DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 22, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: March 8, 2022

Dear Administrator:

On April 18, 2022, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 22, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: Reinspection Results
Event ID: 5INK12

Dear Administrator:

On April 18, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 18, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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
March 25, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: March 8, 2022

Dear Administrator:

On March 8, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 8, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 8, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / 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
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 03/08/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 3/7/22 through 3/8/22, a standard abbreviated investigation survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5236085C (MN81298), with deficiencies cited at (F580). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		4/4/22

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

Electronically Signed | 04/04/2022

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 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	R1 discharged and did not return to the	

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F 580	Continued From page 2 facility failed to ensure a resident's medical provider was notified in a timely manner of a change in condition for 1 of 1 resident (R1) related to a change in vital signs, poor appetitie, insulin refusals and deterioraring respiratory status. The facility's failure resulted in actual harm for R1 whose treatment was delayed despite requiring an increase in oxygen from 2 liters (L) to 6 L since hospital discharge and an elevated temperature of 100.5 degrees. R1 required hospitalization related to a low oxygen saturation level of 54% even with the use of 6 L of oxygen. Findings include: R1's diagnoses obtained from the hospital Discharge Summary dated 12/17/20, included: fracture of unspecified part of left clavicle, primary subsequent encounter for fracture with routine healing, chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure chronic diastolic (congestive) heart failure, chronic atrial fibrillation, abnormalities of gait and mobility and weakness. Review of R1's nurse's notes revealed the following: -Admission Note dated 12/17/20, at 9:40 p.m. indicated R1 was admitted to the facility for rehabilitation from the hospital where he had been treated for gastrointestinal (GI) bleeding and left clavicle fracture secondary to resident reporting he "felt a pop" while transferring into his wheelchair and had experienced left shoulder/clavicle pain. The note indicated R1 was alert and orientated, but had some memory loss/forgetfulness. The note also indicated R1's lung sounds were somewhat diminished in	F 580	facility An audit was completed of all current residents for any changes of conditions that were not yet reported to resident's physician or resident representative. Facility policy for Change in Condition reviewed and remains appropriate. Staff education provided to all licensed nurses in regards to policy and procedures for notification of changes to physicians and resident representative's. Two audits per week of all residents will be conducted weekly to review residents with a change in condition to ensure appropriate notifications were completed. Compliance date April 4th, 2022	

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F 580	Continued From page 3	F 580		

bilateral bases and some crackles were noted to right lower lobe. R1 had shortness of breath with minimal exertion, was unable to tolerate lying in bed, and had reported he felt too short of breath even with head of bed elevated at 90 degrees. Further the note indicated R1 reported he preferred to sit/sleep in his recliner at night and wore continuous oxygen at 2 liters (L) via nasal cannula. The resident's oxygen saturation was identified as 92%.

-Progress Note dated 12/18/20, at 10:54 a.m. indicated R1 had a temperature of 99.3 this AM (morning) with resident also de-sating (blood oxygen levels dropping) to 76-77% on 2 L of oxygen, with respirations at 24 per minute. The note also indicated the resident complained of "mild" congestion that started "about 2 days ago" and was complaining of feeling light headed while at rest in wheelchair. Resident also stated he felt more fatigued and weaker in comparison to yesterday. Resident had some conflicting reports; told therapy he was experiencing shortness of breathe (SOB) at night and did not get any adequate sleep and told writer that he had a good night of sleep and denied SOB. Lung sounds diminished. Binex swab was negative for Covid. The note indicated St. Luke's Community Care (SLCC) was updated and orders were obtained to check labs which included complete blood count (CBC) with differential, comprehensive metabolic panel (CMP- is a test that measures 14 different substances in your blood), B-type natriuretic peptide (BNP- blood test measures the levels of the BNP hormone in your blood which can indicate heart failure), daily weights are to be obtained every morning, chest x-ray and oxygen orders changed to state "maintain oxygen [02] between 88-92%, document liter flow." The note

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further indicated R1's oxygen had been increased from 2 LPM to 5 LPM to get the oxygen saturations up to 88-89% . There was no documentation/order for the oxygen liter flow being bumped above 4 liters according to the nurse practitioner.

-Progress Note dated 12/18/20, at 1:52 p.m. indicated, "Chest X-ray came back with the following impression: Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia. The heart size and pulmonary vascularity appear stable. The right hemidiaphragm remains elevated. The lateral view is nondiagnostic. Results faxed to SLCC. Lab results still pending. Infection nurse and nurse manager updated. Copy of results placed in resident's chart."

-Progress Note dated 12/18/20, at 5:22 p.m. indicated labs had been drawn and the tests that were elevated (high) included: BNP 196.0 with normal levels (0.0-100.0 K/ul); carbon dioxide (C02) 38 with normal level (23-32 mmol/L); glucose 112 (60-99 mg/dL); blood urea nitrogen 27 (a test that reveals how well one's kidneys are working with normal levels 8-23 mg/dL); WBC 12.3 (a blood test to measure the number of white blood cells in the blood. WBC's help fight infections with normal level 4.0-10.0 K/uL) and Neutrophils 8.95 (a type of white blood cell that act as the immune system's first line of defense. Having a high percentage of neutrophils in the blood is a sign that a person's body has an infection with normal levels 1.56-6.13 K/uL). The noted further indicated Family member (FM)-A was updated, a copy of results were placed in resident's chart, the rounding nurse practitioner

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(NP) was updated, and an order for CBC and BMP to be rechecked on Monday was obtained.

During further review of R1's medical record it was revealed the medical record lacked who the rounding NP was who provided the orders to repeat the labs on 12/21/20. There was also no record of the order as a telephone order or verbal order written in R1's medical record for re-checking the labs. In addition, the medical record lacked documentation from the rounding physician/NP of why other treatments were not initiated despite R1 having elevated white blood cell count at 12.3 with normal levels (3.8-10.6) and Neutrophil's 8.95 with normal levels (1.8-7.8) despite this being abnormal compared to the last labs obtained prior to discharge from the hospital the day prior, 12/17/20, when results of 9.4 for WBC and 6.1 Neutrophil's (both normal lab values) were identified.

