DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 18, 2020

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: October 16, 2020

Dear Administrator:

On November 2, 2020, we notified you a remedy was imposed. On December 9, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 26, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 2, 2020 be discontinued as of November 26, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of November 2, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 2, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
November 16, 2020

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: October 16, 2020

Dear Administrator:

On November 2, 2020, we informed you of imposed enforcement remedies.

On October 26, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 2, 2020 will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 2, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 2, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of November 2, 2020, in accordance with Federal law, as specified in

the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 2, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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

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

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

DEPARTMENT CONTACT

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

Duluth District Office
Teresa Ament, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290

Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 16, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after

receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	C 10/26/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/22/20, through 10/26/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be substantiated: H5236056C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 660 SS=G	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the	F 660		11/26/20

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

Electronically Signed | 11/25/2020

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

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F 660	Continued From page 1	F 660		

development of a discharge plan for each resident.
(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.
(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.
(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.
(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.
(vi) Address the resident's goals of care and treatment preferences.
(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.
(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.
(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.
(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.
(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident

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F 660	Continued From page 2 representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide ongoing comprehensive discharge planning to ensure all discharge needs of the resident were identified in order to avoid the development or worsening pressure ulcers, and to avoid readmission for 1 of 3 residents (R1) reviewed for discharge planning. This resulted in actual harm to R1, who had developed a pressure ulcer that worsened, and had an unsuccessful discharge that resulted in readmission to the facility. Findings include: R1's Face Sheet printed 10/26/20, indicated R1 was admitted to the facility on 9/22/20, and	F 660	F660 R1 readmitted to the facility on 10/15/2020. A full skin assessment was completed upon admission and appropriate skin treatments were implemented. The nurse responsible for implementing the dressing on R1 has been educated on the process of initialing and dating dressing, implementing new treatment orders, and notifying family and MD. All licensed staff have been educated on the process of initialing and dating dressing, implementing new treatment orders, and notifying family and MD.	

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F 660	Continued From page 3 diagnoses included malignant neoplasm of transverse colon (colon cancer) with resection, rib fractures, anemia, and diabetes. R1's admission Minimum Data Set (MDS) dated 9/29/20, indicated R1 was cognitively intact, required assistance of two for bed mobility, and assist of one for ambulation, dressing, eating, toileting, and personal hygiene. R1 had an indwelling urinary catheter, and had bowel incontinence. R1 was at risk for pressure ulcers (PU), and had no unhealed PU. R1's care plan dated 9/24/20, indicated R2 had impaired mobility, required limited assistance with ambulation and transfers, and supervision with bed mobility. R1's care plan indicated R1 had a cognitive loss, and required assistance with activities of daily living (ADLs), medication management, and supervision for safety. R1's care plan indicated R1 was at risk for skin breakdown, and required assistance of two for turning and repositioning every two hours. The care plan further indicated R1's goal was to return to home with necessary referrals and supportive services. R1's physical therapy (PT) plan of care dated 9/23/20, indicated R1 was referred to PT post hospitalization due to a fall resulting in multiple rib fractures, and required PT services for improving activity intolerance, transfers, gait, balance, and safety with functional mobility. R1's goal was to return home. PT treatment plan included PT visits six times a week for five weeks. R1's occupational therapy (OT) plan of care note dated 9/23/20, indicated R1 presented with decreased activity intolerance, impaired balance	F 660	All currently planned discharges have been reviewed to ensure all appropriate education and communication has been met prior to discharge. To include treatments for impaired skin, medication administration, care for indwelling catheters, ostomy care and insulin administration and safety at home. Community will implement Discharge Summary and Discharge Plan of Care located within Matrix Observations. The observation will be opened at the time of the admission. The components of this Discharge Plan of Care include wound care, medication, equipment, discharge teaching which includes indwelling catheters, and home care services to name a few. At the time of discharge these documents will be reviewed with the resident and family accompanying them. The observation will be signed and a copy given to the resident and/or family. The facility will add a topic to their daily IDT meeting to confirm that the discharge plans and support systems for the resident with an upcoming discharge date has not changed. If a change in the support system is noted, the facility will start the discharge process over. 3 audits per week on Discharge Summary and Discharge Plan of Care will be performed to ensure that the observations have been opened on date of admission and completed upon discharge. Director of Social Services or designee is responsible for the audits.	

