Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 17, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: August 25, 2022

Dear Administrator:

On September 15, 2022, we notified you a remedy was imposed. On October 18, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 2, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 15, 2022 be discontinued as of November 2, 2022. (42 CFR 488.417 (b))

However, as we notified you in our letter of September 15, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 15, 2022. 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, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
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

November 17, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: Reinspection Results
Event ID: M75P12

Dear Administrator:

On November 3, 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 . 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
Health Regulation Division
Telephone: 651-201-4161
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
October 19, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

RE: CCN: 245236
Cycle Start Date: August 25, 2022

Dear Administrator:

On September 15, 2022, we informed you of imposed enforcement remedies.

On October 4, 2022, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 15, 2022, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 15, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 15, 2022.

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

As we notified you in our letter of September 15, 2022, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 15, 2022.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" 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 - 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 February 25, 2023 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

letter, by mailing to the following address:

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

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

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health

Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	C 10/04/2022

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 10/3/22 - 10/4/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirments for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H52364917C (MN00087191 and MN00087223), with deficiencies cited at F656 and F684. The following complaints were found to be UNSUBSTANTIATED: H52364847C (MN00086658) H52364976C (MN00086422) 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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		10/29/22

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

Electronically Signed | 10/25/2022

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 656	Continued From page 1 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide, and involve, 1 of 1 residents (R1), who repeatedly declined weekly	F 656	F656 Develop/Implement Comprehensive Care Plan	

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F 656	Continued From page 2 full body bathing, with alternative bathing options and care planned approaches to ensure R1 received weekly bathing to minimize negative outcomes. In addition, the facility failed to inform and educate R1 about the risks/benefits of repeatedly declining weekly bathing. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/7/22, indicated R1 was cognitively intact and lacked rejection of care behaviors. In addition, the MDS indicated R1 did not participate in bathing during the seven day assessment period. R1's diagnosis included aftercare following surgical amputation of his right transmetatarsals, a diabetic foot ulcer, and chronic ulcer to his left fifth toe. R1 required surgical wound care with applications of wound dressings to his feet. A review of R1's treatment administration record dated 8/3/22 through 9/27/22, identified R1 was scheduled for weekly weights, vitals, and skin observations [on his bath day] every Tuesday and designated the following dates (Tuesdays): 8/9/22, 8/16/22, 8/23/22, 8/30/22, 9/6/22, 9/13/22, 9/20/22, and 9/27/22. A "Reasons/Comments" section on 9/6/22 indicated "unable to complete" and 9/20/22's date remained blank. In addition, 9/27/22 identified R1 was at the ER. A review of R1's medical records identified the following information: -On 8/9/22: the medical record lacked documentation R1 was provided or declined bathing. -On 8/16/22: a progress note identified R1 declined bathing. The note lacked documentation to identify the declined reason or that R1 was	F 656	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R1 no longer resides in the facility. R1 chart and care plan was reviewed for quality assurance and process improvement. Residents who repeatedly decline weekly bathing have been identified. Risk vs benefits have been reviewed and alternative bathing options have been discussed with identified residents. Care plan interventions have been discussed and developed with identified residents. Education provided to nursing and therapy staff including a competency post-test regarding documentation of risk vs benefits of bathing, identifying and offering alternative bathing options and involving residents in developing and implementing a plan. Education to be provided by, or before 10/29/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Competency to be reviewed by DON or designee for further education as needed. The policy for Comprehensive	

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F 656	Continued From page 3 provided with risk/benefit education. -On 8/23/22: the medical record lacked documentation R1 was provided or declined bathing. -On 9/6/22: the medical record lacked documentation which identified the reason R1 was unable to have bathing completed. In addition, the record lacked documentation R1 was provided with risk/benefit education. -On 9/13/22: the medical record lacked documentation R1 was provided or declined bathing; however, a progress note dated 9/14/22, identified R1 was assisted with bathing on 9/13/22. -On 9/15/22: a progress note identified R1 was "a rather independent, private man and [liked] to do most cares for himself." There was a concern R1 was unable to perform his daily cares adequately/thoroughly. In addition, R1 was resistive to cares "not necessarily behaviorally" but rather because he wanted to maintain his independence. R1 was very resistive to showering; however, he agreed to bathing that week with much encouragement. R1's wheelchair cushion presented with a "strong odor" and suggested his self-performed cares were not as "thorough as [they] should be." An occupational therapy (OT) referral was initiated to determine R1's self-care abilities and to provide staff with suggestions for successful interventions to assist R1 with his cares. -On 9/20/22, at 12:35 p.m. a progress note identified R1 completed an evaluation with OT in which OT would work with R1 on "self-cares" starting 9/21/22. -On 9/20/22: a progress note identified R1 declined bathing and indicated he would be working with therapy the following day in relation to independent showers.	F 656	Assessments and Care Planning has been reviewed and remains appropriate. DON or designee will audit resident bath acceptance and associated documentation for refusals 10 residents per week on each unit for 4 weeks then 5 residents per week on each unit for 8 weeks. Audit findings will be presented to the facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Compliance to be achieved by October 29, 2022.	

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F 656	Continued From page 4 R1's OT Evaluation and Plan of Treatment, dated 9/20/22, indicated R1 was independent with functional cognition, showed modified independence with decision making ability for routine activities and his safety awareness was intact; however, a section labeled Complexities identified R1 lacked capacity for chronic disease management and insight into conditions and risk factors. During the evaluation, R1 refused the shower/bathe assessment process. The evaluation identified R1 was independent with lower body dressing; however, lacked documentation specific to OT's assessment of R1's ability to manage/maintain tubigrips or stockings or any observed status of these items. The section labeled Summary of Daily Skilled Services identified OT spoke to the nurse manager in which R1 was felt to be taking care of himself properly and that "up until last week" R1 refused to take a shower. In addition, R1's room still had an "odor" despite his mattress and wheelchair cushion being changed out and his room and equipment being sanitized/cleaned. R1's OT Treatment Encounter Note, dated 9/21/22, identified R1 was observed by OT to perform hygiene cares to his face, neck, underarms, and peri area while at sink-side. In addition, OT observed R1 doff his pajama pants and donned a clean pair of underwear and pair of pants. During the session, R1 was provided with a clean pair of grippy socks for R1 to change into as his grippy socks at that time were "visibly dirty;" however, the note lacked documentation R1 was observed for donning/doffing the grippy socks. In addition, the note lacked documentation R1 was assessed for showering. The note identified R1 was physically able to complete all	F 656		

