DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 11, 2021

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: January 6, 2021

Dear Administrator:

On January 22, 2021, we notified you a remedy was imposed. On February 3, 2021 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 February 1, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective February 21, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of January 22, 2021, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 21, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 1, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, 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
January 22, 2021

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: January 6, 2021

Dear Administrator:

On January 6, 2021, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective February 21, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective February 21, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 21, 2021.

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.

This Department is also recommending that CMS impose:

• 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by February 21, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Health Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 21, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth District Office
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 July 6, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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 (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

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 01/06/2021

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

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F 000	INITIAL COMMENTS On 1/4/21, through 1/6/21, 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 was found to be substantiated: H5236058C, with deficiencies cited at F686. The following complaint was found to be unsubstantiated: H5236059C. 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 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		2/1/21

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

Electronically Signed | 01/29/2021

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

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F 686	Continued From page 1 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a newly identified pressure ulcer was comprehensively assessed and interventions were initiated at the time of identification, to prevent worsening of the pressure injury for 1 of 4 residents (R102) reviewed for pressure ulcers. Findings include: Pressure ulcer stages according to the National Pressure Ulcer Advisory Panel: Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss. 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. R102's Face Sheet printed 1/6/21, indicated R102's diagnoses included congenital malformation syndrome that affects the normal	F 686	R102□s impaired skin is stable showing slight improvement with new granulation tissue appearing. Nursing will continue new treatment that was implemented on 1/18/2021. Care plan includes resident to be side-lying with hourly repositioning and up to custom chair for no greater than an hour. Resident receives tube feeding and protein powder currently. Zinc and Vitamin C were added to promote wound healing. A whole house audit of residents was completed to ensure all areas of pressure are noted and being tracked according to the process. Any new areas of concern will follow our new skin assessment protocol. All licensed staff were educated on how to document weekly skin assessments and the process to follow if a new impaired area is found. This includes updating the doctor, family and clinical manager and implementing a treatment per our wound protocol. Prevention and Treatment of Skin Breakdown Policy reviewed and revised.	

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F 686	Continued From page 2 development and function of the brain, epilepsy (seizures), neuromuscular scoliosis (irregular curvature of the spine), reduced mobility, and muscle weakness. R102's annual Minimum Data Set (MDS) dated 12/9/20, indicated R102 had moderately impaired cognitive skills for daily decision-making, no rejection of care behaviors, required extensive assistance of two staff for bed mobility, and was totally dependent on staff for transfers and toileting cares. R102's MDS further indicated she was always incontinent of bowel and bladder, was at risk for pressure ulcers, and had one unstageable unhealed pressure ulcer. In addition, R102's MDS identified interventions implemented for skin impairments including a pressure-reducing device for wheelchair and bed, nutrition or hydration intervention, and pressure ulcer care and treatments with nonsurgical dressings, and ointments and medications. R102's Care Area Assessment (CAA) for Pressure Ulcer/Injury dated 12/9/20, indicated she was at risk for pressure ulcers related to impaired mobility, and required assistance with repositioning. R102 had one unstageable pressure ulcer on her coccyx (tailbone area) which was treated with a daily dressing change, and a moisture-associated skin damage to her groin for which she received treatment with Nystatin powder (antifungal medicated powder). R102's CAA indicated she had an intellectual disability with the potential for the inability to communicate needs appropriately or to understand the importance of the need for repositioning. R102 was incontinent of bowel and bladder, and required assistance with toileting.	F 686	Six audits will be performed weekly to include all shifts and units to ensure the weekly skin assessment is being completed and documented according to the policy on the resident□s bath day. Audits will be completed until quality council deems 100% compliance. DON or designee will be responsible for completion of audits. Date of Compliance: 2/1/2021	

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F 686	Continued From page 3	F 686		

R102's care plan initiated 6/21/18, indicated R102 was at risk for skin impairments and pressure ulcers, and required total assist of one for bed mobility and total assist of two with a lift device for transfers. R102's care plan was revised on 1/5/21, to direct an up and down schedule for repositioning and offloading (relieving pressure to an area of the body) every hour, including reclining of wheelchair. R102's care plan indicated she was verbally able to make her needs known, and she may refuse repositioning or may request to lay down. R102's care plan revised 1/6/21, with a goal for R102's coccyx skin impairment to not get infected, directed staff to be up in her wheelchair for one hour, and reposition side to side every hour when in bed, check and change every two hours and as needed. R102's care plan further indicated she had a custom tilt wheelchair to provide some offloading during the day.

R102's nursing assistant care guide group sheet provided 1/4/21, directed staff to provide total assistance of two staff to transfer with an EZ lift (mechanical lift device), and provide incontinent cares. R102's care guide indicated she was to be repositioned every two hours side-to-side, and was to be up for activities every day.

