Electronically delivered

June 21, 2021

Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

RE: CCN: 245266
Cycle Start Date: June 3, 2021

Dear Administrator:

On June 3, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

## ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

## DEPARTMENT CONTACT

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 3, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 3, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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 |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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<br><br>On 6/1/21, to 6/3/21, 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, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED:<br><br>H5266090C (MN00056808) with deficiencies cited at F679, F580, and F686.<br>H5266091C (MN00068159) with a deficiency cited at F805.<br>H5266092C (MN00073232) with deficiencies cited at F740, F686, and F558.<br><br>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.<br><br>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 558 SS=D | Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)<br><br>§483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. | F 558 | | 7/16/21 |

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

Electronically Signed | 07/01/2021

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 558 | Continued From page 1<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure necessary equipment for communication, and a call light, were continuously operational and available for 1 of 3 residents (R1) reviewed for accommodation of resident needs.<br><br>Findings include:<br><br>R1's face sheet dated 6/3/21, indicated R1 had diagnoses that included Amyotrophic Lateral Sclerosis (ALS) (a progressive disease that affects the nerve cells in the brain and spinal cord resulting in paralysis), respiratory failure, bilateral paralysis, anxiety, aphonia (inability to speak), and a tracheostomy (a hole made in the neck for a breathing tube) with ventilator dependence (required a machine to breathe).<br><br>R1's annual Minimum Data Set (MDS) dated 3/9/21, indicated R1 had a Brief Interview for Mental Status (BIMS) of 13 with minimal cognitive deficits. The MDS indicated R1 was a total assist of two staff for all activities of daily living (ADLs).<br><br>R1's care plan dated 3/22/21, indicated R1 used a Dynavox computer (an eye gaze-enabled, speech generating device that allowed people who were paralyzed and/or unable to speak, to communicate) to communicate needs to staff. R1's care plan indicated during a care conference on 1/22/20, the provider and R1 determined the Dynavox was the only successful call light for R1. The care plan indicated R1's needs must be anticipated by staff due to R1's very limited/inability to communicate. The care plan also indicated R1 had increased care needs | F 558 | Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>" R1new Dynavox installation was completely with all functions for alarm/call light, phone, and TV control operational.<br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br>" All residents using the Dynavox as a form of communication.<br>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br>" The new Dynavox was installed to hold calibration better.<br>" Therapy, NAR, Social Service, BOM, and Nursing staff trained to assist with placement of the Dynavox will check on placement when providing services in the room.<br>" Staff will understand that the Dynavox is the only way that residents are able to communicate with staff, family, and communicate specific care needs.<br>" Verify placement or positioning when exiting room.<br>4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br>" Therapy, NAR, Social Service, BOM, and Nursing staff that work 2nd floor will receive education regarding placement of the Dynavox.<br>" DON/designee is responsible for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 558 | Continued From page 2<br>related to ALS. Interventions included staff to set up the Dynavox before staff left the room to enable R1 to call for help.<br><br>The Nursing Assistant Worksheet dated 5/26/21, indicated R1's call light was the Dynavox and to ensure it was set up.<br><br>R1's provider note dated 5/7/21, indicated R1 did not have access to the Dynavox during the provider's visit. No explanation or use of alternative means of communication was documented.<br><br>During an interview on 6/1/21, at 9:00 a.m. R1 stated she was often unable to call for help because the Dynavox did not work or was not calibrated and she sometimes waited hours for staff to check on her.<br><br>During an observation and interview on 6/1/21, at 9:09 a.m. registered nurse (RN)-E entered R1's room and stated R1 received a new Dynavox the previous week, but staff were unable to connect R1's phone to the system which would have allowed R1 to text and call her family. RN-E stated the staff could not connect the new Dynavox to R1's TV or the Internet so R1 still used the old Dynavox. RN-E stated the Dynavox required R1 to be positioned upright, in front of the monitor so the device could track both of R1's retinas. RN-E stated the computer had to be recalibrated every time R1 was repositioned or moved during cares. RN-E stated R1 could activate the alarm on the Dynavox to call for assistance; however, if the Dynavox was not calibrated, R1 could not call for help. RN-E indicated they would check on R1 "more often" because R1 was not able to use the call light. | F 558 | compliance. Observation audits will be completed across different shifts 5x/week for 1 weeks and 3x/week for two weeks, and then once a week for 2 week to observe placement.<br>" The facility administrator and/or designee will monitor the observation check list audits results and reviewed in Quality Council for need of ongoing monitoring | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 558 | Continued From page 3 | F 558 | | |