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F 660	Continued From page 4 and mobility, impaired cognition affecting ability to safely complete ADL/IADL tasks. R1's goal was to return home. OT treatment plan included OT visits six times a week for five weeks. On 9/22/20, a progress note indicated R1 was admitted to the facility for short term rehab after a hospitalization from a fall that occurred at home, which resulted in rib and compression fractures. R1's goal was to return to own home when therapies were completed. R1's Weekly Skin Documentation dated 9/22/20, and 9/27/20, indicated R1 had mushy, blanchable heels, and three abdominal surgical incisions with steri-strips. R1's chart lacked further Weekly Skin Documentation from 9/27/20, to R1's discharge on 10/13/20. R1's Admission Skin Observation note dated 9/23/20, indicated R1 was at risk for skin breakdown, and was without pressure ulcers. R1's eight day skin assessment dated 9/29/20, indicated R1 had no areas of pressure. R1's care conference note dated 9/29/20, indicated R1, social services, therapy, nursing, and family member (FM)-D attended R1's care conference. R1's care conference note indicated R1 required contact guard assistance (CGA) for transfers with four wheeled walker (FWW), required stand by assistance (SBA) with bed mobility, required assistance with dressing, and extensive assist with toileting. R1's Allen Cognitive Level Screen (ACLS, a test that evaluates the ability of someone to make decisions, function independently, safely perform basic skills, and learn new abilities) score was 4.5	F 660	An addendum to our Prevention and Treatment of Skin Breakdown policy has been reviewed and revised. Revision now includes dating and initialing any dressing placed on resident's skin.	

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F 660	Continued From page 5	F 660		

which recommended R1 receive daily checks while at home, and required assistance. The care conference note further indicated R1 and FM-D were adamant on R1's return to home, and FM-D indicated she lived near R1, and could be at R1's home at any time. The care conference note indicated therapy questioned if R1 would benefit from an assisted living facility (ALF) if FM-D was unable to provide the level of care R1 needed.

On 10/6/20, R1's physical therapy (PT) daily treatment note indicated FM-D spoke with PT-A, and was informed R1 would not be able to fit her walker in the bedroom next to R1's bed. PT-A worked with R1 on ambulating from the end of the bed towards the head of bed while supporting herself on the bed using upper extremities with CGA (requiring one or two hands on the body for assist). R1 was able to complete the task after multiple cues from therapy, and multiple attempts by R1.

R1's physician signed discharge orders dated 10/7/20, included orders for in home PT, OT, and Home Health Nurse for vital sign checks, medication education, medication set up, and disease education. Discharge medication and treatment orders lacked orders for wound care treatment.

On 10/5/20, R1's OT progress note indicated OT recommended R1's discharge plan include 24 hr care/assistance. The note further indicated FM-D was adamant R1 would do better at home, and FM-D would check on R1 daily.

On 10/6/20, R1's OT daily treatment note indicated R1 required SBA from sit to stand, and CGA with ambulation with FWW. The note further

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F 660	Continued From page 6	F 660		

indicted OT-A and PT-A spoke with FM-D to discuss discharge planned to be 10/12/13. Therapy recommended 24 hour care, which FM-D stated she could not provide, but she would check on R1 during the day. The note indicated FM-D was concerned with R1 being alone at night, and R1's ability to empty her urinary drainage bag. FM-D inquired about home health aide for overnight care, and therapy referred FM-D to social services for information.

On 10/9/20, a progress note indicated R1 had a 1 centimeter (cm) x 0.5 cm area on R1's right buttock, surrounding skin was blanchable but unable to determine center. The area was cleansed, and a foam dressing was applied. R1's medical records lacked further monitoring of the area, or the condition of R1's skin at time of discharge.

On 10/12/20 (day of discharge), R1's OT daily treatment note indicated R1 struggled to sit up on the edge of bed, and required assistance to put her pants over her feet, and thread the catheter bag through the leg of her pants. R1 required SBA to CGA to stand and pull up her pants. The note further indicated during the morning meeting it was discussed family would be staying with R1 for a couple of weeks. OT-A expressed concerns regarding R1 living alone with her cancer diagnoses, and social services reported family was aware of R1's situation.

On 10/12/20, a PT note indicated R1 required SBA to transfer to the toilet, and required assistance of one to remove her lower extremity clothing. The PT note further indicated R1 reported buttock pain, and she had a small dressing over the right of her sacrum area. PT-A

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F 660	Continued From page 7	F 660		

notified nursing, and nursing applied a new dressing to R1's sacrum. R1's medical records lacked documentation of an assessment of R1's sacrum, and lacked discharge orders for at home treatment.

