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: JT0I12

Dear Administrator:

On November 9, 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 November 17, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
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 27, 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 12, 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212

Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 10/12/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/10/22 to 10/12/22, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The following complaints was found to be SUBSTANTIATED: H52364965C (MN 00087210) and cited at harm at F689 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 substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		11/2/22

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

Electronically Signed | 10/31/2022

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.

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 10/12/2022

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F 689	Continued From page 1 by: Based on interview and document review, the facility failed to follow care plan interventions of tilting wheelchair when not eating or in activities to prevent a fall for 1 of 3 residents (R1) reviewed for accidents. This practice resulted in harm when R1 was left unattended sitting upright in her wheelchair resulting in a fall, R1 sustained a injury to her forehead and required sutures as a result of the fall. Finding Include: R1's Face Sheet printed 10/12/22, indicated R1's diagnoses included cerebral atherosclerosis, vascular dementia with behavioral disturbances and peripheral vascular disease. R1's significant change Minimum Data Set (MDS) assessment dated 7/21/22, indicated R1 had severe cognitive impairment and required extensive assistance of staff for all activities of daily living (ADLs). R1's care plan dated 11/16/20, indicated R1 was at risk for falls. Interventions to prevent falls included "tilt wheelchair when not eating or in an activity". R1's progress note dated 9/28/22, at 10:49 a.m. indicated R1 was found on the floor with a large laceration to the right forehead. Bleeding was difficult to control so R1 was sent to ER "for sutures" and evaluation. R1's progress note indicated R1 was at her "normal" baseline for her mental state and physical state prior to leaving for hospital. R1's progress note dated 9/28/22, at 12:43 p.m.	F 689	F689 Free of Accident Hazards/Supervision/Devices 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 experienced a fall within 30 days were identified and assessed to validate fall interventions were in place and effective. Education provided to the nursing staff including a competency posttest regarding group/care sheet location, information and fall interventions. Orientation and education provided to agency/contract staff of job duties and responsibilities. Education to be provided by, or before 11/1/22, 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 2 indicated the facility investigation showed R1's wheelchair was left in the upright position when not at mealtime or activity. R1's progress note dated 9/30/22, at 10:08 a.m. indicated R1 had a significant change with "TIA/Stroke like symptoms" that included mumbled and slurred speech, unable to answer questions, pupils were pinpoint and unresponsive. There was an obvious left sided facial droop. R1's provider note dated 10/3/22 indicated R1 had acute onset of stroke-like symptoms, gazing to the right and murmuring on 9/30/22. Provider notes indicated R1 was kept comfortable and was becoming less responsive. Further, Provider noted the neurological assessment indicated perceived left hemiplegia-paralysis of limbs on the left side of the body and left facial droop. During an interview on 10/10/22, at 11:02 a.m. registered nurse (RN)-B after the fall. RN-B stated R1 was at her normal baseline for mental and physical well-being, which included eating and drinking small amounts, talking short sentences, and "always asking to go to the bathroom". RN-B stated he saw R1 on 9/29/22, and R1 remained at baseline. RN-B said R1 had a large bump over the right eye but R1 denied having a headache and pupils were equal. RN-B stated he was notified on 9/30/22, R1 had a change of condition. RN-B stated when he arrived, R1 was in bed with a right deviated gaze and left sided weakness. RN-B stated those were signs of a possible stroke or other neurological condition. RN-B stated he felt the possible stroke could be related to the recent fall with head injury due to the "timing of the fall related to the change of condition."	F 689	The policy for Staffing and Daily Work Assignments has been reviewed and remains appropriate. Root Cause Analysis completed with DON, Administrator, Executive Director, ADON, and Clinical Nurse Manager on 10/11/22. DON or designee will audit group/care sheets to validate fall intervention implemented and in place for 10 residents each week on each unit for 4 weeks then 5 residents per week on each unit for 8 weeks. DON or designee will audit to validate the appropriate use of group sheet for 10 staff each week on each unit for 4 weeks then 5 staff 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 November 2nd, 2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 3 During an interview on 10/10/22, at 1:31 p.m. nurse assistant (NA)-A stated staff had group sheets and care plans to review prior to providing resident care. NA-A stated 9/28/22 was on her second day working. NA-A had a mentor working with her and remembered going over the care sheets for the residents they were assigned, However, R1 was not on their assignment. NA-A stated the director of nursing (DON) asked her to assist R1 with eating on a different hallway that morning. NA-A stated when she entered R1's room to assist her R1's wheelchair was in the upright position and the meal tray was in front of her. NA-A stated when R1 was finished eating, NA-A left R1 her in the upright position and left the room. NA-A stated she had not checked the group sheets or ask other staff about R1 before assisting her. NA-A stated she was unsure who sat R1 in the upright position prior to her entering the room. During an interview on 10/10/22, at 1:40 p.m. nurse practitioner (NP)-C stated she saw R1 on 9/29/22, and R1 was currently at her baseline. NP-C stated she saw R1 on 10/3/22 and R1 had a left facial droop, slurred speech, and eye deviation. NP-C stated R1 was showing signs of somebody who had a possible significant stroke. NP-C said the fall could have contributed to the "severe stroke-like symptoms" on 9/30/22, and to R1's death on 10/5/22. During an interview on 10/10/22, at 2:06 p.m. RN-A stated she was responsible for keeping the group sheets up to date anytime there was a change, a new group sheet was printed and distributed. RN-A stated she entered R1's room when notified and witnessed R1 on the floor.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER	935 KENWOOD AVENUE DULUTH, MN 55811