R102's Physician Order Report dated 1/6/21, included orders for:
- Beneprotein (protein supplement) 2 scoops twice a day, started 12/14/20
-multivitamin with minerals every evening, started 12/14/20
-Nystatin powder (antifungal) to bilateral groin twice daily after incontinent cares, started 11/19/20
R102's physician orders lacked indication of

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F 686	Continued From page 4 pressure ulcer treatment. R102's progress notes dated 11/4/20, indicated a skin check was done and completed, and a reddened boil was identified on R102's neck. No other skin impairments were documented at that time. R102's Weekly Skin Documentation form dated 11/4/20, indicated previous skin impairments had resolved, and R102 had a new boil on the left neck. R102's progress notes dated 11/11/20, indicated a skin check was completed, and noted a dressing was in place for a small open area in the left axillary area (armpit). No other skin impairments were documented at that time. R102's progress notes dated 11/13/20, indicated R102 had an open wound on her coccyx measuring 0.5 inches x .25 inches. R102's progress notes further indicated a dressing was applied, a new order to change the dressing daily was to be placed, and findings were to be documented in the skin book. R102's progress notes lacked indication of notification of new skin impairment to the resident representative or the physician. R102's progress note indicated a licensed practical nurse (LPN) observed and measured R102's coccyx wound, but lacked documentation to indicate an assessment of the wound and surrounding skin to define the characteristics and type of wound and surrounding tissues, and identify the type or cause of R102's wound. R102's Weekly Skin Documentation dated 11/13/20, identified an open area measuring ".5	F 686		

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F 686	Continued From page 5	F 686		

inches by ¼ inches." The documentation lacked any further assessment of the area, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection.

R102's progress notes dated 11/16/20, indicated the registered dietician (RD) reviewed R102's tube feeding, and noted R102 had an open area on her coccyx per nursing notes dated 11/13/20. R102's progress notes indicated the present dietary regimen was to continue to be followed.

R102's progress notes dated 11/18/20, indicated R102 had a skin check, and skin impairments included a very reddened perineal area, reddened coccyx area, and a boil on the chest. R102's progress note indicated staff applied barrier cream on any reddened areas. R102's progress notes lacked indication of notification of new skin impairment to the resident representative or the physician. The progress note lacked any further assessment of the coccyx pressure ulcer, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection.

R102's progress notes dated 11/25/20, indicated a nursing assistant reported R102 had some redness discoloration on the right inner thigh, which was measured by a registered nurse (RN). R102's progress notes lacked any documention regarding R102's coccyx pressure ulcer.

R102's progress notes dated 12/2/20, at 10:54 am. indicated R102 had a pressure ulcer on her coccyx that had been identified on 11/13/20 (19 days earlier). The progress note identified a pressure area on the gluteal cleft on a bony

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F 686	Continued From page 6	F 686		

prominence, covered with eschar (dead tissue that is tan, brown, or black, and may be crusty) or scab tissue with red, blancheable skin (a normal reaction when reddened tissue turns white with gentle pressure, then goes red again with release of pressure, indicating sufficient blood flow to the area) surrounding the open area. R102's pressure ulcer measured 0.5 centimeters (cm) x 1.0 cm with no depth, and was cleansed with normal saline, skin prep applied, and covered with a foam dressing. R102's progress notes indicated an event was created, treatment was already in place and it was added to weekly wound rounds. R102's progress notes lacked notification of R102's resident representative or physician. R102's progress note lacked staging of R102's coccyx pressure ulcer.

R102's progress notes dated 12/2/20, at 10:34 p.m. indicated a skin check was done, R102 had no new skin areas, and identified redness was still present on R102's coccyx or vaginal area. R102's progress notes lacked assessment of the coccyx pressure ulcer, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection.

R102's Wound Management Detail Report dated 12/2/20, indicated R102's coccyx pressure ulcer was unstageable (had worsened), was covered by 100% eschar, necrotic tissue and measured 0.5 cm x 1 cm with blancheable redness surrounding the wound. The report lacked indication of notification of new skin impairment to the resident representative or the physician

R102's skin integrity event form initiated 12/2/20, indicated R102 had an unstageable pressure area to the coccyx which occurred on 12/2/20.

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F 686	Continued From page 7	F 686		

R102's skin integrity event indicated R102's resident representative and physician were notified of R102's skin impairment on 12/11/20, which was 9 days following initiation of the event form for skin integrity and approximately one month following initial identification of R102's pressure ulcer on her coccyx. Orders for R102's pressure ulcer were initiated on 12/11/20, and included side-to-side repositioning, and wound care with cleansing with normal saline, skin prep around edges, and cover with a foam border dressing to be changed every 3 days.

R102's progress notes dated 12/3/20, indicated the RD did a review of R102's tube feeding and noted an open area on her coccyx, though the present dietary regimen was continued.

R102's progress notes dated 12/4/20, indicated she was repositioned every 2 hours.

R102's annual MDS review in progress notes dated 12/6/20, indicated R102 had a new pressure area on her coccyx and therapy had been requested to research new wheelchair seating options. R102's record lacked documentation of assessment of her coccyx pressure ulcer, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection.

R102's annual skin assessment with Braden scale (a tool used to assist in determining risk for pressure related skin impairments) dated 12/7/20, identified R102 as being at risk for pressure ulcers related to impaired mobility and need for assistance with bed mobility and incontinent cares, and as having one unstageable pressure ulcer to her coccyx, and a moisture associated

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skin damage to her groin. R102 had a pressure relieving mattress and wheelchair cushion and was repositioned per her care plan.

