

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 Therefore, the NATCEP prohibition is rescinded.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



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>Tamika.Brown@cms.hhs.gov.</u>

### 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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>

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

		AND HUMAN SERVICES				FORM	APPROVED . 0938-0391		
STATEMENT	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				CE CONSTRUCTION	(X3) DAT CON	TE SURVEY MPLETED		
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	survey was comple complaint investiga NOT to be in comp Requirements for L	h 1/6/21, an abbreviated ted at your facility to conduct a tion. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.							
	substantiated: H52 at F686.	plaint was found to be 36058C, with deficiencies cited plaint was found to be 15236059C.							
		f correction (POC) will serve f compliance upon the ptance.							
	signature is not req page of the CMS-2	nrolled in ePOC, your uired at the bottom of the first 567 form. Your electronic POC will be used as bliance.							
	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with							
F 686 SS=D		Prevent/Heal Pressure Ulcer 1)(i)(ii)	F 6	386	3		2/1/21		
	resident, the facility (i) A resident receiv professional standa	sure ulcers. prehensive assessment of a							
	director's or provie	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE 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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	<ul> <li>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.</li> <li>This REQUIREMENT is not met as evidenced by:</li> <li>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.</li> <li>Findings include:</li> <li>Pressure ulcer stages according to the National Pressure Ulcer Advisory Panel:</li> </ul>			R102□s impaired skin i slight improvement with tissue appearing. Nursi new treatment that was 1/18/2021. Care plan in be side-lying with hourly up to custom chair for n hour. Resident receives protein powder currently Vitamin C were added to healing. A whole house audit of n	new granulation ing will continue implemented on acludes resident to repositioning and o greater than an s tube feeding and r. Zinc and o promote wound	
	loss with exposed viable, pink or red, as an intact or rupt Adipose (fat) is no not visible. Granula are not present. Unstageable Press full-thickness skin skin and tissue los damage within the because it is obscu	Ulcer: Partial-thickness skin dermis. The wound bed is moist, and may also present tured serum-filled blister. t visible and deeper tissues are ation tissue, slough and eschar sure Ulcer: Obscured and tissue loss. Full-thickness s in which the extent of tissue ulcer cannot be confirmed ured by slough or eschar. t printed 1/6/21, indicated		<ul> <li>A whole house addition a completed to ensure all are noted and being tracting the process. Any new a will follow our new skin a protocol.</li> <li>All licensed staff were e document weekly skin a the process to follow if a area is found. This includector, family and clinical implementing a treatme protocol.</li> <li>Prevention and Treatme</li> </ul>	areas of pressure cked according to areas of concern assessment ducated on how to assessments and a new impaired udes updating the al manager and nt per our wound	

Facility ID: 00861

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/03/2021 APPROVED 0938-0391
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F 686	(seizures), neuromy curvature of the spi muscle weakness. R102's annual Mini 12/9/20, indicated F cognitive skills for d rejection of care be assistance of two s totally dependent of toileting cares. R10 was always incontir at risk for pressure unstageable unhea addition, R102's MI implemented for sk pressure-reducing on nutrition or hydratio ulcer care and treat dressings, and ointr R102's Care Area A Pressure Ulcer/Inju she was at risk for p impaired mobility, a repositioning. R102 pressure ulcer on h which was treated v and a moisture-ass groin for which she Nystatin powder (ar R102's CAA indicat disability with the po communicate need understand the imp repositioning. R102	ge 2 unction of the brain, epilepsy uscular scoliosis (irregular ne), reduced mobility, and mum Data Set (MDS) dated R102 had moderately impaired laily decision-making, no haviors, required extensive taff for bed mobility, and was n staff for transfers and 2's MDS further indicated she nent of bowel and bladder, was ulcers, and had one led pressure ulcer. In DS identified interventions in impairments including a device for wheelchair and bed, n intervention, and pressure ments with nonsurgical ments and medications. Assessment (CAA) for ry dated 12/9/20, indicated pressure ulcers related to nd required assistance with had one unstageable er coccyx (tailbone area) with a daily dressing change, ociated skin damage to her received treatment with ntifungal medicated powder). ed she had an intellectual otential for the inability to s appropriately or to ortance of the need for 2 was incontinent of bowel and ed assistance with toileting.	F	686	Six audits will be performed weekly include all shifts and units to ensur weekly skin assessment is being completed and documented accord the policy on the resident⊡s bath d Audits will be completed until qualit council deems 100% compliance. DON or designee will be responsib completion of audits. Date of Compliance: 2/1/2021	e the ding to ay. y	

DEPART CENTER		FORM APPROVED OMB NO. 0938-0391					
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 686	was at risk for skin ulcers, and required mobility and total as transfers. R102's of 1/5/21, to direct an repositioning and of an area of the body reclining of wheelch indicated she was w needs known, and s or may request to la revised 1/6/21, with impairment to not g up in her wheelchai side to side every h change every two h care plan further ind wheelchair to provid day. R102's nursing ass provided 1/4/21, dir assistance of two st (mechanical lift dev cares. R102's care be repositioned ever was to be up for act R102's Physician O included orders for: - Beneprotein (prote twice a day, started -multivitamin with m 12/14/20 -Nystatin powder (a twice daily after inco 11/19/20	itiated 6/21/18, indicated R102 impairments and pressure d total assist of one for bed ssist of two with a lift device for are plan was revised on up and down schedule for ffloading (relieving pressure to ) every hour, including hair. R102's care plan verbally able to make her she may refuse repositioning ay down. R102's care plan a goal for R102's coccyx skin et infected, directed staff to be r for one hour, and reposition our when in bed, check and ours and as needed. R102's dicated she had a custom tilt de some offloading during the istant care guide group sheet ected staff to provide total taff to transfer with an EZ lift ice), and provide incontinent guide indicated she was to ery two hours side-to-side, and tivities every day.	F 6	\$86			