On 10/12/20, a progress note indicated R1 transferred and ambulated with limited assist of one with FWW. R1 required assistance with bathing, dressing, and was independent with eating.

On 10/13/20, a progress note indicated R1 was discharged to home with family providing transportation, and a referral was made to a home care agency (HCA) for in-home nursing, OT, and PT.

The HCA home care visit note dated 10/14/20, indicted home care nurse arrived at R1's home on 10/14/20, to complete R1's initial assessment, and initiate home care services. The note indicated FM-A and FM-C were present during the visit, and expressed concern R1 was discharged from the facility unable to care for herself or manage her Foley (urinary) catheter. The note indicated R1 had three unstageable pressure ulcers (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. Stable eschar [i.e. dry, adherent, intact without erythema or fluctuance] on the heel or ischemic limb should not be softened or removed) on her buttocks that were not noted in R1's discharge paperwork from the facility. The note further indicated R1 required one to two assist to transfer, and was unable to change position on her own when she was in bed. The note indicated R1 required a higher level of

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care than the agency could provide, and R1 would need to either go to the emergency department (ED) or back to the facility. FM-A and FM-C agreed to stay with R1 until R1 was able to be readmitted back to the facility. The home care nurse called R1's primary care provider (PCP), and agreed to re-admit R1 back to the facility.

R1's physician orders dated 10/15/20, included orders to re-admit back to the facility, and OT and PT to evaluate and treat.

On 10/15/20, R1's Wound Management sheet indicated R1 was re-admitted to the facility with a Stage 1 pressure ulcer (Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury), which measured 0.7 cm in length by 0.5 cm in width to R1's right buttock near rectum. Opened area had a small amount of serous (clear, thin, watery) drainage. Skin surrounding open area was excoriated.

On 10/16/20, R1's OT progress note indicated R1's discharge to home was unsuccessful, and R1 returned to the facility. The note further indicated therapy made recommendations for an assisted living facility or 24 hour supervision if R1 stayed at home.

On 10/15/20, R1's PT daily treatment note indicated R1 required CGA with FWW with ambulation, required cues for proper walker use,

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and R1 had some unsteadiness when rising.

On 10/22/20, at 10:03 a.m. family member (FM)-A was interviewed and stated he was informed R1 was being discharged from the facility a few days before R1's scheduled discharge date of 10/13/20. FM-A stated he lived out of town, had planned to stay with R1 for a few days, and FM-B planned to stay with R1 for about 12 days. FM-A stated when R1 got home from the facility, FM-A was unaware how much assistance R1 required. FM-A stated R1 could not get up on her own, needed assistance with incontinent cares, and could not care for her urinary catheter. FM-A stated R1 had a urinary catheter for about eight years, and used to be able to empty the urinary drainage bag on her own, but could not longer manage. FM-A stated he didn't know how to empty R1's urinary drainage bag, and the facility did not offer FM-A education. FM-A stated R1 was sent home with some medications, and two different medication lists. FM-A called the facility and spoke with registered nurse (RN)-A to clarify R1's medication list. FM-A stated he expressed concern with R1 needing more assistance than FM-A felt comfortable in providing. FM-A stated nursing and therapy did not recommend R1 to return home, and R1 needed 24 hour supervision for safety. FM-A stated he called FM-B and informed FM-B of R1's condition, and explained R1 was unable to do anything on her own except feed herself. FM-A stated FM-B called FM-C, and FM-C planned to arrive at R1's home the next day to be present when the home care nurse arrived.

FM-A stated FM-D was not a close family member, and should not have been listed as R1's primary contact and caregiver. FM-A stated

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because of that, the facility never included FM-A or FM-B in R1's discharge planning. FM-A stated after the facility was aware of FM-A and FM-B's involvement on 10/7/20, and FM-D was no longer involved in R1's care, the facility did not offer a discharge care conference before R1's was discharged home. FM-A stated R1's family never spoke with any staff from the therapy department to discuss R1's care needs, and felt family was not prepared. FM-A stated he thought he was just going to be helping with R1's meals, cleaning, and being around for a few days to make sure R1 got settled in. FM-A stated if he was properly informed of R1's care level needs, he never would have allowed R1 to return home.