-Progress Note dated 12/18/20, at 9:59 p.m. indicated "Resident is alert and orientated, can use call light and verbalize needs. Resident had no complaints of pain. Resident had complaints of increased SOB when getting ready for bed, oxygen saturation was at 87% on 5 L, Resident was situated into his recliner and told to take deep breathes through his nose, oxygen was turned up to 6 L and nurse observed him taking deep breaths, resident is now sating at 92% on 6 L. Resident's blood sugars were 169 and 110."

-Admission Note dated 12/19/20, at 1:50 a.m. indicated "Resident is able to make needs known, uses call light appropriately. Resident complains of SOB, oxygen on at 6 L, oxygen saturation at 91%, sitting in recliner as it is easier to for resident to breath. Resident had temp of 100.3

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this NOC [night] shift. Residents blood sugar was 110 at bedtime [HS], had HS snack. Resident had chest x-ray done today, still awaiting results. COVID swab done, still awaiting results." The progress note lacked evidence the physician/provider had been contacted about the elevated temperature as this was the first time following the abnormal x-ray and chest x-ray with pending labs on 12/21/20.

-New Admit Note dated 12/19/20, at 3:04 p.m. indicated "Resident ate poorly this day shift. Held insulin due to BS [blood suger] only 74 in am and poor appetite. Res refused noon insulin. Ate only about 1/3 of lunch. BS was 282 before lunch, res still did not want the insulin. Next nurse notified. Res sats were in the low 90's on 6 L high flow O2. Some SOB noted at times, especially when lying in bed to change. Res could not tolerate this, was put back in reclining chair, but sitting upright all shift. Staff able to calm res SOB down by talking him thru deep slow breathing exercises. Afebrile for day shift. Tolerated dressing change. Small yellowing drainage on removed dressing. Wrapped right lower extremity after dressing change and wrapped Kerlix on left lower extremity. Lung sounds [LS] are dim [diminished] with some wheezing noted in upper lobes." The note lacked evidence the physician/provider had been updated on staff holding the insulin as ordered, poor appetite and resident noted "wheezing in upper lobes."

-Admission/Medicare Note dated 12/19/20, at 11:35 p.m. indicated "Resident's lung sounds remain diminished in bilateral bases. He has shortness of breath with minimal exertion and is unable to tolerate lying in bed, as he reports he feels too short of breath--even with head of bed

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F 580	Continued From page 7	F 580		

elevated 90 degrees. He prefers to sit/sleep in recliner. Oxygen sats are 92% on 6 L via NC [nasal cannula]. No cough noted. Resident remains afebrile. Denied chest pain. Left shoulder/clavicle and left lower extremity/stump pain effectively managed with scheduled Gabapentin and prn [as needed] Tylenol. Resident resting comfortably in recliner at this time."

-Admission Note dated 12/20/20, at 3:10 a.m. indicated "Resident able to make needs known, uses call light appropriately. Resident complains of SOB, on 6 L oxygen, sitting in recliner due to [d/t] easier to breath sitting up. Temp [temperature] 100.5. Resident wanted blood sugar [BS] checked d/t feeling low, blood sugars 112 at 0120 [1:20 a.m.] with snack given after checking, rechecked at 0245 [2:45 a.m.]with blood sugar of 234 [2:34 a.m.], feels a little better. No PRN [as needed] medication given. No scheduled medications given. Resident remains on enhanced precautions awaiting Covid testing results." The noted lacked evidence of the physician/provider being updated of the continued SOB and elevated temperature. In addition, the note did not indicate the oxygen saturation level R1 was at with the 6 liters of oxygen.

-New Admit Note dated 12/20/20, at 1:56 p.m. indicated "Res SOB [short of breath]at times. Sats in the 88-90% range on 6 L of O2 [oxygen]. Res appetite poor, insulin held. Granddaughter called for update and stated res has had some history [hx] of bowel obstructions. Res had 2 loose large stools this shift. Granddaughter insisted loose stool could mean an obstruction for him. Abd [abdomen] non-tender, hard. BS [bowel sounds]are active. Res was asked about

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pain/discomfort, res stated his shoulder was uncomfortable, but not that bad. Gave PRN Tylenol. Granddaughter stated res has a hard time telling people of how much pain he is in. Res does state at times he has a hard time breathing. Some anxiety noted with resident. Granddaughter would like res tested further for bacterial pneumonia and possible bowel obstruction. Res is stable, informed granddaughter we are waiting Covid test results. Will update RN case manager and pass on to St Lukes Community Care for f/u [follow up]." The medical record lacked documentation of a physician/provider being updated of the loose stools, insulin being held and R1's responsible party requesting R1 to be tested further related to the issues R1 was experiencing. In addition, the medical record lacked evidence of the nurse manager and SLCC being updated to follow up on the concerns.

-Admission/Medicare Note dated 12/20/20, at 11:40 p.m. indicated "Resident is a diabetic and his blood sugars this shift were 265 prior to dinner. Resident ate less than 25% of dinner, stating he had no appetite. Writer held scheduled 45 units of Novolog secondary to poor intake. At HS, resident's blood sugar was 456. He reported he did not eat anything since dinner. Writer administered the 45 units of Novolog previously held, along with 80 units of scheduled Lantus. At 2230 resident's blood sugar was 118. He was provided an HS snack of milk and Lorna Dune diabetic friendly cookies. Resident's lung sounds remain diminished in bilateral bases. He has shortness of breath with minimal exertion and is unable to tolerate lying in bed, as he reports he feels too short of breath--even with head of bed elevated 90 degrees. He prefers to sit/sleep in recliner. Oxygen sats are 93% on high flow

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BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE DULUTH, MN 55811**

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oxygen of 6 L via NC. No cough noted. Resident remains afebrile. Denied chest pain. Left shoulder/clavicle and left lower extremity/stump pain effectively managed with scheduled Gabapentin and PRN Tylenol. Resident resting comfortably in recliner at this time." The medical noted lacked evidence of the provider/physician being updated of staff holding the scheduled insulin at 4:30 p.m. then administering it at HS together with scheduled Lantus (long acting insulin) and R1's continued report of feeling "too short of breath" plus the diminished lung sounds.