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F 656	Continued From page 5 cares and dressing without OT assistance and OT recommended the following: twice a week showering if R1 agreed with a potential bathing time change, daily foot soak/cleaning as R1 reported he wore the same grippy socks "for some time," review R1's clothing to see if he had enough for him to change them "more frequently," change bedding more frequently than once a week, change tubi-grip daily and wash alternate pairs, and if available alternate seating in room so R1 was not seated on the same surface all day. OT also questioned depression in her recommendation as R1 spoke of his long wait for insurance and his desire to more to an assisted living facility. The note lacked documentation the OT staff conversed with R1 or nursing staff related to her recommendations or to any potential reason as to why R1 declined weekly bathing. In addition, the note lacked documentation R1 was educated on the risks of not bathing weekly. R1's Care Plan last reviewed/revised on 9/21/22, identified R1 participated in his care decisions; however, his sister assisted in making "major medical ...decisions" and that R1 displayed a self-care deficit for activities of daily living in which R1 required assist of one staff for bathing and toileting needs and to help him remain free from skin breakdown. R1's care plan lacked information R1 repeatedly declined weekly bathing, interventions to decrease the risk of R1's bathing declines and OT's 9/21/22 recommendations. From 9/21/22 through 9/27/22, R1's medical record lacked evidence OT's recommendations related to R1 were addressed or that staff communicated R1's declined bathing episodes	F 656		

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F 656	Continued From page 6 with his sister in order for the sister's involvement in assisting R1 with his bathing decisions. In addition, R1's medical record lacked evidence staff followed up on R1's 9/20/22 statement that OT would assist him with bathing to ensure bathing was provided during the 9/21/22 therapy session. Further, R1's medical record lacked evidence R1 was educated on risk/benefits of his weekly bathing decisions or that R1 participated in discussions related to his bathing preferences and/or processes. On 9/27/22: a progress note identified R1 had a skin observation completed after staff observed drainage on R1's tubigrip (support bandage) and smelt "a strong odor." R1 was found to have a new wound on his left lower extremity (calf) region and subsequently was sent to the emergency room for evaluation. When interviewed on 10/3/22, at 1:04 p.m. R1's family member (FM)-A stated he was unaware R1 often declined weekly bathing and he confirmed the facility had not talked to him related to R1's refusals. FM-A indicated R1 was "very compliant" and, "If you tell him what to do he will do it ...he does not like to push the envelope." During interview on 10/3/22, at 2:37 p.m. R1's FM-B stated she was unaware R1 declined or refused cares and she confirmed the facility had not talked with her related to R1's refusals. She indicated, "[R1] would not do that." She stated R1 was a very private person and was not a person who would initiate communication with staff related to any concerns he may have. FM-B stated when she visited R1 approximately two weeks earlier, there was a "very rank" odor in R1's room. She questioned R1 on this to which	F 656		

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F 656	Continued From page 7 R1 declined he smelt. FM-B denied she brought the smell concern to staff. When interviewed on 10/3/22, at 4:05 p.m. clinical manager licensed practical nurse (LPN)-A stated she expected any care refusals and any related follow-up were documented in the resident's progress notes, along with staff communicating to ensure a plan was formulated to decrease the risk of missed weekly bathing. LPN-A expressed R1 refused showers "all the time" and consistently for weeks at a time: R1 was a very private man who liked to do as much for himself as he could despite "significant [physical] limitations." LPN-A acknowledged she was made fully aware of the degree R1 declined showers "early/mid" September and that on 9/13/22 staff were able to arrange for R1 to shower which was his first shower "in weeks," and she initiated an OT referral. On 10/4/22, at 9:26 a.m. R1 was interviewed at the hospital. He stated he had showered "a few times" in the past couple months; however, he bathed himself a couple times a week at the sink in his room. R1 identified he preferred this as he did not want to bother anyone. R1 felt his sink side bathing routine was "adequate enough" and he was unable to express any concerns he had with his routine. He explained he bathed like that for years prior to admitting to the care center. R1 verbalized staff had not communicated with him any concerns related to his bathing practice, his need to bathe weekly or the risks if he did not, nor did staff talk to him recently regarding his bathing preferences. During interview on 10/4/22, at 11:29 a.m. trained medication aide (TMA)-A stated if a resident	F 656		

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F 656	Continued From page 8 declined/refused then the bath sheet would indicate the refusal and the floor nurse and the nurse manager were to be updated. In addition, staff were to follow up with the resident to determine the reason for them declining and if re-approach was ineffective, a progress note would be entered into the residents medical record indicating the declined event. TMA-A stated it was her understanding the nurse managers reviewed the bath sheets or talked with staff to ensure weekly bathing was completed and would follow-up with the resident as needed if issues were noted. On 10/4/22, at 1:58 p.m. a subsequent interview with LPN-A was conducted. She stated if a bathing event was not documented in the progress notes the bathing did not occur. She explained the reason R1 declined bathing was related to "dignity" and that R1 had indicated to her on 9/13/22 he could not shower due to the surgical wound on his right foot. After that, he agreed to a shower when staff explained to him they would cover his foot with a plastic bag; however, LPN-A denied further follow up with R1's showering comment or potential dignity concerns after to ensure R1's involvement with his bathing care planning. In addition, LPN-A confirmed she failed to provide R1 with any risk/benefit information related to his repeated declined bathing or talk to R1 about any bathing preferences or bathing alternatives. She acknowledged R1's care plan was not updated to reflect his bathing refusal and/or refusal reasons as she was unsure how much of his refusals were actual refusals or related to R1's lack of knowledge he could shower with his foot wound. When interviewed on 10/4/22, at 2:33 p.m.	F 656		

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F 656	Continued From page 9 nursing assistant (NA)-A stated R1 "for the most part" declined weekly bathing. She acknowledged she had never asked R1 for a reason; however, she felt R1 was just a private person. In addition, she acknowledged she never talked to R1 about the risks of not bathing, or the benefits. During interview on 10/4/22, at 2:49 p.m. TMA-B stated if a resident declined bathing she attempted to determine the reason and if they continued to decline she explained to them related consequences and benefits. After that, if the resident was adamant they did not desire bathing, she encouraged a partial bath sink side. She stated R1 never declined bathing assist from her. When interviewed on 10/4/22, at 3:11 p.m. the director of nursing (DON) stated he expected resident care/treatment refusals were documented in the medical record, residents were bathed weekly and if they declined all avenues were to be pursed to encourage compliance, and therapy recommendations were reviewed and followed up on. He explained risk associated with not following approaches and/or care planned interventions, along with therapy recommendations, could lead all the way to resident death and R1 was an example of what could happen. The DON identified there was a lack of communication between therapy and nursing related to R1 and R1's therapy recommendations should have been care planed or interventions modified and/or placed on the group sheets. The DON reviewed IDT notes from the month of September and confirmed the only conversation that occurred for R1 was on 9/29/22 when they discussed his hospitalization. The DON acknowledged the facility had processes in	F 656		