During an interview on 6/1/21, at 10:28 a.m. nursing assistant (NA)-K stated R1 usually needed help with the old Dynavox because it would not stay calibrated. NA-K stated she tried to connect R1's phone to the new Dynavox but was unable to.

During an observation on 6/2/21, at 8:22 a.m. NA-M entered R1's room and asked R1 if she could wait to be changed for another 10 minutes. R1 indicated the Dynavox did not work well and attempted to recalibrate it with her eye gaze.

During an interview on 6/2/21, at 10:45 a.m. NA-M stated she was float staff and worked with R1 once or twice a month. NA-M stated she was unable to read R1's lips and needed the Dynavox to be able to communicate with her.

During an interview on 6/2/21, at 2:11 p.m. family member (FM)-M stated R1's family and friends often worried about R1 at night because R1's Dynavox did not work. FM-M stated R1's family and friends were unable to get a hold of R1 and would call the facility to have staff check on R1 and if her Dynavox was set up.

During an observation on 6/2/21, at 2:35 p.m. FM-M visited in R1's room. R1 sat in a chair with the Dynavox positioned in front of her face. The Dynavox did not register R1's eye movements and therefore, R1 was not able to communicate. R1 attempted to activate the alarm/call light on the Dynavox monitor with her eye gaze but was unable to. FM-M left the room to find staff to assist R1 to re-position and recalibrate the Dynavox. At 2:40 p.m. NA-M entered R1's room and, after multiple attempts to recalibrate the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 558 | Continued From page 4<br>Dynavox, NA-M chose to restart the system.<br><br>During an observation and interview on 6/3/21, at 8:45 a.m. NA-I assisted R1 with breakfast in R1's room. The volume on the TV was on the loudest setting of 100. R1 attempted to turn the volume down using the Dynavox but was unsuccessful. NA-I did not attempt to assist R1. At 8:57 a.m. medical doctor (MD)-C entered R1's room and, unable to speak over the volume of the TV, used the remote to turn the volume down to 47. NA-I stated she was allowed to assist R1 with the TV volume but had not been formally trained on the Dynavox and that was the first day NA-I had seen the new device.<br><br>During an interview on 6/3/21, at 2:46 p.m. R1's psychologist (MD)-B stated she taught herself how to use the Dynavox computer so she could better communicate with R1. MD-B stated the Dynavox did not work when she visited R1 the previous day and MD-B had to reposition R1 and the Dynavox before she could recalibrate it, which allowed R1 to communicate. MD-B stated the staff should have improved their efforts to accommodate R1 to set up the Dynavox properly. MD-B stated she did not recall the other residents who used a Dynavox having as many issues with their devices.<br><br>During an interview on 6/2/21, at 3:02 p.m. the director of nursing (DON) stated she thought the staff were trained on the Dynavox but was not certain who did provided the training or how often. The DON stated R1 was unable to hold herself upright and it made it difficult for R1 to use the Dynavox. | F 558 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.) | F 580 | | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 580 | Continued From page 5<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident | F 580 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 580 | Continued From page 6<br>representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to notify a resident representative of a new pressure injury for 1 of 3 residents (R3) who had a state three pressure ulcer.<br><br>Findings include:<br><br>R3's Face Sheet dated 6/3/21, indicated R3's diagnoses included hemiplegia (paralysis of one side of the body), dementia, left knee contracture, and spasticity (condition in which muscles stiffen or tighten).<br><br>R3's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R3 had a severe cognitive impairment. R3 was at risk for development of pressure ulcers.<br><br>R3's progress notes dated 5/3/21, at 11:19 a.m. indicated R3 had a new left heel, unstageable pressure ulcer which appeared. The wound measured 2 centimeters (cm.) by 1.5 cm. with hard eschar and no drainage.<br><br>R3's progress notes dated 5/25/21, at 1:37 p.m. indicated R3 had a left heel stage three pressure | F 580 | 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br><br>" As noted in 2567, resident family was not notified of the heel wound, but since have been modified.<br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br>" Retrospective review of resident□s medical record with pressure ulcers to identify communication with family/legal representative to see if it occurred.<br>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br>" Review of expectations regarding reporting, identified, and communicating it to family/legal representation.<br>" Policy was reviewed no changes made<br>4. How will you monitor the corrective action(s) to ensure the deficient practice | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 580 | Continued From page 7<br>ulcer which measured 2.5 cm. by 2 cm. The wound had soft tan slough (dead skin tissue) at center which pulled away from the surrounding mushy tissue.<br><br>During an interview on 6/2/21, at 9:41 a.m. R3's guardian, family member (FM)-K stated she was not aware R3 had a pressure ulcer or any skin issues. FM-K stated she relied on the facility to keep her informed of R3's health since they were not able to see him regularly.