per family, res. will listen to background classic, jazz, oldies, 50's & Frank Sinatra music, TV/movie shows old time, science fiction and comedy and social visits with staff/family," along with multiple interventions including not listening to the news, staff setting up music on the radio or I-Pad, and tuning the TV to old time, science fiction or comedy shows. On 1/14/25 at 9:15 a.m., R53 was observed lying in bed while in his room. R53's eyes were closed and adjacent ventilator equipment was present at the bedside. R53 did not open his eyes or respond verbally with interaction. However, a few moments later, R53 picked up his left hand without being asked or commanded, and he shook it several times in the air with his eyes seeming to squint down or grimace with the motion. The room had a television mounted on the wall with a white-colored paper underneath which listed R53's favorite activities and television	F 679	Audit 4 residents per week x12 weeks for enrichment activities implemented per care plan. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: Wellness/ED/DON or Designee		

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F 679	Continued From page 24 channels. The room also contained a CD player on the shelf. However, neither of these were activated or turned on and the room was silent. Later, on 1/14/25 at 11:29 a.m., R53's family member (FM)-B was interviewed and stated they were unsure if R53 would be able to enjoy activities or not adding he (R53) was "kind of limited." FM-B stated R53 spent a majority, if not all, of his day in his room and expressed "a few months ago" someone had asked them about R53's activities but could not recall the specifics of the conversation. The following day, on 1/15/25 at 8:45 a.m., R53 was again observed in bed while in his room. R53's eyes remain closed and, again, he demonstrated no obvious response to verbal communication. R53 had a visible tracheotomy and was attached to an external tube feeding pump. However, again, the room was silent with no TV or radio or music being played in the room. When interviewed on 1/15/25 at 8:55 a.m., nursing assistant (NA)-E stated they had worked with R53 multiple times and described him as needing "total care with everything." NA-E stated R53 did, at times, get up to a wheelchair but it was not every day. NA-E stated they had rarely, if ever, seen activities personnel in the room with him or doing one-to-one activities adding, "Not to my knowledge, I haven't seen any." NA-E stated staff, at most, seemed to "maybe peek in" but that was it. NA-E stated nobody had ever told them to play music or have the television on for R53 adding aloud, "Nope." NA-E stated the nursing staff and activities staff "don't interact very well" unless the NAs are told to get "certain people" up to some activities adding, "They [activities] don't really communicate with us very	F 679			

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F 679	Continued From page 25 much." NA-E stated they had, at times, seen R53 with his television set turned on and expressed there was a listing of channels taped to the wall to their recall which R53 enjoyed. NA-E showed this listing to the surveyor and verified it was posted in the room along with an activity calendar for the building. However, NA-E verified R53 did not attend any of the listed or advertised activities adding aloud, "No." NA-E stated it was due to R53 using a ventilator and being unable to take it with him. Further, NA-E stated R53's wife visited and would, at times, turn on the TV or radio for R53 but added, "I haven't seen her lately." On 1/15/25 at 9:29 a.m., registered nurse (RN)-D was interviewed and verified they were assigned to R53's care that day. RN-D explained R53 was "total" help with cares and expressed "the wife" would, at times, come and play music for him using the CD player in his room. RN-D stated themselves and staff didn't turn it on as "the wife comes everyday," then adding aloud, "But I don't know about Winter [if she visits]." When questioned on what, if any, activities were provided or done with R53, RN-D stated aloud, "You'd have to ask activities." When interviewed on 1/15/25 at 10:15 a.m., therapeutic recreation director (TRD) explained R53 was supposed to have the television turned on for him adding such was care-planned and "should be on." TRD explained the floor staff should be doing that or playing music for him and those items were "basically it" for his activities outside of some one-to-ones. TRD verified R53 did not attend group-based activities but explained there were some scheduled for his floor which could be attended, such as music, but getting him to those would "be basically up to the	F 679			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 679	Continued From page 26 nurse." TRD stated they had told staff R53 could attend the music groups on the floor if they brought him adding, "I have told them." TRD stated the activities staff did complete one-to-ones with R53 and tracked those on the flowsheet which they would provide. However, TRD reiterated all staff should be turning on the television for R53 adding there was no specific schedule or times for that but rather "should have it on throughout the day." TRD stated it was important to ensure the television was on so R53 had "some type of stimulation." Later on 1/15/25, at 10:42 a.m., TRD provided R53's one-to-one tracking form. R53's One on One Visits Form, dated 9/2024 to 1/2025, identified all recorded one-to-one visits completed with R53 during the period. This recorded a total of five (5) visits since 12/1/24, and included: "12/1/24 Staff updated residents calendar." "12/16/24 Staff played Frank Sinatra in Ipad and had social visit." "12/19/24 Staff had social visit with resident and made sure resident was comfortable ... made sure TV was tuned." "1/1/25 Staff updated resident calendar to January." "1/10/25 Staff played Frank Sinatra on Ipad and organized residents room." TRD verified the provided one-to-one tracking and reiterated all staff members, including nurse,			F 679			

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F 679	Continued From page 27 should be playing music or turning on R53's radio.			F 679			
F 693 SS=D	A provided Wellness & Life Enrichment policy, dated 3/2024, identified a facility' policy to involve residents in an ongoing program of activities designed to appeal to their interests and enhance their psychosocial well-being. Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure gastrostomy tube water flushes were provided per physician			F 693			2/26/25
					RN-A received education on tube feeding water flushes, following flushing policy and following MD orders on 1/14/25.		