R102's progress notes dated 12/8/20, indicated a care conference was held with R102's resident representative in attendance, and had few concerns for nursing. R102's progress notes lacked documentation regarding any discussion or notification of R102's pressure ulcer to R102's resident representative.

R102's Wound Management Detail Report dated 12/9/20, indicated R102's coccyx pressure ulcer was identified as stage 2, measured 2 cm x 3 cm, with 85% granulation tissue (new connective tissue), and 15% eschar, with well-defined edges, no exudate and was declining.

R102's progress notes dated 12/10/20, indicated R102's pressure ulcer had increased in size and measured 2.0 cm x 3.0 cm, with a mostly red granulation and a small area of eschar tissue on the wound bed. R102's wound care was completed with cleansing of the pressure area with normal saline, skin prep applied, and covered with a foam dressing. Repositioning side to side was implemented. R102's progress note further indicated R102's family had not been notified as the observation was made after 9:00 p.m. and an update was sent to wound care team.

R102's progress notes dated 12/11/20, indicated a full air mattress was requested, R102's resident representative was notified of R102's skin breakdown and the air mattress, R102's physician and wound team was updated, and an appointment made for re-molding of R102's

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custom wheelchair seat.

R102's progress notes dated 12/13/20, indicated the dietician was advised of a new pressure ulcer, and assessed R102's nutritional needs and recommended a protein supplement and a multivitamin with minerals to support wound healing.

R102's progress notes dated 12/17/20, indicated skin check was completed and R102 had redness to anterior aspects of ankle and bony prominences, redness behind her ear, and a red pressure area on her right ribs 2.3 cm x 0.4 cm, and pressure ulcer to her bottom.

R102's medical record between 12/17/20, and 1/5/21, lacked documentation of skin checks and follow up on identified skin impairments identified on 12/17/20.

R102's Wound Management Detail Report dated 12/18/20, identified R102's coccyx pressure ulcer a stage 2 measuring 3.0 cm x 2.0 cm with light serous (clear, amber, thin and watery exudate, a wound bed with 75% eschar and 25% slough (dead tissue; white or yellow covering on the base of the wound), with the surrounding dark purple or rusty discoloration with blancheable redness, and was determined to be stable. R102's report misidentified the stage of R102's wound as a Stage 2, though the wound bed was not visible.

R102's Wound Management Detail Report dated 1/6/21, for observation on 12/21/20, indicated R102's unstageable coccyx pressure ulcer measured 2.0 cm x 2.5 cm and was 80% slough and 20 % granulation tissue with well-defined wound edges, and blancheable redness

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surrounding the wound.

R102's Wound Management Detail Report dated 1/6/21, for observation on 12/28/20, indicated R102's unstageable coccyx pressure ulcer identified 12/2/20, measured 2.2 cm x 20 cm (incorrect, it should have indicated it was 2.0 cm), was 75% slough and 75% epithelialization tissue (regenerating skin tissue, light pink with a shiny pearl appearance), and well defined edges, surrounded by blancheable redness.

R102's Wound Management Detail Report dated 1/4/21, indicated R102's unstageable coccyx pressure ulcer measured 2.0 cm x 2.0 cm and had light serous drainage, with a wound bed of 70% slough, epithelializing tissue and well-defined edges. R102's pressure ulcer was identified as improving.

R102's Wound Management Detail Report dated 1/5/21, indicated R102's unstageable coccyx pressure ulcer measured 1.5 cm x 2.2 cm with the wound bed covered by 100% slough, well-defined wound edges and blancheable redness surrounding the ulcer. R102's pressure ulcer was defined as stable.

On 1/5/21, at 9:00 a.m. R102 was sitting in her upright wheelchair in her room, with her head drooping to the left. At 10:19 a.m. RN-B entered R102's room to allow R102 to call her family, and closed the door.
On 1/5/21, at 10:37 RN-B exited R102's room, and R102 remained sitting in her wheelchair, but tilted to approximately 45 degrees. RN-B stated she had asked R102 if she would like to lie down and R102 had replied that she did not want to lie down. RN-B stated she would get staff to lay her

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down to allow for wound inspection and wound care.

On 1/5/21, at 10:45 a.m. R102 was asked if she wanted to lie down and R102 declined, but RN-C explained wound care needed to be done and then she could get back up. R102's pressure ulcer care was observed. R102 complied and 2 staff transferred R102 to her bed with the mechanical lift. RN-B removed the foam dressing from the coccyx pressure ulcer, and described the pressure ulcer as unstageable, and stated there was more slough to it, with the wound bed 100% yellow slough, measuring 1.5 cm x 2.2 cm. R102's pressure ulcer wound edges were well-defined and the tissue surrounding the pressure ulcer was a blancheable redness. R102 had an air mattress on her bed, and a custom dense foam wheelchair seat.