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F 686	Continued From pa	ige 4	F 6	86	3			
	pressure ulcer treat	tment.						
	skin check was dor reddened boil was i	otes dated 11/4/20, indicated a ne and completed, and a identified on R102's neck. No ents were documented at that						
	11/4/20, indicated p	n Documentation form dated previous skin impairments had 2 had a new boil on the left						
	a skin check was co dressing was in pla left axillary area (ar	otes dated 11/11/20, indicated ompleted, and noted a lice for a small open area in the rmpit). No other skin documented at that time.						
	R102 had an open measuring 0.5 inch progress notes furth applied, a new order was to be placed, a documented in the notes lacked indica impairment to the re physician. R102's p licensed practical n measured R102's of documentation to in wound and surroun characteristics and surrounding tissues cause of R102's wo	s, and identify the type or ound.						
		n Documentation dated an open area measuring ".5						

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F 686	inches by ¼ inches any further assessr wound bed, wound stage, location, dra infection. R102's progress not the registered dietic tube feeding, and n on her coccyx per r R102's progress not dietary regimen wat R102's progress not R102 had a skin ch included a very red coccyx area, and a progress note indic cream on any redde notes lacked indication impairment to the re- physician. The prog assessment of the including wound be tissue, stage, location infection. R102's progress not a nursing assistant redness discoloration which was measure R102's progress not am. indicated R102's cor am. in	ge 5 ." The documentation lacked nent of the area, including edges, surrounding tissue, inage, pain, or signs of thes dated 11/16/20, indicated cian (RD) reviewed R102's oted R102 had an open area bursing notes dated 11/13/20. Intersting notes dated 11/18/20, indicated eck, and skin impairments dened perineal area, reddened boil on the chest. R102's ated staff applied barrier ened areas. R102's progress tion of notification of new skin esident representative or the gress note lacked any further coccyx pressure ulcer, d, wound edges, surrounding on, drainage, pain, or signs of thes dated 11/25/20, indicated reported R102 had some on on the right inner thigh, ed by a registered nurse (RN). Intes lacked any documention for the surrounder. Intes dated 12/2/20, at 10:54 and a pressure ulcer on her en identified on 11/13/20 (19) progress note identified a ne gluteal cleft on a bony	F	886						

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F 686	prominence, covered that is tan, brown, of scab tissue with red reaction when redd gentle pressure, indicat area) surrounding th pressure ulcer mea 1.0 cm with no dept normal saline, skin with a foam dressin indicated an event wa already in place and wound rounds. R10 notification of R102 physician. R102's poor p.m. indicated a skin no new skin areas, still present on R10 R102's progress no coccyx pressure uld wound edges, surround drainage, pain, or s R102's Wound Mar 12/2/20, indicated F was unstageable (h by 100% eschar, ne 0.5 cm x 1 cm with surrounding the wo indication of notificat the resident represe R102's skin integritt indicated R102 had	ed with eschar (dead tissue or black, and may be crusty) or d, blancheable skin (a normal ened tissue turns white with en goes red again with release ing sufficient blood flow to the he open area. R102's usured 0.5 centimeters (cm) x th, and was cleansed with prep applied, and covered ng. R102's progress notes was created, treatment was d it was added to weekly 02's progress notes lacked t's resident representative or progress note lacked staging ressure ulcer. totes dated 12/2/20, at 10:34 in check was done, R102 had and identified redness was 12's coccyx or vaginal area. otes lacked assessment of the cer, including wound bed, bunding tissue, stage, location,	F 6	86			

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		AND HUMAN SERVICES				FORM	02/03/2021 APPROVED 0938-0391
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NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER			35 KENWOOD AVENUE DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 686	resident representa notified of R102's s which was 9 days for form for skin integri month following init pressure ulcer on h pressure ulcer were included side-to-sid care with cleansing around edges, and dressing to be char R102's progress not the RD did a review noted an open area present dietary regi R102's progress not she was repositioned R102's annual MDS dated 12/6/20, indic pressure area on he been requested to r seating options. R1 documentation of a pressure ulcer, inclu edges, surrounding drainage, pain, or s R102's annual skin scale (a tool used to pressure related ski identified R102 as to ulcers related to im assistance with bed cares, and as having	y event indicated R102's tive and physician were kin impairment on 12/11/20, oblowing initiation of the event ty and approximately one ial identification of R102's er coccyx. Orders for R102's e initiated on 12/11/20, and e repositioning, and wound with normal saline, skin prep cover with a foam border nged every 3 days. Ates dated 12/3/20, indicated of R102's tube feeding and on her coccyx, though the men was continued. Ates dated 12/4/20, indicated ed every 2 hours. S review in progress notes cated R102 had a new er coccyx and therapy had research new wheelchair 02's record lacked ssessment of her coccyx uding wound bed, wound tissue, stage, location,	F6	\$86			