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F 693	Continued From page 28 orders for 1 of 1 residents (R75) reviewed for tube feedings. Findings include: R75's quarterly Minimum Data Set (MDS) dated, 12/3/24 identified R75 was severely cognitively impaired, dependent on staff for all oral, toileting, personal hygiene, and mobility. In addition, R75 had diagnoses of a stroke (poor blood flow to a part of the brain causing cell death resulting in parts of the brain to function properly), diabetes, chronic obstructive pulmonary disease, respiratory failure, convulsions, gastrostomy (feeding tube inserted into the stomach), and a tracheostomy (surgical opening in the neck to allow a machine called a ventilator to help with breathing). R75's physician orders (PO) dated 11/2/24 stated, "Tube Feeding: H2O (water) 150 milliliters[ml] per feeding tube q4hrs" (every four hours). R75's care plan goal, dated 9/12/24 stated, "Approach: Water flushes via GT [gastrostomy tube] per MD [physician]". During observation and interview on 1/14/25 at 8:58 a.m., registered nurse (RN)-A entered R75's room to administer medications through GT. R75 was lying in bed with the feeding tube not attached to her. RN-A set up area on rolling bedside table with liquid and crushed medications in three small medication cups, and two larger plastic drinking cups. RN-A obtained an unopened bottle of water from resident room stating it was for mixing R75's medications prior to administering them through the GT. RN-A opened the 500ml water bottle, sanitized her	F 693	All residents with g-tubes were reviewed for proper flushing orders. Education with all nurses on how to flush gastrostomy tubes prior to and following medication administration and following MD orders for flushing Audit 3 nurses per week x12 weeks for gastrostomy tube medication administration and flushing. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Discipline: DON or Designee/SD		

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F 693	Continued From page 29 hands and applied gloves. She then used a large piston syringe, attached it to R75's GT port and pulled back on the syringe to assess for residual (amount of liquid drained from the stomach following administration of tube feeding). RN-A removed the piston syringe from R75's GT port and used the bottled water to dilute and mix the liquid and crushed medications. RN-A withdrew the medication into the syringe and re-attached the syringe to R75's GT port and administered the medications. RN-A repeated the process until all the medication cups were emptied leaving visible residue in each of the cups. RN-A poured water into each of the medication cups and administered the mixtures into R75's GT port. When this was completed, RN-A capped R75's GT port and moved on to changing R75's tracheostomy in-line suctioning apparatus. RN-A did not measure out water to flush R75's GT port completely to ensure the entire GT was clear of residual medications. During interview at 9:18 a.m., RN-A stated, "I flushed with water in each of the med cups". RN-A agreed she did not measure out 150ml of water after administering R75's medications. During interview with RN/infection control preventionist (ICPC) on 1/16/25 at 10:18 a.m., ICPC stated expectation of nursing staff to "flush [GT] with water after administering all of the medications". ICPC stated it was "likely" the medications administered to R75 by RN-A were not flushed "adequately" which could cause complications with GT flow. During interview with director of nursing (DON) on 1/16/25 at 11:06 a.m., DON stated, "the water should be used to flush the tube after administration and not mixed in with the bottom of			F 693			

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F 693	Continued From page 30 all the med cups. There could easily be residual thick medications in those cups, and it not considered clean water. That practice is likely to plug the GT."	F 693			
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed, develop interventions or implement appropriate pain monitoring to ensure comfort for 1 of 2 residents (R53) reviewed for pain management and whom was non-verbal and unable to communicate their needs. In addition, the facility failed to assess for and implement, if requested, non-pharmacological pain interventions for 1 of 2 residents (R70) reviewed for pain management. Findings include: R53 R53's quarterly Minimum Data Set (MDS), dated 11/26/24, identified R53 had severe cognitive impairment, demonstrated no speech, and was	F 697			2/26/25
			R53's pain observation was redone on 2/5/25. R53's PRN pain med orders were reviewed to include symptoms, pain scale before, after, effectiveness, and nonpharmacological tasks. R70's pain observation was completed on 2/5/25. R70's Care plan was reviewed and revised to indicate her preferred pain scale and nonpharmacological interventions. All residents have orders added for non-pharmacological pain interventions and effectiveness. Add tasks for all PRN pain medication		

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

PRINTED: 02/12/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2025	
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F 697	Continued From page 31 unable or rarely able to be understood. The MDS identified R53 was dependent on staff for nearly all self-care and outlined R53 consumed no scheduled medication or non-pharmacological interventions for pain management. However, the completed staff evaluation for pain on the MDS, located under Section J - Pain, identified staff had recorded, "C. Facial expressions (grimaces, winces, ...)," during the review period. On 1/14/25 at 9:15 a.m., R53 was observed lying in bed while in his room. R53's eyes were closed and adjacent ventilator equipment was present at the bedside. R53 did not open his eyes or respond verbally with interaction. However, a few moments later, R53 picked up his left hand without being asked or commanded, and shook it several times in the air with his eyes seeming to squint down or grimace with the motion. Later, on 1/14/25 at 11:43 a.m., R53's family member (FM)-B was interviewed and stated R53 not being in pain was "very important to me" and a concern for them. FM-B stated R53 was hard to read given his lack of verbal communication and post-stroke deficits adding, "It's not easy to read his face." FM-B stated they were unsure if R53 was absolutely free of pain but expressed, in the past, some physicians had communicated they didn't believe R53 to have pain, however, FM-B reiterated aloud, "I don't want him to be suffering." R53's most recent Pain Interview, dated 11/26/24, identified R53 consumed no scheduled pain medication or non-pharmacological interventions for pain; however, had received a PRN (as-needed) medication within the past five days. The evaluation identified the pain interview with R53 should not be completed as he was rarely or never understood. As a result, a Staff			F 697	orders to include pain scale (prior to), pain scale (after), effectiveness, symptoms present or pain location (site). All residents reviewed for non-pharmacological interventions and the care plan updated. All nursing staff are educated on nonverbal pain indicators. Nursing to complete a staff assessment for pain for all nonverbal residents. All PRN pain orders must include pain scale before and after, effectiveness, nonpharmacological interventions and for nonverbal residents, symptoms present. Audit 4 residents per week x12 weeks for pain management, non-pharmacological interventions and updated care plans. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Discipline: SD/DON or Designee		