FM-A stated on 10/14/20, the home care nurse arrived and told him R1 should have never been discharged from the facility and required 24 hr care. FM-A stated the home care nurse and FM-C discovered three pressure ulcers on R1's buttocks that he was not informed of. FM-A stated the home care agency could not provide care for R1 due to her high level care needs, and R1 required 24 hour supervision. FM-A stated the HCA nurse told him R1 needed to return to the facility, or go to the ED. FM-A stated family stayed with R1 until after her oncology appointment 10/15/20, and brought R1 back to the facility to be re-admitted. FM-A stated when R1 was brought back to the facility on 10/15/20, family talked to RN-A and expressed their frustration of the facility's lack of communication to the family of R1's high care level needs, and pressure ulcers on R1's buttocks that were not addressed at discharge. FM-A stated family had not been involved in R1's care conferences and discharge planning.

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On 10/22/20, at 1:18 p.m. FM-B was interviewed and stated R1 had FM-D listed as R1's primary contact and caregiver so the facility communicated with FM-D about R1's care and discharge. FM-B stated she received a call from FM-A the day R1 was discharged home. FM-A was informed R1 was weak, needed help to stand, could barely walk with her walker, and could not empty her urinary drainage bag. FM-B stated on 10/7/20, she found out R1 was being discharged to home, she had planned to spend 12 days with R1 to help with cleaning, meals, and shopping since FM-D was no longer involved in R1's care. FM-B stated the first interactions with the facility was via email with the social worker (SW)-A on 10/7/20. FM-B stated SW-A was informed FM-D was no longer involved in R1's care, and SW-A sent a return email with information on medical assistance application for R1 and links for resources for R1's diet. FM-B stated the facility did not offer a care conference after the facility was informed FM-D was no longer going to be providing care for R1.

On 10/22/20, at 2:13 p.m. the HCA RN-K stated she arrived at R1's home on 10/14/20, to initiate home care services for nursing, OT, and PT. RN-K stated when she arrived at R1's home, FM-A and FM-C were present and R1 was in bed. RN-K stated R1's condition was poor, she had 3 unstageable PU to her buttocks, and there was a transparent dressing on R1's buttocks that did not cover R1's PU. RN-K was unable to admit R1 to home care due to R1's high skill level needs, cognitive deficit, and inabilty to make safe decisions. RN-K stated R1 needed 24 hr care/supervision, and family was unable to meet R1's care needs. RN-K recommended R1 be taken to the ED or re-admitted to the facility.

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RN-K called R1's primary physician to update, the PCP agreed R1 should not be home, and to readmit R1 to facility.

On 10/22/20, at 2:33 p.m. the HCA manager (HCA)-M stated they received R1's referral from SW-A on 10/6/20, with planned discharge for 10/13/20. HCA-M stated R1's referral requested nursing services for vital signs, medication set up and education, disease education, PT, and OT services. HCA-M stated R1's referral paperwork from SW-A included physician orders, physician visit, and therapy notes. HCA-M stated based on the information in R1's referral, R1 would be an acceptable client for admission. HCA-M stated therapy notes indicated R1 required assistance with footwear, and SBA with ambulation. HCA-M stated R1's referral did not indicate R1 had any skin concerns or wound care orders in place. HCA-M stated based on the home cares nurse observations and assessment, R1 was not admitted to home care due to R1's high skill level needs which the agency was not able to provide.

On 10/22/20, at 2:50 p.m. RN-A stated she was a part of R1's discharge planning. R1 stated at the time of discharge, R1 required assistance of one with transferring, dressing, grooming, toileting, and ambulation. RN-A stated nursing and therapy did not recommend R1's discharge to home and recommended 24 hr care in the home or an assisted living facility. RN-A stated R1 and FM-D were determined to get R1 home. RN-A stated, "People had the right to make bad decisions." RN-A stated R1's discharge plan included FM-D to assist R1 in the home during the day, and home care services for nursing, OT, and PT were to be initiated. RN-A stated FM-D attended R1's care conferences via phone, and

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had spoken with OT and PT, was aware of R1's care level needs, and therapy's recommendations for 24 hour care. RN-A stated R1 was readmitted to the facility two days after being home, because family was unable to care for R1 at home. RN-A stated she spoke with R1's family when R1 was brought back to the facility. RN-A stated R1's family expressed they were not aware R1 had pressure ulcers, and they were not informed of R1's high care level needs. RN-A stated skin observations were not completed at the time of discharge, and RN-A was unaware R1 had any skin concerns or had a transparent dressing to her buttocks at the time of discharge. RN-A verified R1 did not have treatment orders at the time of discharge for pressure ulcer care.