<br><br>During an interview on 6/2/21, at 10:13 a.m. registered nurse (RN)-A confirmed R3 had a pressure ulcer on his heel. RN-A was not sure if R3's representative was notified of the pressure ulcer. RN-A stated documentation of notification should have been in a progress note. RN-A verified there was no documentation to support if FM-K was notified. RN-A stated R3's representative should had been updated when the pressure ulcer opened on 4/29/21.<br><br>During an interview on 6/2/21, at 11:51 a.m. licensed practical nurse (LPN)-C stated when a pressure ulcer was found she was to notify a resident's guardian/family.<br><br>During an interview on 6/2/21, at 2:35 p.m. the director of nursing (DON) verified it was her expectation for a resident representative to be informed when a resident obtains a pressure ulcer and communicated the progression of the pressure ulcer.<br><br>The facility Change in Condition policy 2018, directed when there is a significant change in condition a licensed nursing associate was to consult the provider and notify the resident and | F 580 | will not recur, i.e., what quality assurance program will be put into place?<br>" IDT will audit progress notes for presence of indications of change of condition; if present verify follow up occurred. This will occur weekly for 4 weeks duration with four record reviews per weekly audit. Followed by a random audit for 2 months. Review of audits results with Quality Council for further direction. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 580 | Continued From page 8<br>resident representative. | F 580 | | |
| F 679 SS=D | Activities Meet Interest/Needs Each Resident<br>CFR(s): 483.24(c)(1)<br><br>§483.24(c) Activities.<br>§483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide meaningful activities for 1 of 3 residents (R2) reviewed for activities.<br><br>Finding include:<br><br>R2's Face Sheet dated 6/3/21, indicated diagnoses of anoxic brain damage and visual loss.<br><br>R2's quarterly Minimum Data Set dated 4/1/21, indicated severe cognitive impairment and minimal risk for depression. R2 sometimes adequately responded to simple, direct communication to make self understood or to understand others. The MDS had no indication of daily or activity preferences. The MDS indicated R2 was totally dependent on staff for transfers and locomotion on unit. R2 had an impairment on both sides of his upper and lower extremities. | F 679 | 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>" R-2 has a list of activity preferences posted in his/her room and preferences reviewed as part of the MDS process.<br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br>" All residents that have the potential to be affected include all residents that are totally dependent on staff for activity setup.<br>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br>" When MDS is updated care plan updated to include a list of specific preferences for activities. | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 679 | Continued From page 9<br><br>R2's Physician Orders Report dated 5/26/21, indicated to be up in a Broda chair as tolerated and to lay down after lunch. R2 was to be up in his Broda chair after breakfast at 10:30 a.m., back to bed after lunch and back up for dinner around 4:00 p.m.<br><br>R2's care plan dated 10/9/20, had no indication of R2's specific activities preferences. Interventions came from family; R2 enjoyed action movies, animals, game shows and one on one socialization.<br><br>R2's significant change Activity Assessment dated 1/7/21, indicated R2 enjoyed bingo, board games, and cards. R2's music preference included religious, gospel, oldies, R&B,and BB King. R2 enjoyed the outdoors, scenic drives, shopping, parties and special events. R2 needed assistance to and from programs. The assessment also indicated R2 required assistance at programs, encouragement and one to ones. R2 preferred one to ones and preferred his own room. Finally, the assessment indicated R2's family was supportive and involved.<br><br>R2's Individual Attendance Record for May 2021, indicated R2 was in his room with television/radio sensory each day in May except on 5/4/21. The record indicated R2 received one staff visit on 5/1/21, and one family/friend visit on 5/6/21.<br><br>R2's One on One Visits Form dated 6/1/21, indicated on 4/8/21, staff gave R2 some water and fixed his pillow, turned the radio on and had small talk. On 3/16/21, R2 requested water; activities (A)-B held the straw while R2 drank water. There was no other indication of one on | F 679 | " A single sheet to identify preferences will be posted in the room referencing the most current completed MDS.<br>" Tracking measures will be put into place to track invites and attendance at activities by the wellness staff<br>4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br>" The Wellness, social service, maintenance, and nursing staff will receive education around the new signs in the room to help make sure preferences are met/resident invited and have the ability to attend activities<br>" Administrator/designee is responsible for compliance. Audits of sign posting resident preference in room, care plan audits, and individual□s engagement in activities provided and accepted; will occur weekly for 4 weeks with random audits following if needed specific to posting of preferences.<br>" The facility administrator and/or designee will monitor the audits have been completed and results will be reviewed in Quality Council specific for ongoing monitoring or until substantial compliance is maintained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 679 | Continued From page 10 | F 679 | | |