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

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F 697	Continued From page 32 Assessment For Pain was completed which, again, identified R53 demonstrated facial expressions of potential pain within the past five day period. The frequency was marked, "Indicators of pain or possible pain observed 1 to 2 days," and the evaluation identified a non-pharmacological intervention listed as, "Rest," and scheduled Tylenol recorded for symptom management. The completed evaluation lacked any detail on how R53's pain would be monitored to ensure comfort despite R53 being recorded as unable to be understood, nor evidence what, if any, assessment had been completed to determine if the identified symptom management techniques (i.e., rest, Tylenol) were adequate or not despite R53 having physical symptoms of possible pain. R53's pain management care plan, dated 9/5/24, identified R53 was at risk for pain due to a history of stroke with hemiparesis (paralysis on one side of the body) and " ... no ability to communicate to staff. Observation of non-verbal signs of pain is needed." The care plan listed a goal, "[R53] will appear comfortable and rest well, without signs of pain or discomfort through the review date," along with multiple interventions including medications as ordered, assessing pain prior and post medication administration, completing pain assessments quarterly and as-needed, and rating his pain via a facial expression scale. All the listed interventions were created in 3/2023 and lacked documented revision or edit. When interviewed on 1/15/25 at 8:55 a.m., nursing assistant (NA)-E stated they had worked with R53 multiple times over the past months and described him as "total care with everything." NA-E stated they had noticed, at times, R53	F 697			

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

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F 697	Continued From page 33 would raise his hand up in a ball while staff did cares and place it by his face adding, "He put his hand up there." NA-E stated they had noticed R53 also, at times, seemed to squinch his eyes with facial washing, however, felt it was just random movement and not pain. NA-E stated R53 seemed "not really" in pain. R53's Medication Administration History, dated 1/2025, identified R53's medications and nursing treatments for the month period. This identified R53 was receiving baclofen (muscle relaxant) three times daily for spasms, and had an order for Tylenol 650 milligrams (mg) every six hours as needed for mild pain or temperature. The MAR identified Tylenol as being administered once on 1/11/25 at 5:52 p.m. for pain with results listed, "SE [somewhat effective]." However, the MAR lacked what specific symptoms were observed which indicated pain and warranted medication, nor did the MAR have any ongoing pain monitoring to demonstrate what, if any, symptoms were being tracked or observed to ensure R53 remained comfortable despite floor staff seeing him make movements with cares which could be pain related (i.e., hand to face, squinted eyes) and now having Tylenol provided with only somewhat effective results. On 1/15/25 at 9:29 a.m., registered nurse (RN)-D was interviewed. RN-D verified they were assigned care for R53 and expressed he was "total" help with care. RN-D stated they felt R53 had no pain but voiced grimacing would be considered a sign of pain for him as he was non-verbal. RN-D reiterated, "I've never seen [R53] in pain." RN-D stated they had observed R53 raise his clenched fists up before but felt he didn't appear uncomfortable with it adding, "I've	F 697			

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

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F 697	Continued From page 34 never associated that [movement] with pain." RN-D stated pain assessments would be done by the floor nurse "in the moment" when they determine whether or not to give pain medication, adding, a progress note would be completed. RN-D reviewed R53's MAR and verified PRN Tylenol was given on 1/11/25 and stated such administration "must be new" as they had never given him any before to their recall. RN-D reviewed R53's medical record and the corresponding progress note, dated 1/11/25, which merely recorded R53 as being "uncomfortable" and lacking what specific symptoms were displayed. RN-D then directed the surveyor to the unit manager for further discussion on pain monitoring and evaluation. R53's medical record was reviewed and lacked evidence R53 had been recently comprehensively assessed for his pain management needs despite having ongoing physical symptoms of pain (i.e., squinted eyes) and staff providing as-needed medication for pain. Further, the record lacked evidence of ongoing, comprehensive monitoring of pain (i.e., every shift, consistent manner) to ensure R53 was kept comfortable and ensure appropriate care-planning was completed for pain. On 1/15/25 at 12:49 p.m., registered nurse manager (RN)-E was interviewed. RN-E reviewed R53's medical record and verified it lacked ongoing pain monitoring adding aloud, "We should be monitoring it too." RN-E verified the completed Pain Interview (dated 11/26/24) identified physical symptoms were identified, however, lacked what, if any, interventions were done or placed despite them. RN-E stated they had not reviewed the evaluation prior as those	F 697			

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

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F 697	Continued From page 35 were mainly done for the MDS. RN-E stated nobody had reported potential pain symptoms to them and, had they, then monitoring would have been placed in the order set. RN-E stated they recalled reading R53's note, dated 1/11/25, about being uncomfortable but "didn't put two and two together" with it being a pain issue. RN-E verified R53's demonstrated physical symptoms had not been comprehensively evaluated for what, if any, pain management was needed for them and expressed doing such would be important as "we [staff] need to get to the bottom of what his pain is and help it." A provided Pain Management policy, dated 9/2023, identified the staff would evaluate residents for verbal and non-verbal symptoms of pain including the resident and responsible party in the development of pain management interventions. The policy directed, "Reevaluate pain and document ... [bullet] At regular intervals according to the needs of the resident ... [bullet] With each new report of pain ... [bullet] At appropriate intervals after pharmacological on [sic] non-pharmacological interventions." However, the policy lacked specific information on how a non-verbal resident would have their pain assessed or monitored. R70 R70's admission Minimum Data Set (MDS) assessment dated 12/1/24, indicated R70 had intact cognition with no hallucinations or delusions. Assessment indicated in section J-Health Conditions section J0100 pain	F 697			