On 10/22/20, at 3:32 p.m. FM-C stated she arrived at R1's home around 10:00 a.m. on 10/14/20. FMC stated R1 was lying in bed, and her urinary catheter leg bag was full of dark colored urine. FM-C stated R1 was weak, unable to care for her catheter, required assistance to turn in bed, and one to two assist to transfer. FM-C stated R1 had pressures ulcers on the right side of her coccyx, and had a transparent dressing to her buttocks that was undated and scrunched up. FM-C stated the home care nurse cleaned R1's pressure ulcers and applied a new dressing. FM-C stated she was a home care nurse, and was surprised the facility discharged R1 home with the skilled level of care she required, and expected untrained family to be able to provide appropriate care for R1.

On 10/22/20, at 4:05 p.m. SW-A stated she was involved in R1's discharge planning, and made a referral to the HCA for R1 to receive nursing, OT, and PT in-home services. SW-A stated the home

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care services were temporary, and did not include evening or overnight care, and FM-D was going to help R1 at home. SW-A stated FM-D was listed on R1's contact information from the hospital as R1's caregiver, and R1 confirmed FM-D lived close to her and helped R1 in her home. SW-A stated FM-A and FM-B did not live in town and were unable to assist R1 in her home, and were not initially involved in R1 care planning. SW-A stated FM-D attended R1's initial care conference via phone and agreed to provide daily checks, and assist with meals when R1 returned home. SW-A stated FM-D expressed concern of R1 being alone at night, and SW-A referred FM-D to Senior Linkage. SW-A stated she was contacted by FM-B via email, and FM-B requested FM-D not be involved in R1's care plan moving forward due to concern of FM-D taking financial advantage of R1. SW-A stated she emailed FM-B a link for resources for R1's diet, an application for medical assitance, and contact number to report concerns or financial abuse. SW-A stated FM-A and FM-B did not request a discharge meeting for R1. SW-A verified FM-A and FM-B were not offered a discharge care conference for R1.

On 10/23/20, at 12:07 a.m. an interview was conducted with physical therapist (PT)-B and occupational therapist (OT)-A. PT-A stated R1 required supervision with ambulation with FWW for safety and cues. OT-A stated R1's ability to dress herself varied on a day to day basis. OT-A stated R1 was unable to manage her urinary drainage bag or manage medication on own. OT-A stated she and PT-A talked with FM-D via phone and discussed R1's discharge recommendations of 24 hour in-home care, and that R1 required CG with transfers. OT-A stated

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it was her impression R1's family that lived out of town was going to stay with R1 for a couple of weeks. OT-A stated R1 did not have a discharge care conference because FM-D declined. PT-B and OT-A stated FM-A and FM-B were not offered a discharge care conference, and both were unaware FM-D was no longer involved in R1's care.

On 10/23/20, at 2:55 p.m. social services director (SSD)-A stated she was not involved with R1's original discharge on 10/13/20. SSD-A stated SW-A forwarded an email received from FM-B on 10/7/20, indicating family had concerns with FM-D taking financial advantage of R1, and requested the removal of FM-D from R1's plan of care. SSD-A stated she was unaware there were any concerns with R1's discharge to home.

On 10/23/20, at 3:31 p.m. a follow up phone interview was conducted with RN-A. RN-A stated the morning of R1's discharge, RN-A called FM-D to review R1's medications, was informed by FM-D she was no longer involved in R1's care, and was directed to call FM-A. RN-A called FM-A and reviewed R1's medications, and informed him of R1's scheduled oncology appointment. RN-A stated she informed SW-A that FM-D was no longer R1's caregiver. RN-A stated she was informed by SW-A that R1's family was coming from out of town to stay with R1 for a while. RN-A stated she did not review R1's care needs with FM-A once she found out R1's original caregiver, FM-D was no longer involved in R1's care. RN-A stated a change in discharge planning should be discussed as a team to make sure all disciplines involved were aware of the changes to ensure the discharge plan remained a safe plan. RN-A stated there were no adjustments made to R1's

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discharge plan.