-Shift Note dated 12/21/20, at 3:37 a.m. indicated "Beginning midnight resident's O2 dropped between 88 to 54 on 6 L free airflow. O2 sat went back up to 90 with help of deep breathing. O2 sat continued going up and down through the night till 3 am. Unable to keep sat above 88, stayed 74." Writer called on-call St Lukes Community Care physician who gave verbal order to send R1 to emergency room (ER). Nurse at ER was updated with resident's condition. Family member was notified, and resident consent to going to ER. The medical record lacked documentation of the provider/physician being notified timely when the oxygen saturation levels were dropping between 88% to 54% beginning at midnight so the physician could make the decision to continue monitoring R1 at the facility or send R1 to the hospital. The nurse waited until 3:00 a.m. which was 3 hours later and although R1's oxygen saturations went back to 90% with deep breathing, R1's oxygen level continued to go up and down through the night. In addition, the medical record lacked documentation of what the oxygen levels were through out the time frame from when the level stayed at 74% upon which the nurse called the on-call physician who gave

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order to send R1 to ER. The note also lacked R1's temperature at the time of the assessment prior to transferring R1 to the hospital.

During review of the physician orders the following was revealed:
-12/18/20, order for O2 to keep sats between 88-92%. Document liter flow every shift.
-12/18/20, check temperature, blood pressure (BP), pulse, respirations and O2 sats once daily. Special Instructions: Report Temperature over 100 to registered nurse [RN]."

During review of the hospital Internal Med Progress Note dated 12/23/20, the note indicated R1's admitting diagnoses included COPD exacerbation, congestive heart failure exacerbation, acute hypercapnia (elevated carbon dioxide level), respiratory failure, acute and chronic diastolic congestive heart failure and acute respiratory failure with hypoxia. The note indicated a CT scan of the chest had been completed with the following results "Extensive ground glass [finding on CT (computerized tomography) scan that indicates a partial filling of air spaces in the lungs], interstitial and airspace opacities were seen throughout the bilateral hemithoraces likely representing pulmonary edema versus multifocal with associated small basilar effusions and compressive atelectasis." In addition, the note indicated R1 had blood gas showing acute respiratory acidosis with arterial blood gas (ABG- test measures the oxygen and carbon dioxide levels in your blood) with carbon dioxide level of 82 with normal levels (35-45 mmHg); WBC 13.5 K/ul with normal (4.0-10.0 K/ul) and due to R1 showing signs of respiratory distress R1 was started on Lasix (water pill), BiPap (a type of ventilator machine used to treat

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chronic conditions that affect your breathing), Solumedrol (used to treat many different inflammatory conditions including exacerbations) and two antibiotics Azithromycin and Rocephin).

During interview on 3/7/22, at 12:39 p.m. RN-A clinical coordinator stated she recalled R1 coming from the hospital and seemed medically complex and did not feel it was a safe discharge from the hospital. RN-A stated she had tried to work with the other nurse to make sure R1 got all the orders he needed to get good care. RN-A stated after going through her documentation, the chest x-ray was inconclusive and she had brought it up to the provider and had updated the responsible party. RN-A then stated without reviewing the medical record and from the little she could remember R1 had been tested for Covid-19 and the result ended up testing negative. RN-A stated after she had received the results for the x-ray and the labs she had documented them in the progress note and she had contacted the provider about R1 along the way as she wanted R1 to be managed. When asked where she would document which provider she had contacted she stated it would have been the resident notes. RN-A also stated she also would have communicated with the supervisor RN-B, nurse on the cart or would have documented in the 24 hour board. RN-A stated usually the process was if a resident oxygen level they were receiving needed to be bumped, or there was a change in condition, or a significant lab result typically the expectation was "we contact the on-call so we know how to proceed moving forward. I know when I was working with him I was keeping close contact with the providers I don't recall who I spoke with."

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During interview on 3/7/22, at 1:34 p.m. licensed practical nurse (LPN)-A reviewed both her progress note for 12/19/20 at 3:04 p.m. and 12/20/20, at 1:56 p.m. and verified R1 had been on 6 liters of oxygen and had still continued to complain of being short of breath. LPN-A stated during both times she had worked with R1, she had found R1 was on 6 liters of oxygen and that was what R1 had for the shift. LPN-A stated from her recollection, R1 "was very sick and had a lot of things wrong." When asked about the charting and who she had spoken to or updated regarding R1's responsible party concerns on 12/20/20, at 1:56 p.m. progress note, LPN-A stated after reading the note she had spoken to R1's responsible party because the responsible party was insisting about the loose stools and had questioned if R1 had a bowel obstruction. LPN-A also stated she had assessed R1, and had passed the responsible party concern to the RN manager and RN-B. When asked where she would have documented who she had communicated about R1's responsible party concerns, LPN-A stated she would have called the on-call, put a "SBAR" Situation, Background, Assessment and Recommendation note in the provider binder for the provider to review when in the building next or could have done both. LPN-A acknowledged the medical record lacked documentation of her following up with the responsible party concerns to review the course for treatment. LPN-A further acknowledged it was the weekend and since the nurse manager was not in the building she could have sent an e-mail.