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

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F 697	Continued From page 36 medication section A: been on a schedule pain medication regimen marked "yes", section B: received PRN (as needed) pain medication marked "yes", section C: received non-medication interventions for pain marked "no". Further the form indicated R70 frequently has pain which occasionally effects sleep and rated pain with a verbal descriptor scale of moderate pain. R70's face sheet, printed 1/16/25, included the following diagnoses: hip stress fracture (crack or break of the hip), fracture of the left lower leg, fracture of the right femur (crack or break of the right upper leg bone), upper abdominal pain, rheumatoid arthritis with rheumatoid factor of multiple sights (a chronic inflammatory disorder usually causing painful swelling of joint linings), muscle weakness and fibromyalgia (a long term condition that involves widespread body pain and tiredness). R70's care plan, printed 1/16/25, indicated R70 experienced pain related to broken hip/ankle as evidenced by reports of pain with the following approaches: -Administer my pain medications as ordered -Assess for psychological pain & document interventions used to address. -Assess the characteristics of my pain: location, severity based off pain scale appropriate to me, type, frequency. -Consult with physician for pain management, notify physician of any changes in level or frequency of pain, any increase in use of PRN pain medications, and any noted side effects of pain medications. -Discuss with me the factors that precipitate pain and what may reduce it. -Discuss with me the importance of requesting	F 697			

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

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F 697	Continued From page 37 PRN pain medications before pain becomes severe. -Educate me and my family about pain care and pain medications. -Offer alternative comfort measures: Acupressure, Acupuncture, Biofeedback, Brace, Cold, Comfort food, Decreased stimulation, Distraction, Guided imagery, Heat, Massage, Music, Prayer, Psychotherapy, Relaxation, Repositioning, Rest, Sleep, Television, TENS Unit, Whirlpool bath. -Reassess intervention with any changes in response to pain or pain medications and routinely per facility protocol. The care plan lacked evidence of what non-pharmacological interventions have been tried, what had been effective and not effective and what non-pharmacological interventions should be used. Furthermore, the care plan lacked identification of what pain scale would be appropriate/resident's preference to use. R70's January 2025 Medication Administration Record (MAR/TAR), printed 1/16/25, included the following orders and administrations: -acetaminophen [Tylenol] (pain reliever) tablet 500 milligrams (mg) tablet administer 1000 mg oral [by mouth] every 6 hours PRN [as needed] for pain. MAX DOSE 4000 MG daily. Started 12/13/24. The MAR indicated it was administered 21 times in the month of January. Of those administrations, 2/21 had a numeric pain scale and 5/21 had a location of pain listed. The remaining administrations, 19/21 administrations, did not have a pain scale listed and 16/21 administrations did not have a location of pain listed. -oxycodone (narcotic pain medication) 5 mg			F 697			

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

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FORM APPROVED
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F 697	Continued From page 38 tablet administer daily as needed. Discontinued 1/2/25. The MAR indicated it had been administered 2 times in the month of January. Of those administered, 0/2 had a numeric pain scale and 0/2 had a location of pain listed. -oxycodone 5 mg tablet administer twice a day as needed. Started 1/3/25. The MAR indicated it was administered two times a day for the month of January starting on 1/3/25. Of those administrations, 4/26 had a numeric pain scale and 4/26 had a location of pain. The remaining administrations, 18/26 administrations, did not have a pain scale and 18/26 administrations did not have a location of pain listed. The MAR/TAR lacked orders or administrations of any non-pharmacological interventions offered, declined, or accepted prior to administration of pain medications. R70's progress notes, dated 1/1/25 to 1/15/25, were reviewed. The progress notes lacked evidence of pain scales being used prior to or after administration of pain medications. Furthermore, lacking evidence of any nonpharmacological interventions being offered, accepted, or declined. R70's Pain Interview completed 12/12/24 revealed the following: Pain Interview: questions are answered with radio-button answers: Pain: received scheduled pain med regimen at any time in the last 5 days: yes Received PRN pain medications OR was offered and declined in the last 5 days: yes Received non-medication intervention for pain: No Should Pain Assessment interview be conducted:	F 697			

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

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F 697	Continued From page 39 yes Presence of pain: yes Pain frequency: frequently Pain effect on sleep: frequently Pain interference with therapy activities: does not apply. Pain interference with day-to-day activities: Not assessed/no information Verbal scale rating: severe On 1/16/25 at 11:00 a.m., R70 indicated the pain can get "pretty intense." R70 indicated the facility had her try distraction once for pain reduction. R70 indicated they were open to trying other nonpharmacological interventions and added the facility had not talked to them about this before. R70 indicated their pain level was typically at a 6/7 and their goal was a 3/10. On 1/16/25 at 11:11 a.m., registered nurse (RN)-F stated when a resident reported pain then a pain assessment was completed which included: "location, what is the pain, frequency, quality of the pain and have them rate the pain." RN-F indicated this would be documented in the progress notes or on the MAR. RN-F stated nonpharmacologic interventions are offered to residents such as repositioning, distraction and music and stated this would be documented on the MAR. RN-F verified R70 did not have any nonpharmacological interventions on their MAR/TAR. On 1/16/25 at 11:39 a.m., RN-G stated that pain assessments for a resident reporting pain was documented in the progress notes which would include the pain level (either numeric scale or face scale), how long they have had the pain (chronic or new), location of pain and to check the	F 697			

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

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F 697	Continued From page 40 site. RN-G stated a pain level was not always assessed for scheduled pain medications. RN-G indicated the pain level for new pain was assessed prior to giving PRN pain medications which would be documented on the MAR or possibly in the progress note. RN-G stated any non-pharmacological interventions would be documented in the progress notes. RN-G reviewed recent administrations of PRN acetaminophen and oxycodone and stated the pain scale was not completed as "it is not new pain." On 1/16/25 at 11:56 a.m., assistant director of nursing (ADON) indicated the location of documentation of nonpharmacological interventions prior to PRN medication use, along with pain scales with pain medication adminsitration, would depend on what floor the resident was on and the manager on the floor. During a follow up interview at 1:25 p.m., ADON verified a pain scale was not used (except for what was listed above) for the administration of acetaminophen and oxycodone. ADON verified the location of R70's pain was not documented (except for listed above) during the administration of PRN pain medication. ADON did indicate she had a follow up conversation with R70 about nonpharmacological interventions and preferred pain scale. On 1/16/25 at 12:50 p.m., director of nursing (DON) indicated the expectation would be nursing to do an assessment prior to administering PRN pain medication which would include assessing a pain level and location along with offering nonpharmacological interventions. A facility policy titled Pain Management reviewed			F 697			