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F 689	Continued From page 4 RN-A stated other than lots of blood, R1 was at her baseline. RN-A completed the investigation after the fall. RN-A stated R1's wheelchair was supposed to be leaned back when not eating or in an activity. R1 was a high fall risk because R1 had enough torso strength to lean forward while in her wheel chair. RN-A stated the wheelchair, in the upright position, would have contributed to her falling out of the wheelchair. RN-A stated the expectation was nursing assistants would carry and check group sheets prior to working with any residents. During an interview on 10/11/22, at 8:32 a.m. DON stated he had asked NA-A to assist R1 with her meal. DON stated he did not see NA-A look at group sheets that included R1 or ask staff about R1's conditions and treatment information. DON stated he had not told NA-A anything about R1 nor remind NA-A to check the group sheets, but he should have. DON stated the expectation was all staff looked at care sheets prior to working with residents. The DON stated if there were time constraints then staff pulled to other units should at least talk with other staff on the unit to find out about resident needs prior to providing care. Facility policy Comprehensive Assessments and Care planning last revised 7/2/18, indicated care plan interventions may be communicated through electronic health record, resident profile, assignment sheets, and/or verbal communication. The policy lacked any discussion about assignment/group sheets and how/when to utilize them.	F 689		

Electronically delivered
October 27, 2022

Administrator
Benedictine Health Center
935 Kenwood Avenue
Duluth, MN 55811

Re: State Nursing Home Licensing Orders
Event ID: JT0I11

Dear Administrator:

The above facility was surveyed on October 10, 2022 through October 12, 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:

Judy Loecken, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 10/12/2022

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/10/22 to 10/12/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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 10/12/2022

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: : H52364965C (MN 00087210) with a licensing order issued at 0830 The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow care plan interventions of tilting wheelchair when not eating or in activities to prevent a fall for 1 of 3 residents (R1) reviewed for accidents. This practice resulted in harm when R1 was left unattended sitting upright in her wheelchair resulting in a fall, R1 sustained a injury to her forehead and required sutures as a result of the fall. Finding Include: R1's Face Sheet printed 10/12/22, indicated R1's	2 830	F689 Free of Accident Hazards/Supervision/Devices 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	11/2/22

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2 830	Continued From page 3 diagnoses included cerebral atherosclerosis, vascular dementia with behavioral disturbances and peripheral vascular disease. R1's significant change Minimum Data Set (MDS) assessment dated 7/21/22, indicated R1 had severe cognitive impairment and required extensive assistance of staff for all activities of daily living (ADLs). R1's care plan dated 11/16/20, indicated R1 was at risk for falls. Interventions to prevent falls included "tilt wheelchair when not eating or in an activity". R1's progress note dated 9/28/22, at 10:49 a.m. indicated R1 was found on the floor with a large laceration to the right forehead. Bleeding was difficult to control so R1 was sent to ER "for sutures" and evaluation. R1's progress note indicated R1 was at her "normal" baseline for her mental state and physical state prior to leaving for hospital. R1's progress note dated 9/28/22, at 12:43 p.m. indicated the facility investigation showed R1's wheelchair was left in the upright position when not at mealtime or activity. R1's progress note dated 9/30/22, at 10:08 a.m. indicated R1 had a significant change with "TIA/Stroke like symptoms" that included mumbled and slurred speech, unable to answer questions, pupils were pinpoint and unresponsive. There was an obvious left sided facial droop. R1's provider note dated 10/3/22 indicated R1 had acute onset of stroke-like symptoms, gazing to the right and murmuring on 9/30/22. Provider notes indicated R1 was kept comfortable and was	2 830	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 experienced a fall within 30 days were identified and assessed to validate fall interventions were in place and effective. Education provided to the nursing staff including a competency posttest regarding group/care sheet location, information and fall interventions. Orientation and education provided to agency/contract staff of job duties and responsibilities. Education to be provided by, or before 11/1/22, 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 Staffing and Daily Work Assignments has been reviewed and remains appropriate. Root Cause Analysis completed with DON, Administrator, Executive Director, ADON, and Clinical Nurse Manager on 10/11/22. DON or designee will audit group/care sheets to validate fall intervention implemented and in place for 10 residents each week on each unit for 4 weeks then 5 residents per week on each unit for 8 weeks. DON or designee will audit to	