During interview on 3/7/22, at 4:49 p.m. primary facility nurse practitioner (NP) stated he had not seen R1 as the resident was admitted on 12/17/20, which was a Thursday and R1 was sent

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to the hospital 12/21/20, before he could do the first visit with R1. The NP reviewed the lab result for 12/18/20, and acknowledged R1 had an elevated WBC count. NP stated although the 12/18/20, results were elevated for WBC count and the Neutrophils, it was hard to draw a conclusion if R1 had an infection because someone had to look at the previous labs results to compare the trends. The NP stated going by the nursing note about the provider being updated of the lab results on 12/18/20, it appeared at 5:22 p.m. he would have been off work that time and the facility nurse would have called the on-call at those hours. The NP acknowledged he did not have any documentation of seeing R1 or regarding the nurse update of the lab results and the chest x-ray. The NP reviewed R1's hospital lab results dated 12/17/20, and acknowledged R1 had within normal WBC count and Neutrophils which was different from the labs on 12/18/20. The NP reviewed the staff nursing notes and stated according to the notes, R1 had appeared to have gotten worse as the night went on from 12/18/20, and was going a different direction compared to the hospital labs. When asked if the nurses were supposed to call the on-call about R1's elevated temperatures, SOB, loose stools, responsible party concerns about treatment, insulin being held and the lung sounds, the NP stated someone had to review the whole picture including the chest x-ray, code status if R1 had any specific measures and the lab results. The NP stated since R1 was on 2 liters of oxygen from the hospital and continued to need more, normally staff were to run the oxygen flow rate at 1-4 liters, the nurses should have known to call the on-call with a change of condition when they had increased the oxygen to over 4 liters. "The question is the nursing judgement we are only as

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good as our notes. Someone's judgement must have felt he was not deteriorating. When did he tip when someone should have been notified." When asked about the chest x-ray indicating the result was: "Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia" the NP stated it was hard to answer the question about what atypical meant because this question would have to be asked of the person who read the x-ray. The NP stated atypical infectious process in simple terms "would be like walking pneumonia, they did not say consolidation it's like more of a fog like look mycoplasma. It's hard to know with atypical because it was not showing fluid lines so I think that's the challenge. It will be difficult to be able to tell from the x-ray if it's viral pneumonia. It's hard to put judgement into this."

During interview on 3/7/20, at 3:37 p.m. the interim director of nursing (DON) stated the chest x-ray results from 12/18/20, were faxed to the NP and the rounding NP had also been updated of the lab results and had given orders to re-check CBC and BMP on Monday 12/21/20, which were both seen by RN-A. The interim DON stated R1 was "very sick" when he was admitted to the facility. The interim DON acknowledged the medical record lacked documentation of the nurses notifying the provider/physician through the weekend when R1 had elevated temperatures, insulin was held, when the responsible party had concerns with R1's condition and the decreased oxygen saturation levels leading up to being sent to the hospital. The interim DON stated, "I see there was no documentation of the nurses doing a follow up during the day. Myself, I have gone over the notes and looked at them. He was not eating and

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they were not giving him his insulin and this is in the notes." The interim DON acknowledged the nurses had opportunities to notify the physician between the course of the 3 days when the resident required the increased oxygen level, as the standing house was 1-4 liters, when R1 had a temperature and stated that was the reason why RN-C was no longer working at the facility.

During interview on 3/7/22, at 5:28 p.m. when asked about her documentation regarding R1's diminished lung sounds, RN-B stated she had reviewed the chest x-ray and the lab results which had been faxed to SLCC and in her opinion nothing had changed with R1's lung sounds from admission. RN-B stated R1 continued to have the intolerance to lying in bed from admit. RN-B stated to her R1 looked like he had improved compared to when he had admitted to the facility because at admission time "he was compensated and I felt we needed to keep a close eye on him we had been keeping the primary informed I felt with the labs and x-ray being done. I was not there during the night shift when he was sent in to judge what he was like. RN-B stated, "During my shift, when we notice people are not at their baseline we follow the care plan and the treatment orders and if we feel a resident has had a change in condition we would notify the doctor." RN-B also stated, "If family came back and was questioning the treatment plan, basically I would do an assessment and update the RN coordinator, she is right there able to be in contact with the provider and would update them. We would e-mail the care coordinator and update St Luke's Community Care on the weekends on-call and tell them what is going on and would find out what they want us to do." RN-B then stated, "I train the nurses to do a SBAR

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[Situation- Background -Assessment - Recommendation] and tell them if something is urgent they need to call the on-call or you can fax a SBAR to the provider during the business hours." When asked where the SBARs completed for residents were kept, RN-B stated some of the providers will sign off on the SBARs as orders and others will write it in the orders as there is no regulation of where really they can document the orders. RN-B further stated, "The nurses are supposed to write notes of what is going on with the residents during their shifts." RN-B reviewed R1's notes leading up to being sent to the hospital and acknowledged there was no documentation of what the resident condition was before the nurse notified the physician who ordered R1 to be sent to the hospital.

During interview with the medical director (MD) on 3/8/22, 8:18 a.m. when asked about the chest X-ray results, "Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia." The facility MD stated atypical mycoplasma pneumonia like Covid could be either bacterial or viral however, in R1's chest x-ray, it would have been bacterial pneumonia but the result did not come out and say that. The MD stated he was aware of R1's incident however, acknowledged he had not reviewed R1's medical record. The MD stated the issue was R1 had tests completed and the staff were aware of the x-ray results and the labs and the rounding nurse practitioner had ordered the labs to be repeated in 3 days adding, "I would say someone should have had a nurse practitioner or someone on call to have weighed in on it given the fact he was continuing to have the sats going down even with the increased oxygen and the other things including the

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temperature. The nurses are to notify the provider on call to see if there was need to alter the course of treatment." The MD further stated there was just a lot of things which made the issue complex including the medical history and being the weekend which should not be an excuse. "They should have called the on-call."

The facility undated Change in Condition policy directed the following:
"Purpose: To provide care and services based upon the current needs of the resident under the direction of the attending provider. To inform resident/resident representative and attending provider when a significant change in resident condition occurs.

Policy: When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative

Procedure
Licensed nursing associate:
1. Assess significant change in the resident's condition noted through direct observation, interview or report for other staff.
2. Obtain a set of vital signs and repeat as needed or ordered.
3. Open Matrix Event and conduct a symptom review and assessment, as condition warrants.
4. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the Medical Director, as appropriate.