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F 697	Continued From page 41	F 697			
F 700 SS=D	9/7/23 indicated the facility will "evaluate the resident for verbal and nonverbal signs and symptoms of pain" and reevaluate pain and document: at regular intervals according to the needs of the resident; with each new report of pain; at appropriate intervals after pharmacological and non-pharmacological interventions." Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to attempt alternatives and ensure ongoing assessments for safety and	F 700			2/26/25
			R18 was reassessed for appropriate use of bedrails and observation completed on 02/03/25.		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404			
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F 700	Continued From page 42 appropriate use of side rails were completed for 1 of 1 resident (R18) who was observed to have side rails affixed to the bed. Findings include: R18's annual Minimum Data Set (MDS) dated 9/12/22, indicated R18 had moderately impaired cognition. R18's significant change MDS dated 6/17/24, indicated R18 had moderately impaired cognition. R18's quarterly MDS dated 12/02/24, indicated R18 had severely impaired cognition. R18's Restraint/Adaptive Equipment Use Observation was completed on 3/12/20 and 9/08/22. Both reports included assessments of R18 for side rail entrapment risk factors such as falls and medication use. The assessments indicated R18 had half side rails for bed mobility and assistance with transfers. R18's medical record was reviewed and lacked indication R18 was assessed for safety and appropriate use of side rails and alternatives were attempted since the assessment on 9/22. R18's Physical Therapy Discharge Summary dated 12/14/22, indicated R18 needed stand by assistance from staff for bed mobility. R18's Physical Therapy Discharge Summary dated 9/11/24, indicated R18 required maximum assistance with all bed mobility tasks on the baseline assessment completed on 8/21/24. At the time of discharge from physical therapy, on 9/11/24, R18 required assistance with bed mobility related to knee and hip pain.			F 700	It was determined resident is safe to continue to use. All residents with current bedrails reviewed for appropriate use of side rails, alternatives offered, observations reviewed and revised, consents obtained, and measurements complete. Staff education on side rail process/policy completed by DON and ADON. All side rails removed upon discharge and not implemented until alternatives tried, observation, consent, and measurements completed. Audit 1 resident with side rails per unit x12 weeks. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: DON or Designee		

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

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OMB NO. 0938-0391

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F 700	Continued From page 43 R18's care plan dated 12/16/24, indicated staff were to ensure R18's upper side rails were in the upright position and were to provide cues to use rails for bed mobility. During an observation on 1/14/25 at 12:45 p.m., R18 was observed sitting in a chair next to her bed. R18's bed was observed with half side rails in the fully upright position on both sides of the bed. During an interview on 1/15/25 at 12:20 p.m., LPN-A stated she thought all residents should have been assessed before bed rails were installed and have an order for bed rails. LPN-A stated she was unaware what further assessments or reassessments were required for bed rail use and referred further questions to the Director of Nursing (DON). On 1/16/25 at 10:47 a.m., LPN-A stated she had worked with R18 since her admission in 2018 and was her primary day shift nurse. LPN-A stated R18 had side rails on her bed that she could use while turning. LPN-A stated staff had to help R18 turn in bed as she had been declining over the last year and had been required more assistance. LPN-A stated R18 used to be able to use her walker with only stand by assistance but had not been able to recently. During an interview on 1/15/25 at 1:05 p.m., the Director of Nursing (DON) stated bed rails should be assessed when they are installed but admitted that the facility did not have a process to ensure ongoing bed rail monitoring or reassessment of resident's risk related to side rail use. On 1/16/25 at 12:02 p.m., the DON stated she expected a resident to be assessed for the risk of entrapment			F 700			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 700	Continued From page 44 and the safe use of bed rails anytime the resident had a change of condition but especially if it required a significant change such as the one R18 had in 6/24. The DON stated she would otherwise expect these resident specific entrapment risk assessments to be completed annually. The DON stated it was important that residents were reassessed for the continued need for bed rails as well as the potentially elevated risk of entrapment with resident changes of condition to minimize entrapment and potential resident injury. The DON confirmed the facility had reviewed the medical record and was unable to find an updated assessment of R18's potential risk and use of bed rails.	F 700			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758			2/26/25

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

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F 758	Continued From page 45 resident, the facility must ensure that--- §483.45(e)(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 clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete comprehensive and ongoing behavioral	F 758			
			R62's target behaviors have been added to care plan on 1/14/25.		