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F 656	Continued From page 10 place; however, staff failed to follow them. A policy titled Charting and Documentation in the Medical Record, dated 2/19, identified the purpose to ensure a clinically complete medical record. The policy directed an event involving the resident was to be documented in the medical record, which included incidents where the resident refused procedures/treatments. Additionally, the policy directed staff were to document education regarding risk/benefits and the residents response when a refusal occurred. A policy titled Activities of Daily Living (ADL), dated 6/21, identified residents were to "receive the services necessary to maintain ...personal hygiene." The policy directed if a resident refused cares staff were to approach at a different time or have another staff member speak with the resident as needed. In addition, interventions to improved and/or minimize a resident's abilities was to be in accordance with their assessed needs, preferences, stated goals and recognized standards of practice. The resident's response to the interventions was then to be documented, monitored, evaluated and revised as appropriate.	F 656		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		10/29/22

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F 684	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a physician order for tubi-grips was followed as directed for 1 of 1 residents (R1) which resulted in tubi-grips remaining on R1 longer then manufacturer and standard of practice instructions, and the facility failed to ensure therapy recommendations were followed up on for R1 after being evaluated for activities of daily living (ADL) and hygiene concerns. In addition, the facility failed to ensure weekly skin assessments were conducted on R1, who repeatedly declined weekly full body bathing. Subsequently, R1 was hospitalized after R1 was assessed to have a new wound to his left lower leg (ankle to calf). Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/7/22, indicated R1 was cognitively intact and he lacked rejection of care behaviors. In addition, the MDS indicated R1 did not participate in bathing during the seven day assessment period and he was independent with lower body dressing with setup. R1's diagnosis included aftercare following surgical amputation of his right transmetatarsals, diabetes with a diabetic foot ulcer, and chronic ulcer to his left fifth toe. R1 required surgical wound care with applications of wound dressings to his feet. A review of R1's Physician Order Report, printed 10/3/22, indicated an order for compression socks - tubi-grips (support stockings) was ordered per the wound clinic on 7/12/22. The order directed to apply "from toes to knees when up." R1's associated treatment administration	F 684	F684 Quality of Care This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. R1 no longer resides in the facility. R1 chart and care plan was reviewed for quality assurance and process improvement. All residents received a skin assessment. Residents with compression stockings were identified and assessed for an appropriate physician order and to ensure proper following of manufacturer instructions. Therapy to nursing recommendation process reviewed. Residents who refused treatments or care were identified and reviewed to validate current skin assessment. Education provided to nursing the therapy staff including a competency posttest regarding therapy to nursing recommendation process, completing and documenting weekly skin assessments, donning and doffing of tubigrips according	

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F 684	Continued From page 12 record (TAR) directed staff to apply in the morning and remove at hour of sleep (HS). A review of R1's TAR dated 8/3/22 through 9/27/22, identified per staff documentation R1 utilized his tubi-grips during the day and they were off at HS on all days with the exception of 8/14/22 and 9/20/22. The "Reasons/Comments" section on 8/14/22 identified the tubi-grips were not administered at HS in which no reason was identified and the dedicated area for staff signature on 9/20/22 at HS remained blank. In addition, R1's TAR identified he was scheduled for weekly weights, vitals, and skin observations [on his bath day] every Tuesday and designated the following dates (Tuesdays): 8/9/22, 8/16/22, 8/23/22, 8/30/22, 9/6/22, 9/13/22, 9/20/22, and 9/27/22. The "Reasons/Comments" section on 9/6/22 indicated "unable to complete" and 9/20/22's date remained blank. In addition, 9/27/22 identified R1 was at the ER. A review of R1's medical records identified the following information: -On 8/9/22: the medical record lacked documentation R1 was provided or declined bathing or that R1's skin was assessed. -On 8/16/22: a progress note identified R1 declined bathing. The note lacked documentation to identify the declined reason or that R1's skin was assessed. -On 8/23/22: the medical record lacked documentation R1 was provided or declined bathing or that R1's skin was assessed. -On 9/6/22: the medical record lacked documentation which identified the reason R1 was unable to have bathing completed or that R1's skin was assessed. -On 9/13/22: the medical record lacked	F 684	to physician order. Education to be provided by, or before 10/29/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Competency to be reviewed by DON or designee for further education as needed. The policy for Prevention and Treatment of Skin Breakdown has been reviewed and remains appropriate. Root Cause Analysis completed with IDT on 10/4/22. DON or designee will audit 10 resident skin assessments to validate completion each week on each unit for 4 weeks then 5 residents per week on each unit for 8 weeks. DON or designee will audit 6 residents with compression stockings each week on each unit for 4 weeks then 3 residents per week on each unit for 8 weeks. DON or designee will audit 6 resident therapy to nursing recommendations to validate completion each week on each unit for 4 weeks then 3 residents per week on each unit for 8 weeks. Audit findings will be presented to the facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and duration to be determined through analysis and review of results. Baseline compliance to be achieved by	

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F 684	Continued From page 13 documentation R1 was provided or declined bathing; however, a progress note dated 9/14/22, identified R1 was assisted with bathing on 9/13/22 and no skin issues were reported. The note lacked documentation a skin assessment was completed on 9/14/22. -On 9/15/22: a progress note identified R1 was "a rather independent, private man and [liked] to do most cares for himself." There was a concern R1 was unable to perform his daily cares adequately/thoroughly. In addition, R1 was resistive to cares "not necessarily behaviorally" but rather because he wanted to maintain his independence. R1 was very resistive to showering; however, he agreed to bathing that week with much encouragement. R1's wheelchair cushion presented with a "strong odor" and suggested his self-performed cares were not as "thorough as [they] should be." An occupational therapy (OT) referral was initiated to determine R1's self-care abilities and to provide staff with suggestions for successful interventions to assist R1 with his cares. -On 9/20/22, at 12:35 p.m. a progress note identified R1 completed an evaluation with OT in which OT would work with R1 on "self-cares" starting 9/21/22. -On 9/20/22: a progress note identified R1 declined bathing and indicated he would be working with therapy the following day in relation to independent showers. The note lacked documentation R1's skin was assessed. R1's OT Evaluation and Plan of Treatment, dated 9/20/22, indicated R1 was independent with functional cognition, showed modified independence with decision making ability for routine activities and his safety awareness was intact; however, a section labeled Complexities	F 684	October 29, 2022.	