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2 830	Continued From page 4 becoming less responsive. Further, Provider noted the neurological assessment indicated perceived left hemiplegia-paralysis of limbs on the left side of the body and left facial droop. During an interview on 10/10/22, at 11:02 a.m. registered nurse (RN)-B after the fall. RN-B stated R1 was at her normal baseline for mental and physical well-being, which included eating and drinking small amounts, talking short sentences, and "always asking to go to the bathroom". RN-B stated he saw R1 on 9/29/22, and R1 remained at baseline. RN-B said R1 had a large bump over the right eye but R1 denied having a headache and pupils were equal. RN-B stated he was notified on 9/30/22, R1 had a change of condition. RN-B stated when he arrived, R1 was in bed with a right deviated gaze and left sided weakness. RN-B stated those were signs of a possible stroke or other neurological condition. RN-B stated he felt the possible stroke could be related to the recent fall with head injury due to the "timing of the fall related to the change of condition." During an interview on 10/10/22, at 1:31 p.m. nurse assistant (NA)-A stated staff had group sheets and care plans to review prior to providing resident care. NA-A stated 9/28/22 was on her second day working. NA-A had a mentor working with her and remembered going over the care sheets for the residents they were assigned, However, R1 was not on their assignment. NA-A stated the director of nursing (DON) asked her to assist R1 with eating on a different hallway that morning. NA-A stated when she entered R1's room to assist her R1's wheelchair was in the upright position and the meal tray was in front of her. NA-A stated when R1 was finished eating, NA-A left R1 her in the upright position and left	2 830	validate the appropriate use of group sheet for 10 staff each week on each unit for 4 weeks then 5 staff 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 November 2nd, 2022.	

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2 830	Continued From page 5 the room. NA-A stated she had not checked the group sheets or ask other staff about R1 before assisting her. NA-A stated she was unsure who sat R1 in the upright position prior to her entering the room. During an interview on 10/10/22, at 1:40 p.m. nurse practitioner (NP)-C stated she saw R1 on 9/29/22, and R1 was currently at her baseline. NP-C stated she saw R1 on 10/3/22 and R1 had a left facial droop, slurred speech, and eye deviation. NP-C stated R1 was showing signs of somebody who had a possible significant stroke. NP-C said the fall could have contributed to the "severe stroke-like symptoms" on 9/30/22, and to R1's death on 10/5/22. During an interview on 10/10/22, at 2:06 p.m. RN-A stated she was responsible for keeping the group sheets up to date anytime there was a change, a new group sheet was printed and distributed. RN-A stated she entered R1's room when notified and witnessed R1 on the floor. RN-A stated other than lots of blood, R1 was at her baseline. RN-A completed the investigation after the fall. RN-A stated R1's wheelchair was supposed to be leaned back when not eating or in an activity. R1 was a high fall risk because R1 had enough torso strength to lean forward while in her wheel chair. RN-A stated the wheelchair, in the upright position, would have contributed to her falling out of the wheelchair. RN-A stated the expectation was nursing assistants would carry and check group sheets prior to working with any residents. During an interview on 10/11/22, at 8:32 a.m. DON stated he had asked NA-A to assist R1 with her meal. DON stated he did not see NA-A look at group sheets that included R1 or ask staff about	2 830		

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2 830	Continued From page 6 R1's conditions and treatment information. DON stated he had not told NA-A anything about R1 nor remind NA-A to check the group sheets, but he should have. DON stated the expectation was all staff looked at care sheets prior to working with residents. The DON stated if there were time constraints then staff pulled to other units should at least talk with other staff on the unit to find out about resident needs prior to providing care. Facility policy Comprehensive Assessments and Care planning last revised 7/2/18, indicated care plan interventions may be communicated through electronic health record, resident profile, assignment sheets, and/or verbal communication. The policy lacked any discussion about assignment/group sheets and how/when to utilize them. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents avoid falls and falls that occur are fully analyzed for root cause. The Director of Nursing or designee could develop, review, and or revise policies and procedures to ensure resident group sheets are reviewed and followed. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		