one visits provided to R2 for March 2021, April 2021, May 2021 or June 2021.

During an observation on 6/1/21, at 8:55 a.m. R2 laid in his bed and the television was on.

During an observation on 6/1/21, at 11:11 a.m. R2 laid in his bed while A-B hung the activities calendar on his wall. A-B left the room and did not explain to R2 what the calendar said.

During an observation on 6/1/21, at 2:09 p.m. R2 laid in his bed and the television was on.

During an interview on 6/1/21, at 9:20 a.m. nursing assistant (NA)-B stated R2 did not usually get out of his bed when she worked with him and was unsure when R2 got out of bed.

During an interview and observation on 6/1/21, at 9:30 a.m. R2 stated he liked to go outside but was not able to and did not know why. R2 further stated he told staff but nothing had happened. R2 also stated he liked to listen to BB-King, Blues and R & B but it was rare if he could. R2 had a smile on his face and his eye brows raised when he reported what he liked to do.

During an interview on 6/1/21, at 10:52 a.m. registered nurse (RN)-B stated he was not sure what R2 liked to do.

During an interview on on 6/1/21, at 11:11 a.m. A-B stated R2 was blind and did not go to activities in the building. R2 stayed in his bed and watched television often, as they had to rely on nursing to get him out of bed. A-B also stated staff provided one on one visits when they would go into his room to provide cares or give water

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 679 | Continued From page 11 | F 679 | | |

during the day.

During an interview on 6/1/21, at 11:16 a.m. NA-C stated R2 did not get to go to group activities in the building and was not sure why.