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F 684	Continued From page 14 identified R1 lacked capacity for chronic disease management and insight into conditions and risk factors. During the evaluation, R1 refused the shower/bathe assessment process. The evaluation identified R1 was independent with lower body dressing; however, lacked documentation specific to OT's assessment of R1's ability to manage/maintain tubi-grips or stockings or any observed status of these items. The section labeled Summary of Daily Skilled Services identified OT spoke to the nurse manager in which R1 was felt to be taking care of himself properly and that "up until last week" R1 refused to take a shower. In addition, R1's room still had an "odor" despite his mattress and wheelchair cushion being changed out and his room and equipment being sanitized/cleaned. R1's OT Treatment Encounter Note, dated 9/21/22, identified R1 was observed by OT to perform hygiene cares to his face, neck, underarms, and peri area while at sink-side. In addition, OT observed R1 doff his pajama pants and donned a clean pair of underwear and pair of pants. During the session, R1 was provided with a clean pair of grippy socks for R1 to change into as his grippy socks at that time were "visibly dirty;" however, the note lacked documentation R1 was observed for donning/doffing the grippy socks. In addition, the note lacked documentation R1 was assessed for showering. The note identified R1 was physically able to complete all cares and dressing without OT assistance and OT recommended the following: twice a week showering if R1 agreed with a potential bathing time change, daily foot soak/cleaning as R1 reported he wore the same grippy socks "for some time," review R1's clothing to see if he had enough for him to change them "more frequently,"	F 684		

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F 684	Continued From page 15 change bedding more frequently than once a week, change tubi-grip daily and wash alternate pairs, and if available alternate seating in room so R1 was not seated on the same surface all day. OT also questioned depression in her recommendation as R1 spoke of his long wait for insurance and his desire to more to an assisted living facility. The note lacked documentation the OT staff conversed with R1 or nursing staff related to her recommendations or to any potential reason as to why R1 declined weekly bathing. R1's Care Plan last reviewed/revised on 9/21/22, identified R1 participated in his care decisions; however, his sister assisted in making "major medical ...decisions" and that R1 displayed a self-care deficit for activities of daily living in which R1 required assist of one staff for bathing and toileting needs and to help him remain free from skin breakdown. R1's care plan lacked information R1 repeatedly declined weekly bathing, interventions to decrease the risk of R1's bathing declines, R1's order for tubi-grips, and OT's 9/21/22 recommendations. R1's Woodland Way: Group 6 nursing assistant information group sheet directed R1's tubi-grips were to be on in the morning and off in the evening. In addition, the group sheet directed one staff to assist R1 with his ADLs. From 9/13/22 through 9/26/22, R1's medical record identified R1 went 13 days without evidence that R1 participated in full body bathing or that R1 received a full body skin observation after his 9/13/22 shower. In addition, R1's medical record lacked documentation R1's family (sister) was updated or involved with R1's weekly	F 684		

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F 684	Continued From page 16 bathing concerns. From 9/21/22 through 9/26/22, R1's medical record lacked evidence OT's recommendations related to R1 were addressed or that staff followed-up to ensure R1 received a shower during his therapy session. On 9/27/22: a progress note identified R1 had a skin observation completed after staff observed drainage on R1's tubi-grip and smelt "a strong odor." R1 was found to have a new wound on his left lower extremity (back calf) region and subsequently was sent to the emergency room for evaluation. In addition, the progress note identified R1 received a bath every Tuesday evening in which the last skin observation did not reveal this area was present and that R1 had chronic bilateral lower extremity edema (left greater then right) in which he wore tubi-grips and grippy socks. R1's Emergency Department (ED) Provider Note, dated 9/27/22, indicated R1 presented to the ED with a "Wound: Foul smelling the left lower extremity with eschar (dead tissue) over it, discharge present, some slight erythema (redness) in the periphery (outer edges)." The note identified R1 reported the wound was present "for the last two weeks," in which nursing staff had not looked at his left leg. R1 attributed the wound to his "not eating for a couple weeks." R1 denied sensation to the area. An ED Addendum Note, dated 9/27/22 completed by a registered nurse, identified R1 present with "significant 4+ (most severe type) swelling" to his left lower extremity. R1's leg was wrapped in Kerlix (gauze dressing) upon his arrival which	F 684		

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F 684	Continued From page 17 was removed without issues; however, once removed R1 was noted to have "a compression stocking adhered (stuck) to the wound." R1 stated he noticed the wound approximately one to two weeks ago "when it was a small red spot." A hospital Discharge Planning Assessment, dated 9/27/22, identified hospital staff contacted care center staff who reported R1 had self-decreased his outpatient wound care visits due to improvements of the left foot and right elbow wounds and presented with recent concerns R1 was not completing adequate ADLs independently. OT worked with him a couple times a week on this and recently R1 was noted to be "malodorous." In addition, the assessment indicated R1 "typically" applied his own Tubi-grips and that his sister was a source of support for him. A Hospital Medicine Service progress note, dated 10/3/22, indicated R1 underwent wound debridement (procedure to remove infected/dead tissue) on 9/30/22 with findings of extensive necrotic (dying) tissue down to the fascia (tissue that encases the body and binds it together) and Achilles tendon (heel cord). Per the surgeon R1 did not appear to have enough of a posterior flap for a below-knee amputation and thus a decision was pending for either an above-knee amputation or extensive reconstruction. R1 initially required intravenous (IV) antibiotics for infection which were discontinued on 9/30/22 and oral antibiotics started as the majority of the infection was controlled with "source control [debridement]. " A Molnlycke Tubi-grip self-care guide, dated 2021, directed the tubi-grips "should be work as instructed" and replaced "upon health care	F 684		

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F 684	Continued From page 18 professional direction." A Skin and Wound Product Information Sheet for Tubi-grip (Lower Leg Application), adapted from Molnlycke product information, revised 9/22, directed the tubi-grips were to be removed daily to allow for skin checks and skin care in which the tubi-grip was to be hand washed daily in cold water and hung to dry. In addition, the sheet directed the tubi-grip was to be without wrinkles, creases, or pulled down/slouched around the ankles as improper placement "may cause a tourniquet effect." Weekly bath sheets for R1 were requested. None were provided. When interviewed on 10/3/22, at 1:04 p.m. R1's family member (FM)-A stated he was unaware R1 often declined weekly bathing and he confirmed the facility had not talked to him related to R1's refusals. FM-A indicated R1 was "very compliant" and, "If you tell him what to do he will do it ...he does not like to push the envelope." During interview on 10/3/22, at 2:37 p.m. R1's FM-B stated she was unaware R1 declined or refused cares and she confirmed the facility had not talked with her related to R1's refusals. She indicated, "[R1] would not do that." She stated R1 was a very private person and was not a person who would initiate communication with staff related to any concerns he may have. FM-B stated when she visited R1 approximately two weeks earlier, there was a "very rank" odor in R1's room. She questioned R1 on this to which R1 declined he smelt. FM-B denied she brought the smell concern to staff. FM- B explained she felt the facility "dropped the ball" and that the	F 684		