On 1/5/21, at 3:30 p.m. RN-B stated they monitored skin weekly, and she monitored skin impairments, such as pressure ulcers weekly and documented them. RN-B stated she had written the pressure ulcer assessments down, but had not entered them in the medical record yet. RN-B stated R102 had one pressure ulcer that started the beginning of December. RN-B stated when a skin impairment was identified, they notify the wound management team, interdisciplinary team, and enter an "event" in the electronic record. RN-B stated weekly monitoring was initiated, and they notify the physician and family. RN-B verified R102's pressure ulcer had been unstageable since the pressure ulcer was documented on 12/2/20. RN-B was not aware R102's pressure ulcer had first been identified on 11/13/20. RN-B stated therapy was to evaluate wheelchair seating, they talked to dietary,

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increased R102's protein, changed her to an air mattress and changed her repositioning schedule. RN-B stated they now changed her to every hour repositioning.

On 1/6/20, at 12:20 p.m. the DON stated R102's coccyx pressure ulcer was first identified on 11/13/20, though the event form documented the identification of the pressure ulcer on 12/2/20. The DON verified R102's medical record lacked documentation of a comprehensive assessment and follow up on R102's pressure ulcer. The DON stated when a skin impairment was identified, an event form should be initiated and the physician and family should be notified. The DON verified R102's family and physician were not notified upon identification of the pressure ulcer, and were not notified upon initiation of the event form. The DON stated interventions were initiated, but it was noted they were not initiated upon identification of the ulcer. The DON stated R102's pressure ulcer had worsened since initial identification on 11/13/20, until the initial RN assessment of the pressure ulcer on 12/2/20. The DON stated notification of the physician and initiation of interventions occurred on 12/10/20, and later.

The facility policy Prevention and Treatment of Skin Breakdown dated 2018, directed assessments of a resident's skin integrity to be assessed upon admission and weekly thereafter. Residents with an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown and those with a skin impairment are provided care and services to heal the skin. The facility policy directed a Braden Skin Risk Assessment be completed upon admission and weekly for the

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F 686	Continued From page 13 first 4 weeks following admission, and upon a change. Skin is to be observed daily with cares, any skin concerns are to be reported to the licensed nurse and a weekly skin audit is to be completed by licensed nurses. The policy further directed nursing to document a new skin impairment and implement standing orders or protocol, notify the attending provider, resident and resident representative, supervisor, evaluate pressure reduction interventions, revise resident's care plan, notify therapy and interdisciplinary team, and educate resident and resident representative. The licensed nurse was to stage, measure, and examine the wound bed and surrounding skin weekly. Documentation was to reflect the areas addressed in the procedure.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual	F 880		2/1/21

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

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F 880	Continued From page 15 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 1 resident (R103) observed during personal cares. Findings include: R103's Resident Face Sheet printed 1/5/21, indicated diagnoses that included stable burst fracture of fourth lumbar vertebra, pneumonitis due to inhalation of food and vomit, and pain in right hip and knee. R103's admission Minimum Data Set (MDS) dated 12/24/20, indicated R103 was cognitively intact. The MDS indicated R103 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. The MDS further indicated R103 was frequently incontinent of bowel and bladder. On 1/4/21, at 2:16 p.m. nursing assistant (NA)-A and NA-B were observed providing cares for R103. NA-A stated they thought R103 was in isolation for "c-diff" (clostridium difficile is a toxin producing bacterium which can infect the bowel, causing illness with diarrhea and fever). There were no isolation signs posted on R103's door to indicate he was in isolation. NA-A and NA-B turned R103 to his side, NA-A removed R103's	F 880	R103 is no longer in our facility The staff identified immediately knew they made a mistake and correctly identified what the correct procedure was. Clinical leadership met with both staff to review hand hygiene policy and procedure, both staff acknowledged they understand the policy and procedure. Five audits will be conducted on the identified associates for the next three shifts and will continue until 100% compliance is met. Staff will be provided education on infection prevention strategies that includes hand hygiene, additionally staff will go through a hand hygiene competency check. Six hand hygiene and PPE compliance audits will be performed each day and every shift for the next seven days starting 01/28/2021. Quantity of audits will be adjusted based on associates results of the audit. Audits will continue until quality council deems 100% compliance. Hand hygiene policy and procedure were reviewed and remain appropriate. Date of Compliance: 2/1/2021	

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F 880	Continued From page 16 incontinent brief, which was soiled with urine and stool. NA-A cleaned R103 with wipes and applied barrier cream to R103's excoriated buttocks. NA-B reached over and assisted with applying the barrier cream on R103's buttocks. While R103 remained on his side, both NA-A and NA-B removed their soiled gloves, and without performing hand hygiene, put on new gloves. NA-A placed a clean incontinent brief under R103. Both NA-A and NA-B removed their soiled gloves. Both NA-A and NA-B used hand sanitizer on his way out of the room. -at 2:30 p.m. NA-A was interviewed. NA-A stated he did not perform hand hygiene after changing his soiled gloves. NA-A stated but he performed hand hygiene after all cares were completed. -at 2:32 p.m. NA-B was interviewed. NA-B stated hand hygiene should be done between glove changes. NA-B also stated if a resident is in isolation for c-diff, hands should be washed with soap and water, which she stated she did after disposing of the water mug after leaving R103's room. -at 12:23 p.m. registered nurse (RN)-A was interviewed. RN-A was filling in for the director of nursing (DON) who was not available. RN-A stated she would expect hand hygiene to be performed after glove changes. -at 12:30 p.m. licensed practical nurse (LPN)-C, who was the infection control nurse, was interviewed. LPN-C stated she would expect staff to perform hand hygiene after removing gloves, and prior to donning another pair of gloves. The facility policy Hand Hygiene dated June	F 880	DON or designee will be responsible for completion of audits. DPOC Items to be submitted when completed.	