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F 580	Continued From page 18 5. Notify the appropriate members of the IDT (interdisciplinary) team. 6. Notify the resident/resident representative. 7. Document symptom(s), assessment, observations, resident/resident representative, and medical provider notification. 8. Monitor and provide treatment as ordered by the attending provider. 9. Update the care plan as appropriate..."	F 580		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 25, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: 5INK11

Dear Administrator:

The above facility was surveyed on March 7, 2022 through March 8, 2022 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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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
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

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BENEDICTINE HEALTH CENTER	**935 KENWOOD AVENUE DULUTH, MN 55811**

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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 3/7/22, through 3/8/22, a complaint investigation survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000	*****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has	

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	00861	A. BUILDING: _____ B. WING _____	C 03/08/2022

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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H5236085C (MN81298), with a licensing order issued at 0265. 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 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 surveyor ' s 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of	2 000	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:	

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2 000	Continued From page 2 state form. 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.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;	2 265		4/4/22

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2 265	Continued From page 3 D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a resident's medical provider was notified in a timely manner of a change in condition for 1 of 1 resident (R1) related to a change in vital signs, poor appetitie, insulin refusals and deterioraring respiratory status. The facility's failure resulted in actual harm for R1 whose treatment was delayed despite requiring an increase in oxygen from 2 liters (L) to 6 L since hospital discharge and an elevated temperature of 100.5 degrees. R1 required hospitalization related to a low oxygen saturation level of 54% even with the use of 6 L of oxygen. Findings include: R1's diagnoses obtained from the hospital Discharge Summary dated 12/17/20, included: fracture of unspecified part of left clavicle, primary subsequent encounter for fracture with routine healing, chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure chronic diastolic (congestive) heart failure, chronic atrial fibrillation, abnormalities of gait and mobility and weakness. Review of R1's nurse's notes revealed the following: -Admission Note dated 12/17/20, at 9:40 p.m. indicated R1 was admitted to the facility for rehabilitation from the hospital where he had	2 265	Corrected.	

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been treated for gastrointestinal (GI) bleeding and left clavicle fracture secondary to resident reporting he "felt a pop" while transferring into his wheelchair and had experienced left shoulder/clavicle pain. The note indicated R1 was alert and orientated, but had some memory loss/forgetfulness. The note also indicated R1's lung sounds were somewhat diminished in bilateral bases and some crackles were noted to right lower lobe. R1 had shortness of breath with minimal exertion, was unable to tolerate lying in bed, and had reported he felt too short of breath even with head of bed elevated at 90 degrees. Further the note indicated R1 reported he preferred to sit/sleep in his recliner at night and wore continuous oxygen at 2 liters (L) via nasal cannula. The resident's oxygen saturation was identified as 92%.

-Progress Note dated 12/18/20, at 10:54 a.m. indicated R1 had a temperature of 99.3 this AM (morning) with resident also de-sating (blood oxygen levels dropping) to 76-77% on 2 L of oxygen, with respirations at 24 per minute. The note also indicated the resident complained of "mild" congestion that started "about 2 days ago" and was complaining of feeling light headed while at rest in wheelchair. Resident also stated he felt more fatigued and weaker in comparison to yesterday. Resident had some conflicting reports; told therapy he was experiencing shortness of breathe (SOB) at night and did not get any adequate sleep and told writer that he had a good night of sleep and denied SOB. Lung sounds diminished. Binex swab was negative for Covid. The note indicated St. Luke's Community Care (SLCC) was updated and orders were obtained to check labs which included complete blood count (CBC) with differential, comprehensive metabolic panel (CMP- is a test that measures 14 different

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substances in your blood), B-type natriuretic peptide (BNP- blood test measures the levels of the BNP hormone in your blood which can indicate heart failure), daily weights are to be obtained every morning, chest x-ray and oxygen orders changed to state "maintain oxygen [02] between 88-92%, document liter flow." The note further indicated R1's oxygen had been increased from 2 LPM to 5 LPM to get the oxygen saturations up to 88-89% . There was no documentation/order for the oxygen liter flow being bumped above 4 liters according to the nurse practitioner.

-Progress Note dated 12/18/20, at 1:52 p.m. indicated, "Chest X-ray came back with the following impression: Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia. The heart size and pulmonary vascularity appear stable. The right hemidiaphragm remains elevated. The lateral view is nondiagnostic. Results faxed to SLCC. Lab results still pending. Infection nurse and nurse manager updated. Copy of results placed in resident's chart."

-Progress Note dated 12/18/20, at 5:22 p.m. indicated labs had been drawn and the tests that were elevated (high) included: BNP 196.0 with normal levels (0.0-100.0 K/ul); carbon dioxide (C02) 38 with normal level (23-32 mmol/L); glucose 112 (60-99 mg/dL); blood urea nitrogen 27 (a test that reveals how well one's kidneys are working with normal levels 8-23 mg/dL); WBC 12.3 (a blood test to measure the number of white blood cells in the blood. WBC's help fight infections with normal level 4.0-10.0 K/uL) and Neutrophils 8.95 (a type of white blood cell that act as the immune system's first line of defense.

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Having a high percentage of neutrophils in the blood is a sign that a person's body has an infection with normal levels 1.56-6.13 K/uL). The noted further indicated Family member (FM)-A was updated, a copy of results were placed in resident's chart, the rounding nurse practitioner (NP) was updated, and an order for CBC and BMP to be rechecked on Monday was obtained.

During further review of R1's medical record it was revealed the medical record lacked who the rounding NP was who provided the orders to repeat the labs on 12/21/20. There was also no record of the order as a telephone order or verbal order written in R1's medical record for re-checking the labs. In addition, the medical record lacked documentation from the rounding physician/NP of why other treatments were not initiated despite R1 having elevated white blood cell count at 12.3 with normal levels (3.8-10.6) and Neutrophil's 8.95 with normal levels (1.8-7.8) despite this being abnormal compared to the last labs obtained prior to discharge from the hospital the day prior, 12/17/20, when results of 9.4 for WBC and 6.1 Neutrophil's (both normal lab values) were identified.

-Progress Note dated 12/18/20, at 9:59 p.m. indicated "Resident is alert and orientated, can use call light and verbalize needs. Resident had no complaints of pain. Resident had complaints of increased SOB when getting ready for bed, oxygen saturation was at 87% on 5 L, Resident was situated into his recliner and told to take deep breathes through his nose, oxygen was turned up to 6 L and nurse observed him taking deep breaths, resident is now sating at 92% on 6 L. Resident's blood sugars were 169 and 110."