On 10/26/20, at 1:33 p.m. a follow up phone interview was conducted with SW-A. SW-A stated no one "officially" informed her FM-D was no longer involved in R1's care. SW-A stated she heard "second hand" by staff FM-D was no longer R1's caregiver the day R1 was to be discharged. SW-A stated it was her understanding, out of town family would be staying with R1 for a short time, and "assumed" FM-D was going to be involved in R1's care, but unsure to what extent. SW-A stated if FM-D was not going to be involved in R1's care at all, SW-A would have put R1's discharge on hold until R1, family, nursing, and therapy met to make sure everyone had an understanding of R1's needs when home, and R1 had a safe plan for discharge. SW-A stated she did not contact FM-A, FM-B or therapy to ensure all involved parties had an understanding of the changes in R1's discharge plan.

On 10/26/20, at 3:27 p.m. an interview with RN-B and SSD-A was conducted. RN-B stated the discharge planning process started upon admission, and went until the day the resident was discharged. RN-B stated the facility had two Nurse Transition Coordinators that were involved in the day-to-day discharge planning, along with nursing, social services, and therapy who met daily. RN-B and SSD-A both agreed that with any significant changes in R1's caregivers after discharge, they would have expected a meeting to have occurred with the new caregivers, nursing, social services, and R1 to discuss the changes, and to ensue R1 had a safe discharge plan. SSD stated R1's new caregivers would be offered any education if needed, including hands on training by therapy, or by nursing for any

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education on R1's catheter care.

SSD-A verified no discharge care conference occurred with R1's new caregivers. SSD-A stated she was unaware therapy made recommendations for an ALF for R1, or 24/7 care in R1's home. SSD-A further stated if family was unable to provide 24/7 care, R1 should not have been discharged home. SSD-A was unsure if therapy was aware FM-D was no longer involved in R1's care, or if they had communicated therapy recommendations to FM-A or FM-B. RN-B stated she would expect any skin concerns to be addressed in R1's discharge paperwork, and verified R1's discharge orders did not include any dressing treatment to R1's buttocks. RN-B stated it was best practice to date and initial all dressings when applied. RN-B stated skin checks were not completed before the patient was discharged. RN-B stated if a skin check had been completed for R1 at time of discharge, R1's skin concern and dressing to her coccyx would have been discovered, and treatment orders would have been obtained. SSD-A stated it appeared there was a lack of communication between departments with R1's discharge plan.

The facility policy Discharge Planning dated 2017, directed the Social Worker/Licensed Nurse will evaluate and identify resources available and potential health issues that may interfere with the residents ability to return home. The policy directed in collaboration with the resident and family caregivers, a patient-driven education plan with related goals implemented. Prior to discharge, the patient or family caregivers demonstrate achievement of education goals for a safe transition. The policy indicated the Social Worker/Licensed Nurse collaborate with all

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disciplines, to evaluate the reality of the resident's plans and to approximate the time period for moving toward discharge. If discharge to the community is determined not feasible, the facility will document who mad the determination and why. Discharge plans are reviewed at least quarterly by the interdisciplinary team and revisions made as the needs arise. The policy further directs prior to discharge, the Social Worker/Licensed Nurse or nursing staff reviews and provides a written discharge instructions through the Discharge Plan of Care Observation in the electronic health record.

The facility policy Prevention and Treatment of Skin Breakdown/Pressure dated 2018, directed observations of skin to be completed with daily cares, and to report any skin concerns to the licensed nurse. Weekly skin audits are performed by a licensed nurse. The policy indicated if a resident was admitted with impaired skin integrity or new pressure injury or a lower extremity ulcer develops, the licensed nurse implements the following items:
-Documentation of the skin impairment is completed in the medical record. Staging is completed as necessary by trained licensed nursing associates.
-Standing orders/protocol for skin impairment are indicated.
-Notify the attending provider, resident and resident representative. Attending provider determines wound type and may provide additional orders.
-Notify the Supervisor/designee
-Evaluate current pressure reduction interventions and revise resident centered care plan.
-Notify dietician for nutritional interventions

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F 660	Continued From page 19 -Educate resident/resident representative on skin impairment and care plan interventions. -When pressure injury is present, the dressing and/or wound as appropriate are monitored daily. -The Licensed nurse will stage, measure, and examine the wound bed and surrounding skin weekly. -Notify the attending provider, resident/resident representative and supervisor if the skin injury has not shown progress in 2 weeks and/or is deteriorating unexpectedly. Re-evaluate plan of care as appropriate.	F 660		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 16, 2020

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: Event ID: 1UVK11

Dear Administrator:

The above facility survey was completed on October 26, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00861	A. BUILDING: _____ B. WING _____	C 10/26/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/22/20, through 10/26/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities The following complaint(s) were found to be	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 substantiated: H5236056C. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	2 000		