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(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 684	Continued From page 19 facility should have discovered R1's leg wound "much sooner." When interviewed on 10/3/22, at 4:05 p.m. clinical manager licensed practical nurse (LPN)-A stated she expected any care refusals and any related follow-up were documented in the resident's progress notes, along with staff communicating to ensure a plan was formulated to decrease the risk of missed weekly bathing and skin checks. In addition, LPN-A stated she expected a weekly skin check to be completed, even if the resident declined bathing. LPN-A explained after bathing the skin check was written onto a bath sheet, which she kept for approximately a month, and a progress note was entered into the medical record. She denied an official skin check form was placed within the medical record. LPN-A stated tubi-grips were to be removed at HS and she expected staff to follow provider orders and the care plan (group sheets) in order to prevent adverse events from occurring, and if concerns were noted to update her. In addition, . LPN-A expressed R1 refused showers "all the time" and consistently for weeks at a time: R1 was a very private man who liked to do as much for himself as he could despite "significant [physical] limitations." LPN-A acknowledged she was made fully aware of the degree R1 declined showers "early/mid" September and that on 9/13/22 staff were able to arrange for R1 to shower which was his first shower "in weeks," and she initiated an OT referral. In addition, she stated she completed a head to toe skin check on R1 on 9/14/22 in which she removed the tubi-grips. No skin concerns were observed at that time. She acknowledged her documentation on 9/14/22 should have been more detailed. LPN-A stated she expected R1 would have received a skin	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245236	A. BUILDING _____ B. WING _____	C 10/04/2022

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

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F 684	Continued From page 20 check on 9/20/22 when he declined pending an OT session. Further, LPN-A stated she did not discuss R1 with OT after 9/20/22 and acknowledged she was made aware of the OT recommendations after R1 was admitted to the hospital. After reviewing R1's TAR, LPN-A verbalized R1's tubi-grips were signed off as removed at HS; however, commented, "This did not appear as if it had been getting done." She explained when she was a floor nurse on 9/22/22, she signed off that R1's tubi-grips were off without visually observing they were removed. She made an assumption the aides did as the group sheet directed. She stated such an action was "not acceptable" and she acknowledged she and other staff failed to follow facility policy and procedures. LPN-A confirmed R1's medical record lacked documentation R1 received a shower and a full body skin check after his 9/13/22 shower. During interview on 10/3/22, at 4:29 p.m. LPN-B stated the facility expected residents to be bathed weekly in which a skin observation was completed, even if the resident declined the bathing. In addition, she was expected her documentation was accurate and if orders or tasks were not completed there should be a related progress note. She confirmed she worked on 9/13/22; however, was not present for R1's actual shower, but she was aware he agreed to shower after increased encouragement from staff and a plan to cover his feet with plastic bags. She explained she did not complete a skin check on 9/13/22 as she was informed OT would shower R1 the next day. In addition, she did not instruct staff to bathe R1 on 9/14/22 when she discovered OT did not shower him. LPN-B confirmed at times she observed R1's tubi-grips on when they were to be off; however, she was unsure if she	F 684		

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F 684	Continued From page 21 reported this to LPN-A or that she followed-up with the nursing assistants to ensure they were following R1's plan of care. She explained if orders, the care plan, and procedures were not followed it could lead to problems: "We could have sores ...we could have [an incident like R1]." When interviewed on 10/3/22, at 4:50 p.m. OT-A stated she did not assist R1 with a shower on 9/21/22 nor did she remove R1's tubi-grip. She explained she understood nursing assisted R1 with the tubi-grips and felt that was not a concern OT needed to address. She stated the tubi-grips "looked dirty" and R1 declined to change them. OT-A indicated she left new tubi-grip with R1 at the end of the session and she was not concerned he would have issues putting on as he was able to demonstrate no concerns putting his pant on over his feet. She denied she followed up with R1 to ensure he applied the new tubi-grips. OT-A denied she worked with R1 after the 9/21/22 session; however, she indicated she emailed her recommendations for R1 to "the group," which included LPN-A. She expected her recommendations to be followed, but she did not follow up to ensure her recommendations were addressed as the therapy director and nursing staff met weekly to discuss residents and she assumed recommendations were discussed at that meeting. On 10/4/22, at 9:26 a.m. R1 was interviewed at the hospital. He stated he had showered "a few times" in the past couple months; however, he bathed himself a couple times a week at the sink in his room. R1 verbalized staff had not communicated with him any concerns related to his bathing practices or his tubi-grip use and he could not remember him ever declining to remove	F 684		

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F 684	Continued From page 22 the tubi-grips. R1 stated he used the tubi-grip to help his swelling, which was present on 9/27/22. He declined he noticed a change in the swelling. He explained a "couple weeks ago" he noticed a "red spot" on the "side of" his foot. He did not think anything of it and did not update staff. He thought it would just go away. He lacked any ideas of what caused the wound and he denied direct injury to the area. He remembered it the day staff found the wound there and he indicated he experienced a "twinge once in a while" but then disappeared; other than that, he lacked any other indication to remind him there was a wound under his tubi-grip. R1 stated the red spot was present when staff showered him "a couple weeks ago" and was present about "half a week" prior to that. He explained both his feet were covered with bags "so no one really saw it." R1 stated staff did not remove his tubi-grips and the only skin check he remembered right after that shower was to his exposed skin, not his feet, and he felt the tubi-grip they removed at the hospital had been in place "about two weeks prior" to staff finding the wound. R1 stated "what will be will be" when asked how he felt about the possibility of a left leg amputation. During interview on 10/4/22, at 11:29 a.m. trained medication aide (TMA)-A stated if a resident declined/refused the weekly expected bathing then the bath sheet would indicate the refusal and the floor nurse and the nurse manager were to be updated. In addition, staff were expected to ensure a head to toe skin check was still completed if they declined bathing and staff were to follow up with the resident to determine the reason for them declining and if re-approach was ineffective, a progress note would be entered into the residents medical record indicating the	F 684		