-Admission Note dated 12/19/20, at 1:50 a.m.

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indicated "Resident is able to make needs known, uses call light appropriately. Resident complains of SOB, oxygen on at 6 L, oxygen saturation at 91%, sitting in recliner as it is easier to for resident to breath. Resident had temp of 100.3 this NOC [night] shift. Residents blood sugar was 110 at bedtime [HS], had HS snack. Resident had chest x-ray done today, still awaiting results. COVID swab done, still awaiting results." The progress note lacked evidence the physician/provider had been contacted about the elevated temperature as this was the first time following the abnormal x-ray and chest x-ray with pending labs on 12/21/20.

-New Admit Note dated 12/19/20, at 3:04 p.m. indicated "Resident ate poorly this day shift. Held insulin due to BS [blood suger] only 74 in am and poor appetite. Res refused noon insulin. Ate only about 1/3 of lunch. BS was 282 before lunch, res still did not want the insulin. Next nurse notified. Res sats were in the low 90's on 6 L high flow O2. Some SOB noted at times, especially when lying in bed to change. Res could not tolerate this, was put back in reclining chair, but sitting upright all shift. Staff able to calm res SOB down by talking him thru deep slow breathing exercises. Afebrile for day shift. Tolerated dressing change. Small yellowing drainage on removed dressing. Wrapped right lower extremity after dressing change and wrapped Kerlix on left lower extremity. Lung sounds [LS] are dim [diminished] with some wheezing noted in upper lobes." The note lacked evidence the physician/provider had been updated on staff holding the insulin as ordered, poor appetite and resident noted "wheezing in upper lobes."

-Admission/Medicare Note dated 12/19/20, at 11:35 p.m. indicated "Resident's lung sounds

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remain diminished in bilateral bases. He has shortness of breath with minimal exertion and is unable to tolerate lying in bed, as he reports he feels too short of breath--even with head of bed elevated 90 degrees. He prefers to sit/sleep in recliner. Oxygen sats are 92% on 6 L via NC [nasal cannula]. No cough noted. Resident remains afebrile. Denied chest pain. Left shoulder/clavicle and left lower extremity/stump pain effectively managed with scheduled Gabapentin and prn [as needed] Tylenol. Resident resting comfortably in recliner at this time."

-Admission Note dated 12/20/20, at 3:10 a.m. indicated "Resident able to make needs known, uses call light appropriately. Resident complains of SOB, on 6 L oxygen, sitting in recliner due to [d/t] easier to breath sitting up. Temp [temperature] 100.5. Resident wanted blood sugar [BS] checked d/t feeling low, blood sugars 112 at 0120 [1:20 a.m.] with snack given after checking, rechecked at 0245 [2:45 a.m.]with blood sugar of 234 [2:34 a.m.], feels a little better. No PRN [as needed] medication given. No scheduled medications given. Resident remains on enhanced precautions awaiting Covid testing results." The noted lacked evidence of the physician/provider being updated of the continued SOB and elevated temperature. In addition, the note did not indicate the oxygen saturation level R1 was at with the 6 liters of oxygen.

-New Admit Note dated 12/20/20, at 1:56 p.m. indicated "Res SOB [short of breath]at times. Sats in the 88-90% range on 6 L of O2 [oxygen]. Res appetite poor, insulin held. Granddaughter called for update and stated res has had some history [hx] of bowel obstructions. Res had 2 loose large stools this shift. Granddaughter

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insisted loose stool could mean an obstruction for him. Abd [abdomen] non-tender, hard. BS [bowel sounds]are active. Res was asked about pain/discomfort, res stated his shoulder was uncomfortable, but not that bad. Gave PRN Tylenol. Granddaughter stated res has a hard time telling people of how much pain he is in. Res does state at times he has a hard time breathing. Some anxiety noted with resident. Granddaughter would like res tested further for bacterial pneumonia and possible bowel obstruction. Res is stable, informed granddaughter we are waiting Covid test results. Will update RN case manager and pass on to St Lukes Community Care for f/u [follow up]." The medical record lacked documentation of a physician/provider being updated of the loose stools, insulin being held and R1's responsible party requesting R1 to be tested further related to the issues R1 was experiencing. In addition, the medical record lacked evidence of the nurse manager and SLCC being updated to follow up on the concerns.

-Admission/Medicare Note dated 12/20/20, at 11:40 p.m. indicated "Resident is a diabetic and his blood sugars this shift were 265 prior to dinner. Resident ate less than 25% of dinner, stating he had no appetite. Writer held scheduled 45 units of Novolog secondary to poor intake. At HS, resident's blood sugar was 456. He reported he did not eat anything since dinner. Writer administered the 45 units of Novolog previously held, along with 80 units of scheduled Lantus. At 2230 resident's blood sugar was 118. He was provided an HS snack of milk and Lorna Dune diabetic friendly cookies. Resident's lung sounds remain diminished in bilateral bases. He has shortness of breath with minimal exertion and is unable to tolerate lying in bed, as he reports he feels too short of breath--even with head of bed

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elevated 90 degrees. He prefers to sit/sleep in recliner. Oxygen sats are 93% on high flow oxygen of 6 L via NC. No cough noted. Resident remains afebrile. Denied chest pain. Left shoulder/clavicle and left lower extremity/stump pain effectively managed with scheduled Gabapentin and PRN Tylenol. Resident resting comfortably in recliner at this time." The medical noted lacked evidence of the provider/physician being updated of staff holding the scheduled insulin at 4:30 p.m. then administering it at HS together with scheduled Lantus (long acting insulin) and R1's continued report of feeling "too short of breath" plus the diminished lung sounds.