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F 880	Continued From page 17 2017, directed staff to perform hand hygiene after removing gloves or aprons. The policy further directed staff to wash hands with soap and water after known or suspected exposure to Clostridium difficile.	F 880		

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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 1/4/21, through 1/6/21, surveyors of this Department's staff visited the above provider and the following correction orders are issued. The following complaint was found to be SUBSTANTIATED: H5236058C with a licensing order issued at S0900. Minnesota Department of Health is documenting	2 000		

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2 000	Continued From page 1 the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 900	Continued From page 2	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a newly identified pressure ulcer was comprehensively assessed and interventions were initiated at the time of identification, to prevent worsening of the pressure injury for 1 of 4 residents (R102) reviewed for pressure ulcers. Findings include: Pressure ulcer stages according to the National Pressure Ulcer Advisory Panel: Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister.	2 900	Corrected	2/1/21

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2 900	Continued From page 3 Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss. 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. R102's Face Sheet printed 1/6/21, indicated R102's diagnoses included congenital malformation syndrome that affects the normal development and function of the brain, epilepsy (seizures), neuromuscular scoliosis (irregular curvature of the spine), reduced mobility, and muscle weakness. R102's annual Minimum Data Set (MDS) dated 12/9/20, indicated R102 had moderately impaired cognitive skills for daily decision-making, no rejection of care behaviors, required extensive assistance of two staff for bed mobility, and was totally dependent on staff for transfers and toileting cares. R102's MDS further indicated she was always incontinent of bowel and bladder, was at risk for pressure ulcers, and had one unstageable unhealed pressure ulcer. In addition, R102's MDS identified interventions implemented for skin impairments including a pressure-reducing device for wheelchair and bed, nutrition or hydration intervention, and pressure ulcer care and treatments with nonsurgical dressings, and ointments and medications. R102's Care Area Assessment (CAA) for Pressure Ulcer/Injury dated 12/9/20, indicated she was at risk for pressure ulcers related to impaired mobility, and required assistance with repositioning. R102 had one unstageable	2 900		

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2 900	Continued From page 4 pressure ulcer on her coccyx (tailbone area) which was treated with a daily dressing change, and a moisture-associated skin damage to her groin for which she received treatment with Nystatin powder (antifungal medicated powder). R102's CAA indicated she had an intellectual disability with the potential for the inability to communicate needs appropriately or to understand the importance of the need for repositioning. R102 was incontinent of bowel and bladder, and required assistance with toileting. R102's care plan initiated 6/21/18, indicated R102 was at risk for skin impairments and pressure ulcers, and required total assist of one for bed mobility and total assist of two with a lift device for transfers. R102's care plan was revised on 1/5/21, to direct an up and down schedule for repositioning and offloading (relieving pressure to an area of the body) every hour, including reclining of wheelchair. R102's care plan indicated she was verbally able to make her needs known, and she may refuse repositioning or may request to lay down. R102's care plan revised 1/6/21, with a goal for R102's coccyx skin impairment to not get infected, directed staff to be up in her wheelchair for one hour, and reposition side to side every hour when in bed, check and change every two hours and as needed. R102's care plan further indicated she had a custom tilt wheelchair to provide some offloading during the day. R102's nursing assistant care guide group sheet provided 1/4/21, directed staff to provide total assistance of two staff to transfer with an EZ lift (mechanical lift device), and provide incontinent cares. R102's care guide indicated she was to be repositioned every two hours side-to-side, and was to be up for activities every day.	2 900		

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2 900	Continued From page 5 R102's Physician Order Report dated 1/6/21, included orders for: - Beneprotein (protein supplement) 2 scoops twice a day, started 12/14/20 -multivitamin with minerals every evening, started 12/14/20 -Nystatin powder (antifungal) to bilateral groin twice daily after incontinent cares, started 11/19/20 R102's physician orders lacked indication of pressure ulcer treatment. R102's progress notes dated 11/4/20, indicated a skin check was done and completed, and a reddened boil was identified on R102's neck. No other skin impairments were documented at that time. R102's Weekly Skin Documentation form dated 11/4/20, indicated previous skin impairments had resolved, and R102 had a new boil on the left neck. R102's progress notes dated 11/11/20, indicated a skin check was completed, and noted a dressing was in place for a small open area in the left axillary area (armpit). No other skin impairments were documented at that time. R102's progress notes dated 11/13/20, indicated R102 had an open wound on her coccyx measuring 0.5 inches x .25 inches. R102's progress notes further indicated a dressing was applied, a new order to change the dressing daily was to be placed, and findings were to be documented in the skin book. R102's progress notes lacked indication of notification of new skin impairment to the resident representative or the physician. R102's progress note indicated a	2 900		

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2 900	Continued From page 6	2 900		

licensed practical nurse (LPN) observed and measured R102's coccyx wound, but lacked documentation to indicate an assessment of the wound and surrounding skin to define the characteristics and type of wound and surrounding tissues, and identify the type or cause of R102's wound.