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F 684	Continued From page 23 declined event. TMA-A stated she was expected to follow provider orders and resident group sheets in order to decrease residents risks which included "new skin issues." Further, she was expected to visually ensure tubi-grips were on or off if an order was present before she signed the order as complete. She stated "depending on how tight the tubi-grip is" it could cause swelling and discomfort. She acknowledged she had witnessed R1 go to bed at times with the tubi-grips on due to his refusal for them to be removed. She explained in those situations she would expect the event to be documented; however, declined she did this. She confirmed she worked with R1 on 9/24/22 and acknowledged she documented on R1's TAR his tubi-grips were off despite the fact she did not visually confirm. She explained she assumed the nursing assistant would remove them when R1 went to bed. She stated this was a concern and one which may be a reason R1 was found to have a wound. She stated if she would have ensured the tubi-grips were off she may have noticed his leg concerns that evening. On 10/4/22, at 1:58 p.m. a subsequent interview with LPN-A was conducted. She stated if a bathing event and associated skin condition were not documented in the progress notes they did not occur. LPN-A explained it was standard of practice for tubi-grips to be on during the day and off at night. Associated concerns if they were to remain on for an extended period of time [weeks] included constriction and decreased circulation as the "natural process" for circulation would be disrupted. During interview on 10/4/22, at 2:14 p.m. the wound care registered nurse (RN)-A stated he	F 684		

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F 684	Continued From page 24 expected residents to be bathed weekly and a skin check completed in which, depending on the resident and their medical condition, risk factors associated with either of these being missed would fluctuate. In addition, RN-A expected provider orders and group sheets were followed in order to provide assessed resident needs and cares. If a resident were to decline tubi-grip removal, he expected staff to re-approach and educate the resident. If the resident were able to remove them independently, he expected staff to follow-up with the resident to ensure the order was followed. RN-A stated he lacked knowledge on manufacture standards for tubi-grip use and explained he followed the provider order and/or OT recommendations for use. RN-A stated any potential risks with tubi-grips that remained on for extended periods of time depended on a resident's diagnosis and medical factors; however, he did acknowledge he would be concerned if R1's tubi-grips remained on for approximately two weeks. RN-A acknowledged he provided R1 with right foot wound care but he always noted gripper socks on R1's left leg so never observed the state of R1's tubi-grip on that side. In addition, he stated he had noted an odor during wound care; however, he attributed it to R1's right foot wound. When interviewed on 10/4/22, at 2:33 p.m. nursing assistant (NA)-A stated R1 "for the most part" declined weekly bathing but R1 agreed to a shower on 9/13/22 in which she placed plastic over his feet so the tubi-grip and his grippy socks remained dry. NA-A acknowledged she was expected to follow the group sheets and confirmed tubi-grip directions were placed on the group sheets. She confirmed she had assisted R1 with evening cares that night and prior;	F 684		

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F 684	Continued From page 25 however, she identified she had never removed his tubi-grips. She stated she was unaware R1's group sheet directed staff to remove these. During interview on 10/4/22, at 2:49 p.m. TMA-B stated the facility expected residents to be bathed twice a week in which it was expected the "nurse lays eyes on their skin" and group sheets were to be followed. In addition, she confirmed she was expected to follow provider orders and perform accurate documentation. She identified not following tubi-grip orders could lead to constricted blood flow to the applicable limb as their purpose was to assist with "compression." If she were to see them on at HS, she would remove them or direct the nursing assistants to. TMA-B stated R1 never declined bathing assist or tubi-grip removal from her. She acknowledged R1's 9/23/22 tubi-grip documentation which indicated the tubi-grips were removed that evening was her. TMA-B stated she charted that evening R1's tubi-grips were removed as she "thought it would get done." She stated it was a facility policy to make sure they were taken off: "I did not meet that expectation." When interviewed on 10/4/22, at 3:11 p.m. the director of nursing (DON) stated he expected provider orders to be followed, that staff were accountable for their documentation, resident care/treatment refusals were documented in the medical record, group sheets were followed, residents were bathed weekly and if they declined all avenues were to be pursed to encourage compliance, weekly skin checks were completed no matter if the resident declined the bathing or not, and therapy recommendations were reviewed and follow-ed up on. He explained risk associated with not following orders, approaches	F 684		

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F 684	Continued From page 26 and/or care planned interventions, along with therapy recommendations, could lead all the way to resident death and R1 was an example of what could happen. The DON identified there was a lack of communication between therapy and nursing related to R1 and R1's therapy recommendations should have been care planed or interventions modified and/or placed on the group sheets. He acknowledged concerns with tubi-grips remaining on residents for extended periods of time as there could be concealment of a wound under them. The DON reviewed IDT notes from the month of September and confirmed the only conversation that occurred for R1 was on 9/29/22 when they discussed his hospitalization. The DON acknowledged the facility had processes in place; however, staff failed to follow them. A policy titled Prevention and Treatment of Skin Breakdown, dated 9/1/18, identified the policies purpose was to maintain intact skin as it was integral to the resident's health and wellness. The policy directed a residents skin was to be observed daily with cares, and assessed weekly by a licensed nurse. In addition, those residents with increased risk for impaired skin integrity were provided preventative measures, care, and services to maintain skin integrity and prevent potential skin breakdown. A policy titled Charting and Documentation in the Medical Record, dated 2/19, identified the purpose to ensure a clinically complete medical record. The policy directed an event involving the resident was to be documented in the medical record, which included incidents where the resident refused procedures/treatments. Additionally, the policy directed staff were to	F 684		

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F 684	Continued From page 27 document education regarding risk/benefits and the residents response when a refusal occurred. A policy titled Activities of Daily Living (ADL), dated 6/21, identified residents were to "receive the services necessary to maintain ...personal hygiene." The policy directed if a resident refused cares staff were to approach at a different time or have another staff member speak with the resident as needed. In addition, interventions to improved and/or minimize a resident's abilities was to be in accordance with their assessed needs, preferences, stated goals and recognized standards of practice. The resident's response to the interventions was then to be documented, monitored, evaluated and revised as appropriate.	F 684		

Electronically delivered
October 19, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: M75P11

Dear Administrator:

The above facility was surveyed on October 3, 2022 through October 4, 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 feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
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
	00861	A. BUILDING: _____ B. WING _____	C 10/04/2022

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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 10/3/22 - 10/4/22, a complaint survey was conducted at your facility by a surveyor 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 when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H52364917C (MN00087191 and MN00087223), with a licensing order issued at 0565. The following complaints were found to be UNSUBSTANTIATED: H52364847C (MN00086658) H52364976C (MN00086422) 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	2 000		