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F 758	Continued From page 46 monitoring (i.e., symptom or target behavior) for an administered antipsychotic medication to ensure efficacy of the medication for 1 of 5 residents (R62) reviewed for unnecessary medication use. Findings include: R62's quarterly Minimum Data Set, dated 10/8/24, identified R62 had severe cognitive impairment but demonstrated no delusional thinking, hallucinations, or other behaviors (i.e., physical, verbal, other) during the review period. Further, the MDS identified R62's consumed medications for the period which included both antipsychotic and antidepressant medication. On 1/14/25 at 9:05 a.m., R62 was observed while seated in a reclined high-back wheelchair in the commons area. R62 had multiple, red-colored scrapes on the left side of her face but was unable to verbally respond to questions when asked. R62 did not appear in distress at this time. Immediately following, at 9:09 a.m., registered nurse (RN)-D was interviewed. RN-D expressed R62's facial scrapes were due to a fall over the past few days. RN-D stated staff had "heard a boom" and found her on the floor adding, "I'm assuming she tried to get up [from her wheelchair]." R62's Medication Administration Record (MAR), dated 1/2025, identified R62's current physician-ordered medications along with their corresponding administration or refusals. The MAR outlined an order for clonazepam (anti-anxiety medication) three times a day along with an order for Seroquel (antipsychotic medication) 50 milligrams (mg) once daily. The	F 758	All residents on psychotropic medications have been reviewed to ensure target behaviors and side effects are care planned. All nursing staff education: All residents receiving psychotropic medication must be monitored qshift for target behaviors or symptoms to ensure efficacy of the medication. Education with nurse leadership on care planning target behaviors. Audit 4 residents on psychotropic meds for target behaviors on care plan per week x 12wks. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: DON or Designee/SD		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 47 Seroquel had listed start date which read, "12/30/2024 - Open Ended," and listed a diagnosis for the medication as, "Psychosis, MDD [major depression]." The MAR recorded the medication as being administered, as ordered, every day for the month period thus far. R62's corresponding Nursing Orders Flowsheet Administration History (i.e., TAR), dated 1/2025, identified an order which outlined, "Resident on: Seroquel for Major depressive disorder [sic] with psychosis. Target behaviors [blank space]," with a frequency recorded , "Three times a day." This order listed a start date which read, "10/10/2023 - Open Ended," and was recorded by staff, as ordered, three times a day with a negative response (i.e., no, N/A). However, the documentation lacked evidence what symptoms or specific target behaviors were being tracked or monitored to ensure the medications' efficacy. R62's care plan, dated 12/2024, included R62 was identified as being at risk of adverse consequences due to antipsychotic medication use. A goal was listed which read, "Resident will not exhibit signs of drug related side effects or adverse drug reaction," along with multiple interventions including, "Monitor resident's behavior and response to medication," and, "Resident on: Seroquel for Major depressive disorder [sic] with psychosis. Target behaviors [blank space]." The care plan lacked what specific symptoms or target behaviors (i.e., agitation, hallucinations, etc.) had been identified as R62's behavior warranting the medication, nor how such behaviors would be monitored. When interviewed on 1/16/25 at 8:15 a.m., nursing assistant (NA)-D stated they had worked	F 758			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 758	Continued From page 48 with R62 multiple times and described R62 as needing total care adding, "We do everything for her." NA-D explained R62 was mostly non-verbal but could, when seated in her wheelchair, still propel herself around the unit and, at times, even try to board the elevator by herself. NA-D stated they had noticed when R62's significant other leaves, then R62 does seem, at times, to become upset adding, "It triggers a lot of mental [issues]." NA-D stated they had never seen or heard of R62 having other behavioral issues such as hitting out, verbal behaviors, or hallucinations adding, "I haven't noticed none." NA-D stated it wasn't possible to determine what, if any, depression symptoms R62 had, either, as R62 was non-verbal adding, "We can't tell." However, NA-D stated they had noticed R62 to have periods of crying before and reiterated it seemed more frequent when the significant other leaves or doesn't visit as planned. Further, NA-D stated the NA(s) didn't complete routine charting on behaviors but rather, if noticed, would do an "incident report form" and then it was routed to the nurse. R62's progress notes, dated 9/2024 to 1/2025, were reviewed. These notes identified only two recorded episodes of potential behavior including: On 12/9/24, R62 was recorded as crying and being distressed while attempting to pull out her feeding tube. The note concluded, "The patient's condition will continue to be monitored closely." On 12/24/24, R62 was recorded as falling from her bed twice with both falls being unwitnessed. The note recorded, "Res noted to be quite agitative [sic] for the most part of the shift." However, the note lacked what specific symptoms or observations were happening to detail 'agitative'.	F 758			

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F 758	Continued From page 49 When interviewed on 1/16/25 at 10:04 a.m., registered nurse (RN)-D stated they were currently assigned care for R62 and had worked with R62 before. RN-D described her as "aggressive but not hitting people," explaining R62 seemed "aggressive" when attempting to roll her wheelchair at times, but reiterated she had never physical hit anyone or had other behaviors to their recall. RN-D stated they were unsure if R62 had any delusional thinking or hallucinations as "she's not talking, she might but we don't know." RN-D stated they were unsure what, if any, target behaviors were identified or tracked for R62 adding, "I'm not sure." RN-D stated R62 had been "falling a lot" lately and attributed this to periods when R62 gets agitated. RN-D stated usually behaviors or symptoms were listed in the MAR or TAR and answered like a question but added they were unsure where in the medical record any recorded target behaviors or symptoms for the Seroquel use would be. RN-D stated, "I'm not sure specifically for her." R62's most recent Extended Care Nursing Home Visit note, dated 12/10/24 and authored by the medical provider, identified R62 was seen at nursing' request for increased agitation during the day with some falls. The note outlined, "[R62] is on Seroquel at night which has worked for her agitation when she was pulling on her trach she has been very upset and agitated after her significant other calls her or says that he is coming in [and] does not show up, most of these episodes as of cursed [sic] in the evening ..." However, R62's medical record was reviewed, including the recorded progress notes, and lacked evidence of ongoing, consistent monitoring of any identified target symptoms or	F 758			

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F 758	Continued From page 50 behaviors despite being on a scheduled antipsychotic medication and staff reporting potential behaviors (i.e., upset, crying when significant other leaves) as being observed. On 1/16/25 at 11:12 a.m., registered nurse unit manager (RN)-E was interviewed. RN-E verified they had reviewed R62's medical record and it lacked any specific target behaviors or symptoms for the Seroquel use adding, "It wasn't in there." RN-E stated they had just updated the TAR to include the symptoms of wandering, anxiousness and refusing cares. RN-E verified behaviors, if happening, should be documented in the progress notes and tracked so they placed the new order for monitoring to be done every shift adding R62 was, at times, different on the nights versus the waking hours. RN-E stated it was important to ensure behaviors were tracked and monitored adding, "We gotta make sure the medication is working," and, "Make sure it's effective." A provided Psychotropic Medication Use policy, dated 9/2023, identified when a resident exhibited signs of distress which interfered with daily living, the nurse or interdisciplinary team (IDT) would identify target behaviors and non-pharmacological interventions for them. The policy outlined, "Psychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record." The policy directed, "The IDT team monitors the resident condition and target behaviors for efficacy of the medications and any clinically significant adverse consequences," adding further, "Documentation will reflect implementation of the above."	F 758			