Facility ID: 00861

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		AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:			.TIPI ING	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED	
		245236	B. WING			C 01/06/2021		
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDI	CTINE HEALTH CENT	ER			935 KENWOOD AVENUE DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	skin damage to her relieving mattress a was repositioned per R102's progress no care conference wa representative in at concerns for nursin lacked documentation or notification of R1 resident representa R102's Wound Mar 12/9/20, indicated F was identified as st with 85% granulation tissue), and 15% es no exudate and was R102's progress no R102's progress no R102's pressure ut measured 2.0 cm x granulation and a s the wound bed. R1 completed with clear with normal saline, covered with a foan to side was implem further indicated R1 notified as the obse p.m. and an update team. R102's progress no a full air mattress w representative was breakdown and the physician and wour	groin. R102 had a pressure and wheelchair cushion and er her care plan. tes dated 12/8/20, indicated a as held with R102's resident tendance, and had few g. R102's progress notes ion regarding any discussion 02's pressure ulcer to R102's tive. nagement Detail Report dated R102's coccyx pressure ulcer age 2, measured 2 cm x 3 cm, on tissue (new connective schar, with well-defined edges,	Fθ	86				

Facility ID: 00861

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PRINTED: 02/03/2021

		AND HUMAN SERVICES					F	ORM	APPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES           AND PLAN OF CORRECTION           (X1) PROVIDER/SUPPLIER/CLIA           IDENTIFICATION NUMBER:					۶LE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	Э_				
		245236	B. WING						C 06/2021
NAME OF F	PROVIDER OR SUPPLIER				ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BENEDIO	CTINE HEALTH CENT	ER				5 KENWOOD AVENUE JLUTH, MN 55811			
(X4) ID		TEMENT OF DEFICIENCIES	ID		Τ	PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR( DEFICIENCY)			COMPLETION DATE
F 686	Continued From pa	ae 9	F 6	58F	6				
	custom wheelchair	•							
	the dietician was ac and assessed R102 recommended a pro-	ates dated 12/13/20, indicated dvised of a new pressure ulcer, 2's nutritional needs and otein supplement and a inerals to support wound							
	skin check was con to anterior aspects prominences, reduc	ess behind her ear, and a red er right ribs 2.3 cm x 0.4 cm,							
	1/5/21, lacked docu	ord between 12/17/20, and imentation of skin checks and ed skin impairments identified							
	12/18/20, identified a stage 2 measurin serous (clear, ambe- wound bed with 75 (dead tissue; white of the wound), with rusty discoloration was determined to misidentified the sta	nagement Detail Report dated R102's coccyx pressure ulcer g 3.0 cm x 2.0 cm with light er, thin and watery exudate, a % eschar and 25% slough or yellow covering on the base the surrounding dark purple or with blancheable redness, and be stable. R102's report age of R102's wound as a e wound bed was not visible.							
	1/6/21, for observat R102's unstageable measured 2.0 cm x and 20 % granulatio	nagement Detail Report dated ion on 12/21/20, indicated e coccyx pressure ulcer 2.5 cm and was 80% slough on tissue with well-defined blancheable redness							

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PRINTED: 02/03/2021

	-	AND HUMAN SERVICES			FORI	D: 02/03/2021 MAPPROVED D. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	ATE SURVEY	
		245236	B. WING		C 01/06/2021		
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COD	E		
BENEDIC	TINE HEALTH CENT	ER		935 KENWOOD AVENUE DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 686	Continued From pa surrounding the wo	-	F 68	36			
	1/6/21, for observat R102's unstageable identified 12/2/20, r (incorrect, it should was 75% slough an (regenerating skin t	nagement Detail Report dated tion on 12/28/20, indicated e coccyx pressure ulcer neasured 2.2 cm x 20 cm have indicated it was 2.0 cm), of 75% epithelialization tissue tissue, light pink with a shiny and well defined edges, cheable redness.					
	1/4/21, indicated R <sup>-</sup> pressure ulcer mea had light serous dra 70% slough, epithe	R102's pressure ulcer was					
	1/5/21, indicated R <sup>-</sup> pressure ulcer mea the wound bed cover well-defined wound	nagement Detail Report dated 102's unstageable coccyx isured 1.5 cm x 2.2 cm with ered by 100% slough, edges and blancheable g the ulcer. R102's pressure is stable.					
	upright wheelchair i drooping to the left. R102's room to allo closed the door. On 1/5/21, at 10:37 and R102 remained tilted to approximat she had asked R10 and R102 had repli	a.m. R102 was sitting in her in her room, with her head At 10:19 a.m. RN-B entered w R102 to call her family, and RN-B exited R102's room, d sitting in her wheelchair, but ely 45 degrees. RN-B stated 2 if she would like to lie down ed that she did not want to lie I she would get staff to lay her					

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	-	AND HUMAN SERVICES				FORM	: 02/03/2021 APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED	
		245236	B. WING_			C 01/06/2021		
NAME OF F	NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDIC	CTINE HEALTH CENT	ER			35 KENWOOD AVENUE ULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 686	care. On 1/5/21, at 10:45 wanted to lie down explained wound ca then she could get ulcer care was obse staff transferred R1 mechanical lift. RN from the coccyx pre- the pressure ulcer at there was more slo 100% yellow slough R102's pressure ulcer well-defined and the pressure ulcer was had an air mattress dense foam wheeld On 1/5/21, at 3:30 p monitored skin wee impairments, such a documented them. the pressure ulcer a not entered them in stated R102 had on the beginning of De skin impairment wa wound managemer and enter an "event RN-B stated weekly they notify the phys verified R102's pres unstageable since to documented on 12/	a.m. R102 was asked if she and R102 declined, but RN-C are needed to be done and back up. R102's pressure erved. R102 complied and 2 02 to her bed with the I-B removed the foam dressing essure ulcer, and described as unstageable, and stated ugh to it, with the wound bed h, measuring 1.5 cm x 2.2 cm. cer wound edges were e tissue surrounding the a blancheable redness. R102 on her bed, and a custom thair seat. b.m. RN-B stated they ekly, and she monitored skin as pressure ulcers weekly and RN-B stated she had written assessments down, but had the medical record yet. RN-B he pressure ulcer that started ecember. RN-B stated when a is identified, they notify the nt team, interdisciplinary team, t" in the electronic record. y monitoring was initiated, and ician and family. RN-B ssure ulcer had been the pressure ulcer was '2/20. RN-B was not aware	F 68	86				
	11/13/20. RN-B sta	cer had first been identified on ated therapy was to evaluate they talked to dietary,						