-Shift Note dated 12/21/20, at 3:37 a.m. indicated "Beginning midnight resident's O2 dropped between 88 to 54 on 6 L free airflow. O2 sat went back up to 90 with help of deep breathing. O2 sat continued going up and down through the night till 3 am. Unable to keep sat above 88, stayed 74." Writer called on-call St Lukes Community Care physician who gave verbal order to send R1 to emergency room (ER). Nurse at ER was updated with resident's condition. Family member was notified, and resident consent to going to ER. The medical record lacked documentation of the provider/physician being notified timely when the oxygen saturation levels were dropping between 88% to 54% beginning at midnight so the physician could make the decision to continue monitoring R1 at the facility or send R1 to the hospital. The nurse waited until 3:00 a.m. which was 3 hours later and although R1's oxygen saturations went back to 90% with deep breathing, R1's oxygen level continued to go up and down through the night. In addition, the medical record lacked documentation of what the oxygen levels were through out the time frame from when the level stayed at 74% upon which

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the nurse called the on-call physician who gave order to send R1 to ER. The note also lacked R1's temperature at the time of the assessment prior to transferring R1 to the hospital.

During review of the physician orders the following was revealed:
-12/18/20, order for O2 to keep sats between 88-92%. Document liter flow every shift.
-12/18/20, check temperature, blood pressure (BP), pulse, respirations and O2 sats once daily. Special Instructions: Report Temperature over 100 to registered nurse [RN]."

During review of the hospital Internal Med Progress Note dated 12/23/20, the note indicated R1's admitting diagnoses included COPD exacerbation, congestive heart failure exacerbation, acute hypercapnia (elevated carbon dioxide level), respiratory failure, acute and chronic diastolic congestive heart failure and acute respiratory failure with hypoxia. The note indicated a CT scan of the chest had been completed with the following results "Extensive ground glass [finding on CT (computerized tomography) scan that indicates a partial filling of air spaces in the lungs], interstitial and airspace opacities were seen throughout the bilateral hemithoraces likely representing pulmonary edema versus multifocal with associated small basilar effusions and compressive atelectasis." In addition, the note indicated R1 had blood gas showing acute respiratory acidosis with arterial blood gas (ABG- test measures the oxygen and carbon dioxide levels in your blood) with carbon dioxide level of 82 with normal levels (35-45 mmHg); WBC 13.5 K/ul with normal (4.0-10.0 K/ul) and due to R1 showing signs of respiratory distress R1 was started on Lasix (water pill), BiPap (a type of ventilator machine used to treat

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2 265	Continued From page 12 chronic conditions that affect your breathing), Solumedrol (used to treat many different inflammatory conditions including exacerbations) and two antibiotics Azithromycin and Rocephin). During interview on 3/7/22, at 12:39 p.m. RN-A clinical coordinator stated she recalled R1 coming from the hospital and seemed medically complex and did not feel it was a safe discharge from the hospital. RN-A stated she had tried to work with the other nurse to make sure R1 got all the orders he needed to get good care. RN-A stated after going through her documentation, the chest x-ray was inconclusive and she had brought it up to the provider and had updated the responsible party. RN-A then stated without reviewing the medical record and from the little she could remember R1 had been tested for Covid-19 and the result ended up testing negative. RN-A stated after she had received the results for the x-ray and the labs she had documented them in the progress note and she had contacted the provider about R1 along the way as she wanted R1 to be managed. When asked where she would document which provider she had contacted she stated it would have been the resident notes. RN-A also stated she also would have communicated with the supervisor RN-B, nurse on the cart or would have documented in the 24 hour board. RN-A stated usually the process was if a resident oxygen level they were receiving needed to be bumped, or there was a change in condition, or a significant lab result typically the expectation was "we contact the on-call so we know how to proceed moving forward. I know when I was working with him I was keeping close contact with the providers I don't recall who I spoke with." During interview on 3/7/22, at 1:34 p.m. licensed	2 265		

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practical nurse (LPN)-A reviewed both her progress note for 12/19/20 at 3:04 p.m. and 12/20/20, at 1:56 p.m. and verified R1 had been on 6 liters of oxygen and had still continued to complain of being short of breath. LPN-A stated during both times she had worked with R1, she had found R1 was on 6 liters of oxygen and that was what R1 had for the shift. LPN-A stated from her recollection, R1 "was very sick and had a lot of things wrong." When asked about the charting and who she had spoken to or updated regarding R1's responsible party concerns on 12/20/20, at 1:56 p.m. progress note, LPN-A stated after reading the note she had spoken to R1's responsible party because the responsible party was insisting about the loose stools and had questioned if R1 had a bowel obstruction. LPN-A also stated she had assessed R1, and had passed the responsible party concern to the RN manager and RN-B. When asked where she would have documented who she had communicated about R1's responsible party concerns, LPN-A stated she would have called the on-call, put a "SBAR" Situation, Background, Assessment and Recommendation note in the provider binder for the provider to review when in the building next or could have done both. LPN-A acknowledged the medical record lacked documentation of her following up with the responsible party concerns to review the course for treatment. LPN-A further acknowledged it was the weekend and since the nurse manager was not in the building she could have sent an e-mail.

During interview on 3/7/22, at 4:49 p.m. primary facility nurse practitioner (NP) stated he had not seen R1 as the resident was admitted on 12/17/20, which was a Thursday and R1 was sent to the hospital 12/21/20, before he could do the first visit with R1. The NP reviewed the lab result

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for 12/18/20, and acknowledged R1 had an elevated WBC count. NP stated although the 12/18/20, results were elevated for WBC count and the Neutrophils, it was hard to draw a conclusion if R1 had an infection because someone had to look at the previous labs results to compare the trends. The NP stated going by the nursing note about the provider being updated of the lab results on 12/18/20, it appeared at 5:22 p.m. he would have been off work that time and the facility nurse would have called the on-call at those hours. The NP acknowledged he did not have any documentation of seeing R1 or regarding the nurse update of the lab results and the chest x-ray. The NP reviewed R1's hospital lab results dated 12/17/20, and acknowledged R1 had within normal WBC count and Neutrophils which was different from the labs on 12/18/20. The NP reviewed the staff nursing notes and stated according to the notes, R1 had appeared to have gotten worse as the night went on from 12/18/20, and was going a different direction compared to the hospital labs. When asked if the nurses were supposed to call the on-call about R1's elevated temperatures, SOB, loose stools, responsible party concerns about treatment, insulin being held and the lung sounds, the NP stated someone had to review the whole picture including the chest x-ray, code status if R1 had any specific measures and the lab results. The NP stated since R1 was on 2 liters of oxygen from the hospital and continued to need more, normally staff were to run the oxygen flow rate at 1-4 liters, the nurses should have known to call the on-call with a change of condition when they had increased the oxygen to over 4 liters. "The question is the nursing judgement we are only as good as our notes. Someone's judgement must have felt he was not deteriorating. When did he tip when someone should have been notified."