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F 880 F 880 SS=D	Continued From page 51 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880 F 880			2/26/25

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F 880	Continued From page 52 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement appropriate infection control practices with proper glove use to prevent the spread of infection for 1 of 1 residents (R75) who was on enhanced barrier precautions (EBP) observed for tracheostomy care. Findings include:			F 880	RN-A was educated on hand hygiene and gloving on 02/03/25. All nursing staff have been educated on hand hygiene. All staff education: Hand hygiene and gloving 2 Hand hygiene audits per unit per week x		

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F 880	Continued From page 53 The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, indicated MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. Enhanced Barrier Precautions (EBP) is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during "high contact resident care activities" that provide opportunities for transfer of MDROs to staff hands and clothing that lead to indirect transfer of MDROs from resident to resident. The article indicated EBP should be implemented (when contact precautions did not apply) for residents who are high risk for acquiring infections with wounds or indwelling medical devices (central lines, urinary catheter, feeding tube, and ventilator dependent) regardless of MDRO colonization status. The CDC article titled Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 indicated purpose of hand hygiene is to reduce, "The potential spread of deadly germs to patients" and reduce "the risk of healthcare personnel colonization or infection caused by germs received from the patient". Per article, glove use in long term care facilities are to be changed, "If moving from work on a soiled body site to a clean body site on the same patient". R75's quarterly Minimum Data Set (MDS) dated, 12/3/24 identified R75 was in a persistent vegetative state, and dependent on staff for oral care, toileting, personal hygiene, and mobility. In addition, R75 had diagnoses of a stroke (poor blood flow to a part of the brain causing cell death			F 880	12 weeks. Audit results will be reviewed by QAPI to determine the need for ongoing auditing. Responsible Disciplines: Infection Preventionist/SD/DON or Designee		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/16/2025	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS				STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404			
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F 880	Continued From page 54 resulting in parts of the brain to function properly), diabetes, chronic obstructive pulmonary disease, respiratory failure, convulsions, gastrostomy (feeding tube inserted into the stomach), and a tracheostomy (surgical opening in the neck to allow a machine called a ventilator to help with breathing). R75's physician orders (PO) dated 11/3/24 identified, "Tracheal Suction. Every shift". R75's care plan (CP) with start date of 3/21/24 identified, "Change inline suction daily" and "Suction me as needed and record numbers[sic] times and total minutes". In addition, CP with a start date of 6/11/24, identified, "Use Enhanced Barrier Precautions as indicated per facility policy." During observation of on 1/14/25 at 8:53 a.m., registered nurse (RN)-A entered R75's room to administer medications through the gastrostomy tube and to replace the in-line suction (a catheter inside a sterile plastic sleeve attached to the ventilator). RN-A sanitized hands, applied gloves, gown and mask (PPE) prior to contact with R75. RN-A administered the medications through the gastrostomy tube and opened the sterile package containing new in-line suction apparatus. RN-A did not change gloves following the medication administration task and moving to the pulmonary task. RN-A then removed the gauze surrounding the tracheostomy, placed it in the garbage, disconnected the in line suction apparatus attached to R75's tracheostomy and ventilator, and placed it in the garbage. RN-A inserted the sterile in-line suction apparatus and connected it to the portable suction machine at bedside and replaced the gauze surrounding the			F 880			

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F 880	Continued From page 55 tracheostomy. RN-A then informed R75 that she was going to suction R75 through the new in-line suction apparatus and proceeded to suction R75's respiratory secretions twice before re-attaching the tracheostomy to the ventilator. RN-A then removed her gown, and gloves and sanitized her hands prior to exiting the room. During interview with RN-A on 1/14/25 at 9:18 a.m., RN-A stated, "No I did not change gloves after I finished with [R75's] gastrostomy tube feeding and removed the old trach tubing and applying the new one. I should have for infection control." During interview with RN-C on 1/16/25 at 7:59 a.m., RN-C stated, "we are to flush after medication administration in [the] GT [gastrostomy tube]. We must change gloves before going to the tracheostomy. You don't want to transfer infection from the GT to the trach[eostomy]". During interview with facility infection control preventionist (ICPC) on 1/16/25 at 10:14 a.m., ICPC stated, "Change gloves after GT and trach care. [We] don't want to introduce anything that may have been in the GI tract". During interview with director of nursing (DON) on 1/16/25 at 10:40 a.m., DON stated, "She [RN-A] should have changed her gloves between GT medication administration and the trach. I would agree that it is a concern for infection control." Facility policy titled Hand Hygiene reviewed 9/2023 stated, the purpose was identified as, "Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene	F 880			

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F 880	Continued From page 56 practices, associated will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the residents." In addition, the policy identified, "Times to Perform Hand Hygiene are, but not limited to: Before and after direct resident contact, Before and after handling peripheral vascular catheters and other invasive devices, and Before and after changing a dressing".	F 880			

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/16/2025. At the time of this survey, Benedictine Health Center of Minneapolis was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/06/2025

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Benedictine Health Center of Minneapolis is a 5-story building with a full basement that was built in 1969 was determined to be of Type II(222) construction. Each floor of this facility that provides care and sleeping-rooms, is divided into smoke compartments. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.			K 000			

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K 000	Continued From page 2	K 000			
K 211 SS=E	The facility has a capacity of 90 beds and had a census of 85 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain egress corridors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.1, 19.2.3.4, and 7.1.10.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/16/2025 at 12:16 PM, it was revealed by observation that there were three pallets of water in the corridor on the second floor outside of resident room 202 and 204, a facility employee informed me that the pallets had been there since 10:30 AM.	K 211	The three pallets of water were removed from the hallway and taken to identified resident rooms for use The carts in the hallway will be stored in laundry room when not in use. All hallways in the facility were checked for any water pallets All the carts not in use were removed and stored in the laundry room. Water pallets supplier were educated that they will not deliver the pallets to the hallways anymore. The water pallets will		2/26/25