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		AND HUMAN SERVICES					FORM	02/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		PLE CONSTRUCTION	0	(X3) DATI COM	E SURVEY IPLETED
		245236	B. WING	i				C 06/2021
NAME OF	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP C	ODE	-	
BENEDI	CTINE HEALTH CENT	ER			935 KENWOOD AVENUE DULUTH, MN 55811			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 686	increased R102's p mattress and chang schedule. RN-B sta every hour reposition On 1/6/20, at 12:20 coccyx pressure uld 11/13/20, though the identification of the The DON verified F documentation of a and follow up on R2 stated when a skin event form should b R102's family and p upon identification of were not notified up The DON stated intervent identification of the pressure ulcer had identification on 11/ assessment of the DON stated notificat initiation of intervent and later. The facility policy P Skin Breakdown data assessed upon adm Residents with an in integrity are provide reduce the potentiat those with a skin im and services to heat directed a Braden S	rotein, changed her to an air ged her repositioning ated they now changed her to oning. p.m. the DON stated R102's cer was first identified on e event form documented the pressure ulcer on 12/2/20. R102's medical record lacked comprehensive assessment 102's pressure ulcer. The DON impairment was identified, an be initiated and the physician the notified. The DON verified obysician were not notified obysician were not notified of the pressure ulcer, and boon initiation of the event form. terventions were initiated, but it re not initiated upon ulcer. The DON stated R102's worsened since initial 13/20, until the initial RN pressure ulcer on 12/2/20. The ation of the physician and tions occurred on 12/10/20,	F	586				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245236	B. WING _		C 01/06/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER		935 KENWOOD AVENUE DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686 F 880 SS=D	first 4 weeks followichange. Skin is to any skin concerns a licensed nurse and completed by license directed nursing to impairment and imp protocol, notify the and resident repress pressure reduction care plan, notify the team, and educate representative. The measure, and exan surrounding skin we reflect the areas ad Infection Prevention CFR(s): 483.80(a)(() §483.80 Infection C The facility must es infection prevention designed to provide comfortable environ development and tr diseases and infection program. The facility must es and control program a minimum, the foll §483.80(a)(1) A sys reporting, investigat and communicable	ing admission, and upon a be observed daily with cares, are to be reported to the a weekly skin audit is to be sed nurses. The policy further document a new skin blement standing orders or attending provider, resident entative, supervisor, evaluate interventions, revise resident's erapy and interdisciplinary resident and resident e licensed nurse was to stage, nine the wound bed and eekly. Documentation was to dressed in the procedure. n & Control 1)(2)(4)(e)(f) control tablish and maintain an and control program e a safe, sanitary and ment and to help prevent the ansmission of communicable ions. n prevention and control tablish an infection prevention n (IPCP) that must include, at owing elements: etem for preventing, identifying, ting, and controlling infections diseases for all residents, sitors, and other individuals	F 68			2/1/21

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PRINTED: 02/03/2021

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245236	B. WING				C 06/2021
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER			935 KENWOOD AVENUE DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	conducted accordin accepted national s §483.80(a)(2) Writte procedures for the p but are not limited to (i) A system of surve possible communic infections before the persons in the facili (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pre (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos- circumstances. (v) The circumstance must prohibit emplo disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in o §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens.	I upon the facility assessment og to §483.70(e) and following tandards; en standards, policies, and program, which must include, o: eillance designed to identify able diseases or ey can spread to other ty; oom possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a out not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the ces under which the facility oyees with a communicable skin lesions from direct the disease; and he procedures to be followed direct resident contact.	Fξ	380			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		245236	B. WING _		C 01/06/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER		935 KENWOOD AVENUE DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	transport linens so a infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observat review, the facility fa hygiene and glove of for 1 of 1 resident (f personal cares. Findings include: R103's Resident Fa indicated diagnoses fracture of fourth lui due to inhalation of right hip and knee. R103's admission M dated 12/24/20, ind intact. The MDS ind extensive assistand toilet use, and perso indicated R103 was bowel and bladder. On 1/4/21, at 2:16 p and NA-B were obs R103. NA-A stated isolation for "c-diff" producing bacteriur causing illness with were no isolation si indicate he was in is	as to prevent the spread of eview. duct an annual review of its heir program, as necessary. NT is not met as evidenced tion, interview, and document ailed to ensure proper hand use practices were maintained R103) observed during ace Sheet printed 1/5/21, is that included stable burst mbar vertebra, pneumonitis food and vomit, and pain in <i>M</i> inimum Data Set (MDS) icated R103 was cognitively dicated R103 required the with bed mobility, dressing, onal hygiene. The MDS further is frequently incontinent of o.m. nursing assistant (NA)-A served providing cares for they thought R103 was in (clostridium difficile is a toxin n which can infect the bowel, diarrhea and fever). There gns posted on R103's door to solation. NA-A and NA-B	F 88	R103 is no longer in our facility The staff identified immediately knew made a mistake and correctly identifi what the correct procedure was. Clir leadership met with both staff to revis hand hygiene policy and procedure. I staff acknowledged they understand policy and procedure. Five audits wi conducted on the identified associate the next three shifts and will continue 100% compliance is met. Staff will be provided education on infection prevention strategies that includes hand hygiene, additionally s will go through a hand hygiene competency check. Six hand hygiene and PPE complian- audits will be performed each day an every shift for the next seven days st 01/28/2021. Quantity of audits will be adjusted based on associates results the audit. Audits will continue until qu council deems 100% compliance.	ied nical ew both the II be es for e until staff ce tarting e s of uality	
1	turned R103 to his	side, NA-A removed R103's		Date of Compliance: 2/1/2021		