R102's Weekly Skin Documentation dated 11/13/20, identified an open area measuring ".5 inches by ¼ inches." The documentation lacked any further assessment of the area, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection.

R102's progress notes dated 11/16/20, indicated the registered dietician (RD) reviewed R102's tube feeding, and noted R102 had an open area on her coccyx per nursing notes dated 11/13/20. R102's progress notes indicated the present dietary regimen was to continue to be followed.

R102's progress notes dated 11/18/20, indicated R102 had a skin check, and skin impairments included a very reddened perineal area, reddened coccyx area, and a boil on the chest. R102's progress note indicated staff applied barrier cream on any reddened areas. R102's progress notes lacked indication of notification of new skin impairment to the resident representative or the physician. The progress note lacked any further assessment of the coccyx pressure ulcer, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection.

R102's progress notes dated 11/25/20, indicated a nursing assistant reported R102 had some redness discoloration on the right inner thigh,

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2 900	Continued From page 7	2 900		

which was measured by a registered nurse (RN). R102's progress notes lacked any documention regarding R102's coccyx pressure ulcer.

R102's progress notes dated 12/2/20, at 10:54 am. indicated R102 had a pressure ulcer on her coccyx that had been identified on 11/13/20 (19 days earlier). The progress note identified a pressure area on the gluteal cleft on a bony prominence, covered with eschar (dead tissue that is tan, brown, or black, and may be crusty) or scab tissue with red, blancheable skin (a normal reaction when reddened tissue turns white with gentle pressure, then goes red again with release of pressure, indicating sufficient blood flow to the area) surrounding the open area. R102's pressure ulcer measured 0.5 centimeters (cm) x 1.0 cm with no depth, and was cleansed with normal saline, skin prep applied, and covered with a foam dressing. R102's progress notes indicated an event was created, treatment was already in place and it was added to weekly wound rounds. R102's progress notes lacked notification of R102's resident representative or physician. R102's progress note lacked staging of R102's coccyx pressure ulcer.

R102's progress notes dated 12/2/20, at 10:34 p.m. indicated a skin check was done, R102 had no new skin areas, and identified redness was still present on R102's coccyx or vaginal area. R102's progress notes lacked assessment of the coccyx pressure ulcer, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection.

R102's Wound Management Detail Report dated 12/2/20, indicated R102's coccyx pressure ulcer was unstageable (had worsened), was covered by 100% eschar, necrotic tissue and measured

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2 900	Continued From page 8 0.5 cm x 1 cm with blancheable redness surrounding the wound. The report lacked indication of notification of new skin impairment to the resident representative or the physician R102's skin integrity event form initiated 12/2/20, indicated R102 had an unstageable pressure area to the coccyx which occurred on 12/2/20. R102's skin integrity event indicated R102's resident representative and physician were notified of R102's skin impairment on 12/11/20, which was 9 days following initiation of the event form for skin integrity and approximately one month following initial identification of R102's pressure ulcer on her coccyx. Orders for R102's pressure ulcer were initiated on 12/11/20, and included side-to-side repositioning, and wound care with cleansing with normal saline, skin prep around edges, and cover with a foam border dressing to be changed every 3 days. R102's progress notes dated 12/3/20, indicated the RD did a review of R102's tube feeding and noted an open area on her coccyx, though the present dietary regimen was continued. R102's progress notes dated 12/4/20, indicated she was repositioned every 2 hours. R102's annual MDS review in progress notes dated 12/6/20, indicated R102 had a new pressure area on her coccyx and therapy had been requested to research new wheelchair seating options. R102's record lacked documentation of assessment of her coccyx pressure ulcer, including wound bed, wound edges, surrounding tissue, stage, location, drainage, pain, or signs of infection. R102's annual skin assessment with Braden	2 900		

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2 900	Continued From page 9 scale (a tool used to assist in determining risk for pressure related skin impairments) dated 12/7/20, identified R102 as being at risk for pressure ulcers related to impaired mobility and need for assistance with bed mobility and incontinent cares, and as having one unstageable pressure ulcer to her coccyx, and a moisture associated skin damage to her groin. R102 had a pressure relieving mattress and wheelchair cushion and was repositioned per her care plan. R102's progress notes dated 12/8/20, indicated a care conference was held with R102's resident representative in attendance, and had few concerns for nursing. R102's progress notes lacked documentation regarding any discussion or notification of R102's pressure ulcer to R102's resident representative. R102's Wound Management Detail Report dated 12/9/20, indicated R102's coccyx pressure ulcer was identified as stage 2, measured 2 cm x 3 cm, with 85% granulation tissue (new connective tissue), and 15% eschar, with well-defined edges, no exudate and was declining. R102's progress notes dated 12/10/20, indicated R102's pressure ulcer had increased in size and measured 2.0 cm x 3.0 cm, with a mostly red granulation and a small area of eschar tissue on the wound bed. R102's wound care was completed with cleansing of the pressure area with normal saline, skin prep applied, and covered with a foam dressing. Repositioning side to side was implemented. R102's progress note further indicated R102's family had not been notified as the observation was made after 9:00 p.m. and an update was sent to wound care team.	2 900		