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K 211	Continued From page 3 2. On 01/16/2025 at 12:32 PM, it was revealed by observation that there were laundry carts, a trash can, and maintenance carts stored in the corridor in the basement outside of the Occupational Therapy office. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211	be delivered to a different location not to impede means of egress. The staff will be educated on the storage of the carts in the laundry room. Water pallets audit in the hallway will be done monthly during the deliveries for three months. Results will be provided to QA to analyze and determine ongoing frequency and duration Daily checks on the carts in the hallway The EVS director or his designee will be in charge of implementing this poc		
K 225 SS=E	Stairways and Smokeproof Enclosures CFR(s): NFPA 101 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.2.1 and 7.2.1.4.5.1. This deficient finding could have a patterned impact on the	K 225	The quote of the new door has been obtained and the ordered on 1/30/25 All other exit doors were checked and no issues identified.		2/26/25

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K 225	Continued From page 4 residents within the facility. Findings include: On 01/16/2025 at 01:18 PM, it was revealed by observation that the exit door at the bottom of the east stairwell on the first floor was difficult to open. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 225	Reviewed Policy on door egress; no changes made All exit doors will be checked weekly and entered into TELS. Results will be provided to QA to analyze and determine ongoing frequency and duration EVS Director or his designee will be in charge to implement this POC		
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain exit signs per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.10.1, 7.10.5.1, and 7.10.5.2.1. This deficient finding could have an isolated impact on the	K 293	The defective Exit sign on 4th floor was replaced on 1/31/25 All other Exit signs were checked for illumination, no defective exit signs found.		2/26/25

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K 293	Continued From page 5 residents within the facility. Findings include: On 01/16/2025 at 12:47 PM, it was revealed by observation the stairwell exit sign on the fourth floor outside of the elevators was not illuminated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 293	Review Policy, No changes All Exit signs will be checked monthly and entered into TELS; Ongoing Results will be provided to QA to analyze and determine ongoing frequency and duration The EVS Director will be responsible for implementing this plan of correction		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96	K 324			2/26/25

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K 324	Continued From page 6 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain kitchen doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 01/16/2025 at 11:46 AM, it was revealed by observation that door 504 to the kitchen on the fifth floor was propped open with a chair. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K 324	The chair propping the door at the kitchen was removed Doors separating the kitchen from the Dining room were checked, and they remain closed. Sign to keep the kitchen doors closed will be put at the kitchen doors. Culinary staff re-educated on not to prop kitchen doors open at any time. Review Policy No changes Daily checks for any doors being propped at the kitchen will be done. Results will be provided to QA to analyze and determine ongoing frequency and duration The Culinary director will be responsible		

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K 324	Continued From page 7			K 324	for implementing this plan of correction		2/26/25
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to mount, inspect, and maintain access to fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, sections 6.1.3.3.1, 6.1.3.8.3, and 7.3.1.1.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 01/16/2025 between 10:30 AM and 01:45 PM, it was revealed by observation the inspection tags on the fire extinguishers throughout the facility were outdated. The last annual inspection completed for the fire extinguishers was completed in December of 2023. 2. On 01/16/2025 at 01:06 PM, it was revealed by observation that a patient lift was blocking access to the fire extinguisher near resident room 213. 3. On 01/16/2025 between 10:30 AM and 01:45 PM, it was revealed by observation that the water can fire extinguisher near the door to the patio			K 355	The identified fire extinguisher was mounted on the wall. All the fire extinguishers were inspected by the contracted vendor (Summit Fire) Review Policy No changes Annual checks for Fire extinguishers will be monitored in TELS and reminders sent to the contracted vendor; Ongoing The EVS Director will be responsible for implementing this plan of correction		

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K 355	Continued From page 8 was not mounted and sitting on the floor.			K 355			
K 372 SS=E	An interview with the Maintenance Director verified these deficient findings at the time of discovery. Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 01/16/2025 at 11:56 AM, it was revealed by observation there were multiple penetrations into the smoke barrier wall above the ceiling in the west dining room on the fourth floor. The smoke barrier wall had the sign to 4 West rooms			K 372			2/26/25
					Hired outside contractor to seal the open smoke barrier penetration at all floors All open smoke barrier penetrations identified will be sealed by the contractor Review Policy, No changes Quarterly checks on smoke barrier penetrations will be done and whenever there is work done by a vendor.		

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K 372	Continued From page 9 419-425. 2. On 01/16/2025 at 12:05 PM, it was revealed by observation there were multiple penetrations into the smoke barrier wall above the ceiling in the east wall of the dining room on the fourth floor. 3. On 01/16/2025 at 12:11 PM, it was revealed by observation there were multiple penetrations into the smoke barrier wall above the ceiling in the west dining room on the third floor. 4. On 01/16/2025 at 12:23 PM, it was revealed by observation there were multiple penetrations into the smoke barrier wall above the ceiling above the TV near the reception desk on the first floor. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 372	Results will be provided to QA to analyze and determine ongoing frequency and duration The EVS director will be responsible for implementing this plan of correction		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2	K 521	Review Policy Results will be provided to QA to analyze and determine ongoing frequency and duration		2/26/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER OF MINNEAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 618 EAST 17TH STREET MINNEAPOLIS, MN 55404		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 521	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect fire dampers per NFPA 101 (2012 edition), Life Safety Code, section 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2 and 6.5.12. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 01/16/2025 between 10:30 AM and 01:45 PM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the dampers in the facility had been inspected. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 521	Hired a contractor to inspect the fire dampers at the facility All fire dampers at the floors identified will be inspection by the contracted vendor Review Policy, No changes 4-year monitoring schedules entered into TELS to inspect fire dampers The EVS director will be responsible to implement this plan of correction		