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2 265	Continued From page 15 When asked about the chest x-ray indicating the result was: "Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia" the NP stated it was hard to answer the question about what atypical meant because this question would have to be asked of the person who read the x-ray. The NP stated atypical infectious process in simple terms "would be like walking pneumonia, they did not say consolidation it's like more of a fog like look mycoplasma. It's hard to know with atypical because it was not showing fluid lines so I think that's the challenge. It will be difficult to be able to tell from the x-ray if it's viral pneumonia. It's hard to put judgement into this." During interview on 3/7/20, at 3:37 p.m. the interim director of nursing (DON) stated the chest x-ray results from 12/18/20, were faxed to the NP and the rounding NP had also been updated of the lab results and had given orders to re-check CBC and BMP on Monday 12/21/20, which were both seen by RN-A. The interim DON stated R1 was "very sick" when he was admitted to the facility. The interim DON acknowledged the medical record lacked documentation of the nurses notifying the provider/physician through the weekend when R1 had elevated temperatures, insulin was held, when the responsible party had concerns with R1's condition and the decreased oxygen saturation levels leading up to being sent to the hospital. The interim DON stated, "I see there was no documentation of the nurses doing a follow up during the day. Myself, I have gone over the notes and looked at them. He was not eating and they were not giving him his insulin and this is in the notes." The interim DON acknowledged the nurses had opportunities to notify the physician between the course of the 3 days when the	2 265		

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resident required the increased oxygen level, as the standing house was 1-4 liters, when R1 had a temperature and stated that was the reason why RN-C was no longer working at the facility.

During interview on 3/7/22, at 5:28 p.m. when asked about her documentation regarding R1's diminished lung sounds, RN-B stated she had reviewed the chest x-ray and the lab results which had been faxed to SLCC and in her opinion nothing had changed with R1's lung sounds from admission. RN-B stated R1 continued to have the intolerance to lying in bed from admit. RN-B stated to her R1 looked like he had improved compared to when he had admitted to the facility because at admission time "he was compensated and I felt we needed to keep a close eye on him we had been keeping the primary informed I felt with the labs and x-ray being done. I was not there during the night shift when he was sent in to judge what he was like. RN-B stated, "During my shift, when we notice people are not at their baseline we follow the care plan and the treatment orders and if we feel a resident has had a change in condition we would notify the doctor." RN-B also stated, "If family came back and was questioning the treatment plan, basically I would do an assessment and update the RN coordinator, she is right there able to be in contact with the provider and would update them. We would e-mail the care coordinator and update St Luke's Community Care on the weekends on-call and tell them what is going on and would find out what they want us to do." RN-B then stated, "I train the nurses to do a SBAR [Situation- Background -Assessment - Recommendation] and tell them if something is urgent they need to call the on-call or you can fax a SBAR to the provider during the business hours." When asked where the SBARs

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completed for residents were kept, RN-B stated some of the providers will sign off on the SBARs as orders and others will write it in the orders as there is no regulation of where really they can document the orders. RN-B further stated, "The nurses are supposed to write notes of what is going on with the residents during their shifts." RN-B reviewed R1's notes leading up to being sent to the hospital and acknowledged there was no documentation of what the resident condition was before the nurse notified the physician who ordered R1 to be sent to the hospital.

During interview with the medical director (MD) on 3/8/22, 8:18 a.m. when asked about the chest X-ray results, "Peripheral airspace opacities in both lungs are concerning for atypical infectious process such as COVID-19 pneumonia." The facility MD stated atypical mycoplasma pneumonia like Covid could be either bacterial or viral however, in R1's chest x-ray, it would have been bacterial pneumonia but the result did not come out and say that. The MD stated he was aware of R1's incident however, acknowledged he had not reviewed R1's medical record. The MD stated the issue was R1 had tests completed and the staff were aware of the x-ray results and the labs and the rounding nurse practitioner had ordered the labs to be repeated in 3 days adding, "I would say someone should have had a nurse practitioner or someone on call to have weighed in on it given the fact he was continuing to have the sats going down even with the increased oxygen and the other things including the temperature. The nurses are to notify the provider on call to see if there was need to alter the course of treatment." The MD further stated there was just a lot of things which made the issue complex including the medical history and being the weekend which should not be an excuse. "They

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2 265	Continued From page 18 should have called the on-call." The facility undated Change in Condition policy directed the following: "Purpose: To provide care and services based upon the current needs of the resident under the direction of the attending provider. To inform resident/resident representative and attending provider when a significant change in resident condition occurs. Policy: When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, the licensed nursing associate consults with the attending provider and notify the resident/resident representative Procedure Licensed nursing associate: 1. Assess significant change in the resident's condition noted through direct observation, interview or report for other staff. 2. Obtain a set of vital signs and repeat as needed or ordered. 3. Open Matrix Event and conduct a symptom review and assessment, as condition warrants. 4. Notify the attending provider of the change in condition and implement orders for treatment and appropriate monitoring as directed. If unable to contact the physician, contact the Medical Director, as appropriate. 5. Notify the appropriate members of the IDT (interdisciplinary) team. 6. Notify the resident/resident representative. 7. Document symptom(s), assessment, observations, resident/resident representative, and medical provider notification. 8. Monitor and provide treatment as ordered by	2 265		

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2 265	Continued From page 19 the attending provider. 9. Update the care plan as appropriate..." SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies/procedures on notifying medical providers timely regarding significant changes in condition. The DON or designee could educate nursing staff on ensuring the physician was notified timely of significant changes in resident condition, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		