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2 900	Continued From page 10 R102's progress notes dated 12/11/20, indicated a full air mattress was requested, R102's resident representative was notified of R102's skin breakdown and the air mattress, R102's physician and wound team was updated, and an appointment made for re-molding of R102's custom wheelchair seat. R102's progress notes dated 12/13/20, indicated the dietician was advised of a new pressure ulcer, and assessed R102's nutritional needs and recommended a protein supplement and a multivitamin with minerals to support wound healing. R102's progress notes dated 12/17/20, indicated skin check was completed and R102 had redness to anterior aspects of ankle and bony prominences, redness behind her ear, and a red pressure area on her right ribs 2.3 cm x 0.4 cm, and pressure ulcer to her bottom. R102's medical record between 12/17/20, and 1/5/21, lacked documentation of skin checks and follow up on identified skin impairments identified on 12/17/20. R102's Wound Management Detail Report dated 12/18/20, identified R102's coccyx pressure ulcer a stage 2 measuring 3.0 cm x 2.0 cm with light serous (clear, amber, thin and watery exudate, a wound bed with 75% eschar and 25% slough (dead tissue; white or yellow covering on the base of the wound), with the surrounding dark purple or rusty discoloration with blancheable redness, and was determined to be stable. R102's report misidentified the stage of R102's wound as a Stage 2, though the wound bed was not visible. R102's Wound Management Detail Report dated	2 900		

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2 900	Continued From page 11 1/6/21, for observation on 12/21/20, indicated R102's unstageable coccyx pressure ulcer measured 2.0 cm x 2.5 cm and was 80% slough and 20 % granulation tissue with well-defined wound edges, and blancheable redness surrounding the wound. R102's Wound Management Detail Report dated 1/6/21, for observation on 12/28/20, indicated R102's unstageable coccyx pressure ulcer identified 12/2/20, measured 2.2 cm x 20 cm (incorrect, it should have indicated it was 2.0 cm), was 75% slough and 75% epithelialization tissue (regenerating skin tissue, light pink with a shiny pearl appearance), and well defined edges, surrounded by blancheable redness. R102's Wound Management Detail Report dated 1/4/21, indicated R102's unstageable coccyx pressure ulcer measured 2.0 cm x 2.0 cm and had light serous drainage, with a wound bed of 70% slough, epithelializing tissue and well-defined edges. R102's pressure ulcer was identified as improving. R102's Wound Management Detail Report dated 1/5/21, indicated R102's unstageable coccyx pressure ulcer measured 1.5 cm x 2.2 cm with the wound bed covered by 100% slough, well-defined wound edges and blancheable redness surrounding the ulcer. R102's pressure ulcer was defined as stable. On 1/5/21, at 9:00 a.m. R102 was sitting in her upright wheelchair in her room, with her head drooping to the left. At 10:19 a.m. RN-B entered R102's room to allow R102 to call her family, and closed the door. On 1/5/21, at 10:37 RN-B exited R102's room, and R102 remained sitting in her wheelchair, but	2 900		

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tilted to approximately 45 degrees. RN-B stated she had asked R102 if she would like to lie down and R102 had replied that she did not want to lie down. RN-B stated she would get staff to lay her down to allow for wound inspection and wound care.

On 1/5/21, at 10:45 a.m. R102 was asked if she wanted to lie down and R102 declined, but RN-C explained wound care needed to be done and then she could get back up. R102's pressure ulcer care was observed. R102 complied and 2 staff transferred R102 to her bed with the mechanical lift. RN-B removed the foam dressing from the coccyx pressure ulcer, and described the pressure ulcer as unstageable, and stated there was more slough to it, with the wound bed 100% yellow slough, measuring 1.5 cm x 2.2 cm. R102's pressure ulcer wound edges were well-defined and the tissue surrounding the pressure ulcer was a blancheable redness. R102 had an air mattress on her bed, and a custom dense foam wheelchair seat.