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2 000	Continued From page 2 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 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		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide, and involve, 1 of 1 residents (R1), who repeatedly declined weekly full body bathing, with alternative bathing options and care planned approaches to ensure R1 received weekly bathing to minimize negative outcomes. In addition, the facility failed to inform and educate R1 about the risks/benefits of repeatedly declining weekly bathing. Findings include: R1's quarterly Minimum Data Set (MDS) dated 7/7/22, indicated R1 was cognitively intact and lacked rejection of care behaviors. In addition, the MDS indicated R1 did not participate in bathing	2 565	Develop/Implement Comprehensive Care Plan This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	10/29/22

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	00861	A. BUILDING: _____ B. WING _____	C 10/04/2022

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2 565	Continued From page 3 during the seven day assessment period. R1's diagnosis included aftercare following surgical amputation of his right transmetatarsals, a diabetic foot ulcer, and chronic ulcer to his left fifth toe. R1 required surgical wound care with applications of wound dressings to his feet. A review of R1's treatment administration record dated 8/3/22 through 9/27/22, identified R1 was scheduled for weekly weights, vitals, and skin observations [on his bath day] every Tuesday and designated the following dates (Tuesdays): 8/9/22, 8/16/22, 8/23/22, 8/30/22, 9/6/22, 9/13/22, 9/20/22, and 9/27/22. A "Reasons/Comments" section on 9/6/22 indicated "unable to complete" and 9/20/22's date remained blank. In addition, 9/27/22 identified R1 was at the ER. A review of R1's medical records identified the following information: -On 8/9/22: the medical record lacked documentation R1 was provided or declined bathing. -On 8/16/22: a progress note identified R1 declined bathing. The note lacked documentation to identify the declined reason or that R1 was provided with risk/benefit education. -On 8/23/22: the medical record lacked documentation R1 was provided or declined bathing. -On 9/6/22: the medical record lacked documentation which identified the reason R1 was unable to have bathing completed. In addition, the record lacked documentation R1 was provided with risk/benefit education. -On 9/13/22: the medical record lacked documentation R1 was provided or declined bathing; however, a progress note dated 9/14/22, identified R1 was assisted with bathing on 9/13/22.	2 565	R1 no longer resides in the facility. R1 chart and care plan was reviewed for quality assurance and process improvement. Residents who repeatedly decline weekly bathing have been identified. Risk vs benefits have been reviewed and alternative bathing options have been discussed with identified residents. Care plan interventions have been discussed and developed with identified residents. Education provided to nursing and therapy staff including a competency post-test regarding documentation of risk vs benefits of bathing, identifying and offering alternative bathing options and involving residents in developing and implementing a plan. Education to be provided by, or before 10/29/22, if staff are unable to attend, the staff will receive the training on, during or before their next shift. Competency to be reviewed by DON or designee for further education as needed. The policy for Comprehensive Assessments and Care Planning has been reviewed and remains appropriate. DON or designee will audit resident bath acceptance and associated documentation for refusals 10 residents per week on each unit for 4 weeks then 5 residents per week on each unit for 8 weeks. Audit findings will be presented to the facility's Quality Council by DON or designee. Results of monitoring shall be reported at the facility Quality Council meeting with ongoing frequency and	

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2 565	Continued From page 4 -On 9/15/22: a progress note identified R1 was "a rather independent, private man and [liked] to do most cares for himself." There was a concern R1 was unable to perform his daily cares adequately/thoroughly. In addition, R1 was resistive to cares "not necessarily behaviorally" but rather because he wanted to maintain his independence. R1 was very resistive to showering; however, he agreed to bathing that week with much encouragement. R1's wheelchair cushion presented with a "strong odor" and suggested his self-performed cares were not as "thorough as [they] should be." An occupational therapy (OT) referral was initiated to determine R1's self-care abilities and to provide staff with suggestions for successful interventions to assist R1 with his cares. -On 9/20/22, at 12:35 p.m. a progress note identified R1 completed an evaluation with OT in which OT would work with R1 on "self-cares" starting 9/21/22. -On 9/20/22: a progress note identified R1 declined bathing and indicated he would be working with therapy the following day in relation to independent showers. R1's OT Evaluation and Plan of Treatment, dated 9/20/22, indicated R1 was independent with functional cognition, showed modified independence with decision making ability for routine activities and his safety awareness was intact; however, a section labeled Complexities identified R1 lacked capacity for chronic disease management and insight into conditions and risk factors. During the evaluation, R1 refused the shower/bathe assessment process. The evaluation identified R1 was independent with lower body dressing; however, lacked documentation specific to OT's assessment of R1's ability to manage/maintain tubigrips or	2 565	duration to be determined through analysis and review of results. Compliance to be achieved by October 29, 2022.	

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2 565	Continued From page 5 stockings or any observed status of these items. The section labeled Summary of Daily Skilled Services identified OT spoke to the nurse manager in which R1 was felt to be taking care of himself properly and that "up until last week" R1 refused to take a shower. In addition, R1's room still had an "odor" despite his mattress and wheelchair cushion being changed out and his room and equipment being sanitized/cleaned. R1's OT Treatment Encounter Note, dated 9/21/22, identified R1 was observed by OT to perform hygiene cares to his face, neck, underarms, and peri area while at sink-side. In addition, OT observed R1 doff his pajama pants and donned a clean pair of underwear and pair of pants. During the session, R1 was provided with a clean pair of grippy socks for R1 to change into as his grippy socks at that time were "visibly dirty;" however, the note lacked documentation R1 was observed for donning/doffing the grippy socks. In addition, the note lacked documentation R1 was assessed for showering. The note identified R1 was physically able to complete all cares and dressing without OT assistance and OT recommended the following: twice a week showering if R1 agreed with a potential bathing time change, daily foot soak/cleaning as R1 reported he wore the same grippy socks "for some time," review R1's clothing to see if he had enough for him to change them "more frequently," change bedding more frequently than once a week, change tubi-grip daily and wash alternate pairs, and if available alternate seating in room so R1 was not seated on the same surface all day. OT also questioned depression in her recommendation as R1 spoke of his long wait for insurance and his desire to more to an assisted living facility. The note lacked documentation the OT staff conversed with R1 or nursing staff	2 565		