Facility ID: 00861

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		AND HUMAN SERVICES			FORM	02/03/2021 APPROVED
STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COM	0938-0391 E SURVEY PLETED
		245236	B. WING			C 06/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER		935 KENWOOD AVENUE DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	incontinent brief, wi stool. NA-A cleaned barrier cream to R1 NA-B reached over barrier cream on R remained on his sid removed their soile performing hand hy NA-A placed a clea R103. Both NA-A and gloves. Both NA-A and gloves. Both NA-A and gloves. Both NA-A and on his way out of th -at 2:30 p.m. NA-A he did not perform th his soiled gloves. N hand hygiene after -at 2:32 p.m. NA-B hand hygiene should changes. NA-B also isolation for c-diff, h soap and water, wh disposing of the wa room. -at 12:23 p.m. regist interviewed. RN-A v nursing (DON) who stated she would ex- performed after glo -at 12:30 p.m. licen who was the infective interviewed. LPN-C to perform hand hyg and prior to donning	hich was soiled with urine and d R103 with wipes and applied 103's excoriated buttocks. and assisted with applying the 103's buttocks. While R103 de, both NA-A and NA-B d gloves, and without /giene, put on new gloves. in incontinent brief under nd NA-B removed their soiled and NA-B used hand sanitizer he room. was interviewed. NA-A stated hand hygiene after changing IA-A stated but he performed all cares were completed. was interviewed. NA-B stated ld be done between glove o stated if a resident is in hands should be washed with hich she stated she did after ther mug after leaving R103's stered nurse (RN)-A was was filling in for the director of o was not available. RN-A xpect hand hygiene to be we changes. stated she would expect staff giene after removing gloves, g another pair of gloves.	F 880			
		land Hygiene dated June				

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		AND HUMAN SERVICES				FORM	02/03/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		245236	B. WING	i			
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	ER			35 KENWOOD AVENUE DULUTH, MN 55811		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	removing gloves or directed staff to wa	inge 17 To perform hand hygiene after aprons. The policy further sh hands with soap and water bected exposure to Clostridium	F	380			

Facility ID: 00861

Minnesc	ta Department of He	ealth				ATTROVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMP	SURVEY PLETED
		00861	B. WING		01/0	C )6/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR	NOOD AVEN MN 55811	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	Department's staff the following correc The following comp SUBSTANTIATED: order issued at S0	1/6/21, surveyors of this visited the above provider and ction orders are issued. plaint was found to be H5236058C with a licensing				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 01/29/21

Electronically Signed

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If continuation sheet 1 of 18

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00861	B. WING			06/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR	WOOD AVENU , MN 55811	IE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." For are the Suggested Time period for Cor You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "corr text. You must then State licensure pro- completion date, the corrected prior to el Minnesota Departm PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA IS NO REQUIREMI CORRECTION FO	Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled " ID Prefix tute/rule out of compliance is ary Statement of Deficiencies' es the "To Comply" portion of . This column also includes are in violation of the state tement, "This Rule is not met illowing the surveyors findings Method of Correction and rection. participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be ectronically submitting to the nent of Health. RD THE HEADING OF THE I WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED C
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NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	
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2 900	Continued From pa	ge 2	2 900		
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900		2/1/21
	comprehensive res of nursing services development of a n provides that: A. a resident wh without pressure so pressure sores unle	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician			
	authenticates, that B. a resident w receives necessar	they were unavoidable; and ho has pressure sores y treatment and services to revent infection, and prevent			
	by: Based on observati review, the facility f identified pressure assessed and inter time of identification	ent is not met as evidenced ion, interview, and document ailed to ensure a newly ulcer was comprehensively ventions were initiated at the n, to prevent worsening of the 1 of 4 residents (R102) ure ulcers.		Corrected	
	Findings include:				
	Pressure ulcer stag Pressure Ulcer Adv	es according to the National isory Panel:			
	loss with exposed oviable, pink or red,	Jlcer: Partial-thickness skin dermis. The wound bed is moist, and may also present ured serum-filled blister.			

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2 900	Continued From pa	ge 3	2 900			
not visible. Granulati are not present. Unstageable Pressu full-thickness skin ar skin and tissue loss damage within the ul because it is obscure R102's Face Sheet p R102's diagnoses in malformation syndro development and fur (seizures), neuromus	not visible. Granula	visible and deeper tissues are tion tissue, slough and eschar				
	full-thickness skin a skin and tissue loss damage within the	ure Ulcer: Obscured and tissue loss. Full-thickness s in which the extent of tissue ulcer cannot be confirmed red by slough or eschar.				
	printed 1/6/21, indicated ncluded congenital rome that affects the normal unction of the brain, epilepsy uscular scoliosis (irregular ne), reduced mobility, and					
	12/9/20, indicated F cognitive skills for c rejection of care be assistance of two s totally dependent of toileting cares. R10 was always incontir at risk for pressure unstageable unhea addition, R102's MI implemented for sk pressure-reducing of nutrition or hydratio ulcer care and treat	mum Data Set (MDS) dated R102 had moderately impaired laily decision-making, no haviors, required extensive taff for bed mobility, and was n staff for transfers and 2's MDS further indicated she nent of bowel and bladder, was ulcers, and had one led pressure ulcer. In DS identified interventions in impairments including a device for wheelchair and bed, n intervention, and pressure tments with nonsurgical ments and medications.	3			
	Pressure Ulcer/Inju she was at risk for impaired mobility, a	Assessment (CAA) for ry dated 12/9/20, indicated pressure ulcers related to and required assistance with thad one unstageable				