During an interview on 6/1/21, at 11:43 a.m. A-A stated they did not bring R2 to group activities due to R2's lack of endurance to sit up. A-A additionally stated most activities would be hard for him due to his visual impairment. A-A verified the care plan did not indicate R2's specific activity preferences. A-A also stated she got R2's activity preference from the family due to his past cognition and should re-approach him. A-A stated prior to COVID-19, she made cue cards for staff to know a resident's activity preferences but she had not made them recently.

During an interview and observation on 6/1/21, at 11:53 a.m. A-B stated they had an attendance binder. A-B took out the binder and said R2's activities included one staff visit where the activities calendar was hung in R2's room. A-B also pointed out and stated that R2 had one activity noted in April on 4/8/21, which stated staff gave R2 some water, fixed his pillow and turned on the radio for him. Also, A-B stated there were not other indications of activities provided for April 2021, besides television/radio.

During an interview on 6/1/21, at 12:35 p.m. NA-D stated she would look at a resident's care sheet to see what their activities preference were. R2's care sheet did not provide this information.

During an interview on 6/1/21, at 12:28 p.m. R2 stated he could not read what activities were on the calendar since he was blind. When asked, R2

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 679 | Continued From page 12 | F 679 | | |

stated he was often bored. The calendar was read to him and R2 stated he would be interested to attend bingo or cookies and café in the morning.

During an interview on 6/1/21, at 1:45 p.m. RN-B was not aware of what R2 enjoyed doing or if he attended activity programs. RN-B also stated R2 may enjoy coffee with other residents as he liked to talk or have someone read to him. RN-B stated he did not read the activities calendar to R2.

During an interview on 6/3/21, at 8:28 a.m. family member (FM)-J stated she had been concerned of R2's mental and physical health as he was not active and was isolated in his room. FM-J also stated she offered to bring in CD's when R2 was first admitted but had not heard back if he had a CD player or not. FM-J stated she visited often and R2 was always in bed with the television on. FM-J further stated if R2 was in his wheelchair she would like to take him outside or somewhere in the building but he was always in his bed.

During an interview on 6/3/21, at 8:56 a.m. NA-E stated she was not aware of what R2 liked. NA-E also stated staff would talk to him when they brought him water or did cares but was not aware of any other activities he had.

During an interview and observation on 6/3/21, at 9:01 a.m. licensed practical nurse (LPN)-A stated R2 kept to himself and usually watched television. LPN-A also stated he thought R2 liked to watch the news and listen to country music but went to ask R2 to confirm as he was not sure. LPN-A asked R2 what he liked to do and R2 said he would like to go outside or listen to the Blues, BB King or R&B. LPN-A searched R2's room and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 679 | Continued From page 13 | F 679 | | |

stated their was no CD or tape he could find in R2's room to play R2's music preferences. LPN-B also stated activities usually worked with R2 for his social needs.

During an interview on 6/3/21, at 9:22 a.m. A-A verified R2 did not participate in any activities and his participation would be difficult since R2 could not see and needed a one to one. A-A also stated the facility did not have any Blues, BB-King, or R&B music to play for him besides the one facility Ipad which was used for all residents in the building. A-A verified the activities department has not met the expectation to stimulate and meet R2's needs.

During an interview on 6/3/21, at 10:18 a.m. the director of nursing (DON) verified she would expect the facility to have done more for R2. The DON stated she would have expected R2 to have some music he enjoyed or more activities to keep him entertained.