On 1/5/21, at 3:30 p.m. RN-B stated they monitored skin weekly, and she monitored skin impairments, such as pressure ulcers weekly and documented them. RN-B stated she had written the pressure ulcer assessments down, but had not entered them in the medical record yet. RN-B stated R102 had one pressure ulcer that started the beginning of December. RN-B stated when a skin impairment was identified, they notify the wound management team, interdisciplinary team, and enter an "event" in the electronic record. RN-B stated weekly monitoring was initiated, and they notify the physician and family. RN-B verified R102's pressure ulcer had been unstageable since the pressure ulcer was documented on 12/2/20. RN-B was not aware

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2 900	Continued From page 13 R102's pressure ulcer had first been identified on 11/13/20. RN-B stated therapy was to evaluate wheelchair seating, they talked to dietary, increased R102's protein, changed her to an air mattress and changed her repositioning schedule. RN-B stated they now changed her to every hour repositioning. On 1/6/20, at 12:20 p.m. the DON stated R102's coccyx pressure ulcer was first identified on 11/13/20, though the event form documented the identification of the pressure ulcer on 12/2/20. The DON verified R102's medical record lacked documentation of a comprehensive assessment and follow up on R102's pressure ulcer. The DON stated when a skin impairment was identified, an event form should be initiated and the physician and family should be notified. The DON verified R102's family and physician were not notified upon identification of the pressure ulcer, and were not notified upon initiation of the event form. The DON stated interventions were initiated, but it was noted they were not initiated upon identification of the ulcer. The DON stated R102's pressure ulcer had worsened since initial identification on 11/13/20, until the initial RN assessment of the pressure ulcer on 12/2/20. The DON stated notification of the physician and initiation of interventions occurred on 12/10/20, and later. The facility policy Prevention and Treatment of Skin Breakdown dated 2018, directed assessments of a resident's skin integrity to be assessed upon admission and weekly thereafter. Residents with an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown and those with a skin impairment are provided care and services to heal the skin. The facility policy	2 900		

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2 900	Continued From page 14 directed a Braden Skin Risk Assessment be completed upon admission and weekly for the first 4 weeks following admission, and upon a change. Skin is to be observed daily with cares, any skin concerns are to be reported to the licensed nurse and a weekly skin audit is to be completed by licensed nurses. The policy further directed nursing to document a new skin impairment and implement standing orders or protocol, notify the attending provider, resident and resident representative, supervisor, evaluate pressure reduction interventions, revise resident's care plan, notify therapy and interdisciplinary team, and educate resident and resident representative. The licensed nurse was to stage, measure, and examine the wound bed and surrounding skin weekly. Documentation was to reflect the areas addressed in the procedure. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop unavoidable pressure ulcers, and if do, the pressure ulcer does not worsen. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control.	21385		2/1/21

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21385	Continued From page 15 Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene and glove use practices were maintained for 1 of 1 resident (R103) observed during personal cares. Findings include: R103's Resident Face Sheet printed 1/5/21, indicated diagnoses that included stable burst fracture of fourth lumbar vertebra, pneumonitis due to inhalation of food and vomit, and pain in right hip and knee. R103's admission Minimum Data Set (MDS) dated 12/24/20, indicated R103 was cognitively intact. The MDS indicated R103 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. The MDS further indicated R103 was frequently incontinent of bowel and bladder. On 1/4/21, at 2:16 p.m. nursing assistant (NA)-A and NA-B were observed providing cares for R103. NA-A stated they thought R103 was in isolation for "c-diff" (clostridium difficile is a toxin producing bacterium which can infect the bowel, causing illness with diarrhea and fever). There were no isolation signs posted on R103's door to indicate he was in isolation. NA-A and NA-B turned R103 to his side, NA-A removed R103's	21385	Corrected.	

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 01/06/2021

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

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21385	Continued From page 16	21385		

incontinent brief, which was soiled with urine and stool. NA-A cleaned R103 with wipes and applied barrier cream to R103's excoriated buttocks. NA-B reached over and assisted with applying the barrier cream on R103's buttocks. While R103 remained on his side, both NA-A and NA-B removed their soiled gloves, and without performing hand hygiene, put on new gloves. NA-A placed a clean incontinent brief under R103. Both NA-A and NA-B removed their soiled gloves. Both NA-A and NA-B used hand sanitizer on his way out of the room.

-at 2:30 p.m. NA-A was interviewed. NA-A stated he did not perform hand hygiene after changing his soiled gloves. NA-A stated but he performed hand hygiene after all cares were completed.

-at 2:32 p.m. NA-B was interviewed. NA-B stated hand hygiene should be done between glove changes. NA-B also stated if a resident is in isolation for c-diff, hands should be washed with soap and water, which she stated she did after disposing of the water mug after leaving R103's room.

-at 12:23 p.m. registered nurse (RN)-A was interviewed. RN-A was filling in for the director of nursing (DON) who was not available. RN-A stated she would expect hand hygiene to be performed after glove changes.

-at 12:30 p.m. licensed practical nurse (LPN)-C, who was the infection control nurse, was interviewed. LPN-C stated she would expect staff to perform hand hygiene after removing gloves, and prior to donning another pair of gloves.

The facility policy Hand Hygiene dated June 2017, directed staff to perform hand hygiene after

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21385	Continued From page 17 removing gloves or aprons. The policy further directed staff to wash hands with soap and water after known or suspected exposure to Clostridium difficile. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could develop, review, and/or revise policies and procedures to ensure proper hand hygiene is implemented during personal cares to prevent cross contamination. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		

Electronically delivered
January 22, 2021

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: R95011

Dear Administrator:

The above facility was surveyed on January 4, 2021 through January 6, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF

CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Teresa Ament, Unit Supervisor
Duluth District Office
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

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

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

Please feel free to call me with any questions.

Sincerely,

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