	IDENTIFICATION NUMBER:	A. BUILDING: _		COM	E SURVEY PLETED
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PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 900 Continued From pag	je 4	2 900			
<ul> <li>pressure ulcer on he which was treated w and a moisture-asso groin for which she r Nystatin powder (and R102's CAA indicate disability with the pot communicate needs understand the imporepositioning. R102 bladder, and required R102's care plan init was at risk for skin ir ulcers, and required mobility and total ass transfers. R102's care 1/5/21, to direct an u repositioning and off an area of the body) reclining of wheelchair indicated she was veneeds known, and shor may request to lay revised 1/6/21, with a impairment to not ge up in her wheelchair side to side every ho change every two ho care plan further indi wheelchair to provide day.</li> <li>R102's nursing assis provided 1/4/21, dire assistance of two sta (mechanical lift devic cares. R102's care plan</li> </ul>	er coccyx (tailbone area) ith a daily dressing change, ociated skin damage to her received treatment with tifungal medicated powder). ed she had an intellectual tential for the inability to appropriately or to ortance of the need for was incontinent of bowel and d assistance with toileting. tiated 6/21/18, indicated R102 mpairments and pressure total assist of one for bed sist of two with a lift device for are plan was revised on up and down schedule for 'loading (relieving pressure to every hour, including				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00861		CONSTRUCTION	СОМ	E SURVEY PLETED C 06/2021
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2 900	Continued From pa	ge 5	2 900			
	included orders for: - Beneprotein (prote twice a day, started -multivitamin with m 12/14/20 -Nystatin powder (a twice daily after inco 11/19/20 R102's physician or pressure ulcer treat R102's progress no skin check was dor reddened boil was i other skin impairmet time. R102's Weekly Skin	ein supplement) 2 scoops 12/14/20 ninerals every evening, started intifungal) to bilateral groin ontinent cares, started rders lacked indication of				
	resolved, and R102 neck. R102's progress no a skin check was or dressing was in pla left axillary area (ar	tes dated 11/11/20, indicated ompleted, and noted a ce for a small open area in the mpit). No other skin documented at that time.				
	R102's progress no R102 had an open measuring 0.5 inch progress notes furtl applied, a new orde was to be placed, a documented in the notes lacked indica impairment to the re	otes dated 11/13/20, indicated wound on her coccyx es x .25 inches. R102's her indicated a dressing was er to change the dressing daily ind findings were to be skin book. R102's progress tion of notification of new skin esident representative or the progress note indicated a				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMI	E SURVEY PLETED
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	•	-	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.					
	the registered dietic tube feeding, and r on her coccyx per r R102's progress no	otes dated 11/16/20, indicated cian (RD) reviewed R102's noted R102 had an open area nursing notes dated 11/13/20. otes indicated the present s to continue to be followed.				
	R102 had a skin ch included a very red coccyx area, and a progress note indic cream on any redd notes lacked indica impairment to the r physician. The prog assessment of the including wound be	otes dated 11/18/20, indicated neck, and skin impairments dened perineal area, reddened boil on the chest. R102's cated staff applied barrier ened areas. R102's progress ation of notification of new skin esident representative or the gress note lacked any further coccyx pressure ulcer, ed, wound edges, surrounding ion, drainage, pain, or signs of				
	a nursing assistant	otes dated 11/25/20, indicated reported R102 had some on on the right inner thigh,				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		СОМ	E SURVEY PLETED
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2 900	Continued From pa	age 7	2 900			
	R102's progress no	which was measured by a registered nurse (RN). R102's progress notes lacked any documention regarding R102's coccyx pressure ulcer.				
regarding R102's coccyx p R102's progress notes dat am. indicated R102 had a coccyx that had been iden days earlier). The progress pressure area on the glute prominence, covered with that is tan, brown, or black scab tissue with red, bland reaction when reddened ti gentle pressure, then goes of pressure, indicating suff area) surrounding the oper pressure ulcer measured ( 1.0 cm with no depth, and normal saline, skin prep ap with a foam dressing. R10 indicated an event was creater already in place and it was wound rounds. R102's progress of R102's progress notes dat p.m. indicated a skin chec no new skin areas, and ide still present on R102's cocc R102's progress notes lac coccyx pressure ulcer, inc	2 had a pressure ulcer on her en identified on 11/13/20 (19 progress note identified a ne gluteal cleft on a bony ed with eschar (dead tissue or black, and may be crusty) or d, blancheable skin (a normal lened tissue turns white with en goes red again with release ing sufficient blood flow to the the open area. R102's asured 0.5 centimeters (cm) x th, and was cleansed with prep applied, and covered ng. R102's progress notes was created, treatment was d it was added to weekly 02's progress notes lacked 2's resident representative or progress note lacked staging					
	p.m. indicated a ski no new skin areas, still present on R10 R102's progress no coccyx pressure ule wound edges, surre drainage, pain, or s	ounding tissue, stage, location, igns of infection.				
	12/2/20, indicated F was unstageable (h	nagement Detail Report dated R102's coccyx pressure ulcer nad worsened), was covered ecrotic tissue and measured				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 01/06/2021	
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2 900	Continued From pa	ge 8	2 900			
	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.					
	the RD did a review noted an open area	otes dated 12/3/20, indicated / of R102's tube feeding and a on her coccyx, though the men was continued.				
	R102's progress no she was repositione	otes dated 12/4/20, indicated ed every 2 hours.				
	dated 12/6/20, indic pressure area on h been requested to a seating options. R1 documentation of a pressure ulcer, incl	ssessment of her coccyx uding wound bed, wound tissue, stage, location,				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C		
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2 900	scale (a tool used to pressure related sk identified R102 as b ulcers related to im assistance with bed cares, and as havin ulcer to her coccyx, skin damage to her relieving mattress a was repositioned pe R102's progress no care conference wa representative in at concerns for nursin lacked documentati or notification of R1 resident representa R102's Wound Mar 12/9/20, indicated F was identified as sta with 85% granulatio tissue), and 15% es no exudate and was R102's progress no R102's measured 2.0 cm x granulation and a si the wound bed. R1 completed with clea with normal saline, covered with a foan to side was implement further indicated R1 notified as the obset	b assist in determining risk for in impairments) dated 12/7/20 being at risk for pressure paired mobility and need for I mobility and incontinent ig one unstageable pressure and a moisture associated groin. R102 had a pressure and wheelchair cushion and er her care plan. tes dated 12/8/20, indicated a as held with R102's resident tendance, and had few g. R102's progress notes ion regarding any discussion 02's pressure ulcer to R102's tive. hagement Detail Report dated R102's coccyx pressure ulcer age 2, measured 2 cm x 3 cm, on tissue (new connective schar, with well-defined edges,					