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2 565	Continued From page 6 related to her recommendations or to any potential reason as to why R1 declined weekly bathing. In addition, the note lacked documentation R1 was educated on the risks of not bathing weekly. R1's Care Plan last reviewed/revised on 9/21/22, identified R1 participated in his care decisions; however, his sister assisted in making "major medical ...decisions" and that R1 displayed a self-care deficit for activities of daily living in which R1 required assist of one staff for bathing and toileting needs and to help him remain free from skin breakdown. R1's care plan lacked information R1 repeatedly declined weekly bathing, interventions to decrease the risk of R1's bathing declines and OT's 9/21/22 recommendations. From 9/21/22 through 9/27/22, R1's medical record lacked evidence OT's recommendations related to R1 were addressed or that staff communicated R1's declined bathing episodes with his sister in order for the sister's involvement in assisting R1 with his bathing decisions. In addition, R1's medical record lacked evidence staff followed up on R1's 9/20/22 statement that OT would assist him with bathing to ensure bathing was provided during the 9/21/22 therapy session. Further, R1's medical record lacked evidence R1 was educated on risk/benefits of his weekly bathing decisions or that R1 participated in discussions related to his bathing preferences and/or processes. On 9/27/22: a progress note identified R1 had a skin observation completed after staff observed drainage on R1's tubigrip (support bandage) and smelt "a strong odor." R1 was found to have a new wound on his left lower extremity (calf)	2 565		

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2 565	Continued From page 7 region and subsequently was sent to the emergency room for evaluation. When interviewed on 10/3/22, at 1:04 p.m. R1's family member (FM)-A stated he was unaware R1 often declined weekly bathing and he confirmed the facility had not talked to him related to R1's refusals. FM-A indicated R1 was "very compliant" and, "If you tell him what to do he will do it ...he does not like to push the envelope." During interview on 10/3/22, at 2:37 p.m. R1's FM-B stated she was unaware R1 declined or refused cares and she confirmed the facility had not talked with her related to R1's refusals. She indicated, "[R1] would not do that." She stated R1 was a very private person and was not a person who would initiate communication with staff related to any concerns he may have. FM-B stated when she visited R1 approximately two weeks earlier, there was a "very rank" odor in R1's room. She questioned R1 on this to which R1 declined he smelt. FM-B denied she brought the smell concern to staff. When interviewed on 10/3/22, at 4:05 p.m. clinical manager licensed practical nurse (LPN)-A stated she expected any care refusals and any related follow-up were documented in the resident's progress notes, along with staff communicating to ensure a plan was formulated to decrease the risk of missed weekly bathing. LPN-A expressed R1 refused showers "all the time" and consistently for weeks at a time: R1 was a very private man who liked to do as much for himself as he could despite "significant [physical] limitations." LPN-A acknowledged she was made fully aware of the degree R1 declined showers "early/mid" September and that on 9/13/22 staff were able to arrange for R1 to shower which was	2 565		

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2 565	Continued From page 8 his first shower "in weeks," and she initiated an OT referral. On 10/4/22, at 9:26 a.m. R1 was interviewed at the hospital. He stated he had showered "a few times" in the past couple months; however, he bathed himself a couple times a week at the sink in his room. R1 identified he preferred this as he did not want to bother anyone. R1 felt his sink side bathing routine was "adequate enough" and he was unable to express any concerns he had with his routine. He explained he bathed like that for years prior to admitting to the care center. R1 verbalized staff had not communicated with him any concerns related to his bathing practice, his need to bathe weekly or the risks if he did not, nor did staff talk to him recently regarding his bathing preferences. During interview on 10/4/22, at 11:29 a.m. trained medication aide (TMA)-A stated if a resident declined/refused then the bath sheet would indicate the refusal and the floor nurse and the nurse manager were to be updated. In addition, staff were to follow up with the resident to determine the reason for them declining and if re-approach was ineffective, a progress note would be entered into the residents medical record indicating the declined event. TMA-A stated it was her understanding the nurse managers reviewed the bath sheets or talked with staff to ensure weekly bathing was completed and would follow-up with the resident as needed if issues were noted. On 10/4/22, at 1:58 p.m. a subsequent interview with LPN-A was conducted. She stated if a bathing event was not documented in the progress notes the bathing did not occur. She explained the reason R1 declined bathing was	2 565		

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2 565	Continued From page 9 related to "dignity" and that R1 had indicated to her on 9/13/22 he could not shower due to the surgical wound on his right foot. After that, he agreed to a shower when staff explained to him they would cover his foot with a plastic bag; however, LPN-A denied further follow up with R1's showering comment or potential dignity concerns after to ensure R1's involvement with his bathing care planning. In addition, LPN-A confirmed she failed to provide R1 with any risk/benefit information related to his repeated declined bathing or talk to R1 about any bathing preferences or bathing alternatives. She acknowledged R1's care plan was not updated to reflect his bathing refusal and/or refusal reasons as she was unsure how much of his refusals were actual refusals or related to R1's lack of knowledge he could shower with his foot wound. When interviewed on 10/4/22, at 2:33 p.m. nursing assistant (NA)-A stated R1 "for the most part" declined weekly bathing. She acknowledged she had never asked R1 for a reason; however, she felt R1 was just a private person. In addition, she acknowledged she never talked to R1 about the risks of not bathing, or the benefits. During interview on 10/4/22, at 2:49 p.m. TMA-B stated if a resident declined bathing she attempted to determine the reason and if they continued to decline she explained to them related consequences and benefits. After that, if the resident was adamant they did not desire bathing, she encouraged a partial bath sink side. She stated R1 never declined bathing assist from her. When interviewed on 10/4/22, at 3:11 p.m. the director of nursing (DON) stated he expected resident care/treatment refusals were	2 565		

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2 565	Continued From page 10 documented in the medical record, residents were bathed weekly and if they declined all avenues were to be pursed to encourage compliance, and therapy recommendations were reviewed and followed up on. He explained risk associated with not following approaches and/or care planned interventions, along with therapy recommendations, could lead all the way to resident death and R1 was an example of what could happen. The DON identified there was a lack of communication between therapy and nursing related to R1 and R1's therapy recommendations should have been care planed or interventions modified and/or placed on the group sheets. The DON reviewed IDT notes from the month of September and confirmed the only conversation that occurred for R1 was on 9/29/22 when they discussed his hospitalization. The DON acknowledged the facility had processes in place; however, staff failed to follow them. A policy titled Charting and Documentation in the Medical Record, dated 2/19, identified the purpose to ensure a clinically complete medical record. The policy directed an event involving the resident was to be documented in the medical record, which included incidents where the resident refused procedures/treatments. Additionally, the policy directed staff were to document education regarding risk/benefits and the residents response when a refusal occurred. A policy titled Activities of Daily Living (ADL), dated 6/21, identified residents were to "receive the services necessary to maintain ...personal hygiene." The policy directed if a resident refused cares staff were to approach at a different time or have another staff member speak with the resident as needed. In addition, interventions to improved and/or minimize a resident's abilities	2 565		

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2 565	Continued From page 11 was to be in accordance with their assessed needs, preferences, stated goals and recognized standards of practice. The resident's response to the interventions was then to be documented, monitored, evaluated and revised as appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident are individualized, reflect the residents current status, and are followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the current and individualized written plan of care . TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		