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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2 900	Continued From pa	ige 10	2 900			
	a full air mattress w representative was breakdown and the physician and wour appointment made custom wheelchair R102's progress no the dietician was ac	otes dated 12/11/20, indicated vas requested, R102's resident notified of R102's skin e air mattress, R102's nd team was updated, and an for re-molding of R102's seat. otes dated 12/13/20, indicated dvised of a new pressure ulcer 2's nutritional needs and				
	recommended a pr multivitamin with m healing. R102's progress no skin check was cor	otein supplement and a inerals to support wound otes dated 12/17/20, indicated npleted and R102 had redness				
		ess behind her ear, and a red er right ribs 2.3 cm x 0.4 cm,				
	1/5/21, lacked docu	ord between 12/17/20, and Imentation of skin checks and ed skin impairments identified				
	12/18/20, identified a stage 2 measurin serous (clear, ambo wound bed with 750	nagement Detail Report dated R102's coccyx pressure ulcer g 3.0 cm x 2.0 cm with light er, thin and watery exudate, a % eschar and 25% slough or yellow covering on the base				
	of the wound), with rusty discoloration was determined to misidentified the sta	the surrounding dark purple of with blancheable redness, and be stable. R102's report age of R102's wound as a wound bed was not visible.	-			
		nagement Detail Report dated				

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED	
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2 900	Continued From pa	-	2 900				
	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.						
	1/6/21, for observa R102's unstageabl identified 12/2/20, r (incorrect, it should was 75% slough ar (regenerating skin	nagement Detail Report dated tion on 12/28/20, indicated e coccyx pressure ulcer measured 2.2 cm x 20 cm I have indicated it was 2.0 cm), nd 75% epithelialization tissue tissue, light pink with a shiny and well defined edges, incheable redness.					
	1/4/21, indicated R pressure ulcer mea had light serous dra 70% slough, epithe	. R102's pressure ulcer was					
	1/5/21, indicated R pressure ulcer mea the wound bed cov well-defined wound	nagement Detail Report dated 102's unstageable coccyx asured 1.5 cm x 2.2 cm with rered by 100% slough, d edges and blancheable ng the ulcer. R102's pressure as stable.					
	upright wheelchair drooping to the left R102's room to allo closed the door. On 1/5/21, at 10:37	a.m. R102 was sitting in her in her room, with her head . At 10:19 a.m. RN-B entered ow R102 to call her family, and Y RN-B exited R102's room, d sitting in her wheelchair, but					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:				
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2 900	Continued From pa	ge 12	2 900				
	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.						
	monitored skin wee impairments, such documented them. the pressure ulcer a not entered them in stated R102 had or the beginning of De skin impairment wa wound managemer and enter an "event RN-B stated weekly	b.m. RN-B stated they ekly, and she monitored skin as pressure ulcers weekly and RN-B stated she had written assessments down, but had the medical record yet. RN-B he pressure ulcer that started ecember. RN-B stated when a is identified, they notify the the team, interdisciplinary team, t" in the electronic record. y monitoring was initiated, and ician and family. RN-B					

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2 900	R102's pressure uld 11/13/20. RN-B sta wheelchair seating, increased R102's pr mattress and chang schedule. RN-B sta every hour repositio On 1/6/20, at 12:20 coccyx pressure uld 11/13/20, though the identification of the The DON verified R documentation of a and follow up on R1 stated when a skin i event form should b and family should b R102's family and p upon identification of were not notified up The DON stated intr was noted they were identification of the pressure ulcer had identification of the pressure ulcer had identification of the pressure ulcer had identification of the pressure ulcer had identification of a sessment of the p DON stated notifica initiation of intervent and later. The facility policy Pt Skin Breakdown dat assessed upon adm Residents with an in integrity are provide reduce the potential	cer had first been identified on ted therapy was to evaluate they talked to dietary, rotein, changed her to an air ged her repositioning ated they now changed her to ming. p.m. the DON stated R102's cer was first identified on e event form documented the pressure ulcer on 12/2/20. 102's medical record lacked comprehensive assessment 02's pressure ulcer. The DON impairment was identified, an be initiated and the physician e notified. The DON verified hysician were not notified of the pressure ulcer, and on initiation of the event form. erventions were initiated, but if e not initiated upon ulcer. The DON stated R102's worsened since initial 13/20, until the initial RN pressure ulcer on 12/2/20. The tion of the physician and tions occurred on 12/10/20,		DEFICIENC		

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2 900	Continued From pa	ge 14	2 900			
	completed upon ad first 4 weeks follow change. Skin is to any skin concerns a licensed nurse and completed by licens directed nursing to impairment and imp protocol, notify the and resident represe pressure reduction care plan, notify the team, and educate representative. The measure, and examples	Skin Risk Assessment be mission and weekly for the ing admission, and upon a be observed daily with cares, are to be reported to the a weekly skin audit is to be sed nurses. The policy further document a new skin blement standing orders or attending provider, resident sentative, supervisor, evaluate interventions, revise resident's erapy and interdisciplinary resident and resident e licensed nurse was to stage, nine the wound bed and eekly. Documentation was to ldressed in the procedure.	5			
	The Director of Nur develop, review, an procedures to ensu unavoidable pressu pressure ulcer does The Director of Nur educate all appropr procedures. The Director of Nur	THOD OF CORRECTION: rsing or designee could id/or revise policies and ire residents do not develop ire ulcers, and if do, the s not worsen. rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21385	MN Rule 4658.0800 Staff assistance	0 Subp. 3 Infection Control;	21385			2/1/21

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00861		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/06/2021	
						00/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR	1WOOD AVEN 1, MN 55811	IUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLET DATE
IAO				DEFICIENCY		
21385	Continued From pa	ge 15	21385			
	infection control pro the residents and n	assigned to assist with the ogram, based on the needs of ursing home, to implement ocedures of the infection				
	by: Based on observati review, the facility f hygiene and glove	ent is not met as evidenced ion, interview, and document ailed to ensure proper hand use practices were maintained R103) observed during	b	Corrected.		
	Findings include:					
	indicated diagnoses fracture of fourth lu	ace Sheet printed 1/5/21, s that included stable burst mbar vertebra, pneumonitis food and vomit, and pain in				
	dated 12/24/20, ind intact. The MDS ind extensive assistand toilet use, and perso	Minimum Data Set (MDS) licated R103 was cognitively dicated R103 required ce with bed mobility, dressing, onal hygiene. The MDS furthe s frequently incontinent of				
	and NA-B were obs R103. NA-A stated isolation for "c-diff" producing bacteriur causing illness with were no isolation si	o.m. nursing assistant (NA)-A served providing cares for they thought R103 was in (clostridium difficile is a toxin m which can infect the bowel, diarrhea and fever). There gns posted on R103's door to solation. NA-A and NA-B				

STATEMEN	ota Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		00861			01/	01/06/2021	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST				
BENEDI	CTINE HEALTH CENT	FR	WOOD AVENU , MN 55811	JE			
(X4) ID	-		ID	PROVIDER'S PLAN OF		(X5)	
PREFIX TAG	REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE	
21385	Continued From pa	age 16	21385				
	stool. NA-A cleaned barrier cream to R1 NA-B reached over barrier cream on R remained on his sid removed their soile performing hand hy NA-A placed a clea R103. Both NA-A a gloves. Both NA-A a gloves. Both NA-A on his way out of th -at 2:30 p.m. NA-A he did not perform his soiled gloves. N hand hygiene after	hich was soiled with urine and d R103 with wipes and applied 103's excoriated buttocks. and assisted with applying the 103's buttocks. While R103 de, both NA-A and NA-B ed gloves, and without ygiene, put on new gloves. In incontinent brief under nd NA-B removed their soiled and NA-B used hand sanitizer ne room. was interviewed. NA-A stated hand hygiene after changing IA-A stated but he performed r all cares were completed. was interviewed. NA-B stated					
	hand hygiene shou changes. NA-B also isolation for c-diff, h soap and water, wh disposing of the wa room.	Id be done between glove o stated if a resident is in hands should be washed with hich she stated she did after ater mug after leaving R103's					
	interviewed. RN-A nursing (DON) who	stered nurse (RN)-A was was filling in for the director of o was not available. RN-A xpect hand hygiene to be ove changes.					
	who was the infecti interviewed. LPN-C to perform hand hy	used practical nurse (LPN)-C, ion control nurse, was C stated she would expect staff giene after removing gloves, g another pair of gloves.					
		land Hygiene dated June f to perform hand hygiene after					

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00861	B. WING		C 01/06/2021		
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	ADDRESS, CITY, STATE, ZIP CODE				
BENEDIC	CTINE HEALTH CENT	FR	VOOD AVENU MN 55811	IE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE	
21385	directed staff to wa after known or sus difficile. SUGGESTED MET The Director of Nu develop, review, ar procedures to ensu implemented durin cross contaminatio The Director of Nu educate all approp procedures. The Director of Nu develop monitoring compliance.	r aprons. The policy further ish hands with soap and water pected exposure to Clostridium THOD OF CORRECTION: rsing and/or designee could nd/or revise policies and ure proper hand hygiene is g personal cares to prevent	21385	DEFICIENCY			
inesota De	epartment of Health						



Protecting, Maintaining and Improving the Health of All Minnesotans

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 <u>only a suggestion</u> 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 <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</u>. 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

Benedictine Health Center January 22, 2021 Page 2 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