The facility Wellness policy undated, indicated to involve each resident in an ongoing program of activities that is designed to appeal to their interest and would be reflected in the residents individualized person-centered care plan. Each resident's activity program should have been individualized meeting their interests and needs with the residents desired outcomes, including one to ones. Activities referred to any endeavor other than routine activities of daily living (ADL)'s which was intended to enhance the sense of well-being. These included but were not limited to activities that promoted self-esteem, pleasure, comfort, education, creativity, success, and independence.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 14 | F 686 | | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan and/or implement interventions to prevent the development of pressure ulcers for 2 of 3 residents (R3, R1) who were identified to have pressure related injuries.<br><br>Findings include:<br><br>The National Pressure Injury Advisory Panel defined pressure injury ulcer descriptions as follows:<br><br>Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be | F 686 | 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>• Plan of care for residents R1 & R-3 have been reviewed and modified where appropriate.<br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br>• Review of plan of care for other current residents at risk for pressure ulcers.<br>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br>• Review of expectations regarding observation of skin during cares and communication when changes are | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 15<br>removed after careful clinical consideration and consultation with the resident 's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.<br><br>Stage 3: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.<br><br>R3's Face Sheet dated 6/3/21, indicated R3 had diagnoses which included hemiplegia (paralysis of one side of the body), dementia, stiffness of left knee, left knee contracture, and spasticity (condition in which muscles stiffen or tighten).<br><br>R3's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R3 had a severe cognitive impairment. R3 required extensive assistance of staff for bed mobility. R3 was totally dependent on staff for transfers and locomotion. R3 had an impairment on one side of his lower extremity, was at risk for pressure ulcers, and used a wheelchair for mobility. | F 686 | observed.<br>• Review with licensed nurses the importance of and the expectation that skin risk assessments are completed including review of risk factors and current plan of care approaches. This assessment includes Braden score, prior history, disease and dependency risk factors<br>• Notification of floor staff will be the inclusion of pressure ulcer care on nursing/NAR care worksheet. Presence also noted in treatment orders in Matrix Care for nurses.<br>4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br>• Audit of three risk assessment per unit for 4 weeks and one assessment weekly for 2 months for accuracy and action or communication identified when appropriate.<br>• DON/designee is responsible for compliance through random visual observations of implementation of approaches for those reviewed in the above process.<br>• The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in Quality Council for need of ongoing monitoring or until substantial compliance is maintained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 16 | F 686 | | |

Review of R3's Physician Orders indicated the following:
- On 2/23/21, occupational therapy (OT) was to evaluate and treat R3's positioning, neck, and hip.
- On 5/3/21, R3 was to wear a heel lift foam boot for seven hours three times per day.
- On 5/8/21, physical therapy (PT) was to evaluate and treat for shearing and friction on R3's leg.

R3's care plan dated 6/1/21, lacked indication of a pressure ulcer.

R3's nursing care worksheet dated 5/27/21, lacked indication R3 had a pressure ulcer on his left heel.

R3's treatment administration record (TAR) dated 6/3/21, indicated R3 had a specialty Broda chair, "with straps across the thigh" to keep R3 in a functional position. The order was open ended and began on 8/1/18.

R3's OT progress note dated 2/24/21, indicated R3's Broda chair (wheelchair) had a foot elevator feature which did not function consistently. The OT progress note further indicated R3's Broda chair needed some padding replacement.

Nurse practitioner (NP)-E progress note dated 4/29/21, indicated R3 complained of pain in his left leg. The progress note further indicated the cause of pain in R3's left leg was positional in appearance.

R3's progress notes dated 5/3/21, at 11:19 a.m. indicated a new left heel, unstageable pressure ulcer was caused by R3 moving his leg. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 17 | F 686 | | |

would measured 2 centimeters (cm.) by 1.5 cm. and had hard eschar (dead tissue) with no drainage.

R3's progress notes dated 5/11/21, at 1:29 p.m. indicated a left Achilles heel pressure ulcer was unstageable due to eschar. The wound measured 2 cm. x 1.5 cm. and had no drainage. The eschar slightly softened with the use of Hydrocolloid (gel forming agent).

NP-E's progress note dated 5/12/21, indicated R3 had left leg pain a couple weeks ago and developed a pressure ulcer on his left heel. The progress note also indicated prevention measures were in-place which included heel boots and a referral to PT and OT for a positioning evaluation.

R3's progress notes dated 5/13/21, at 1:06 p.m. indicated R3 was seen by OT for positioning in his chair due to an unstageable pressure ulcer which was discovered on his left heel. PT was to evaluate range of motion in R3's left leg.

R3's progress notes dated 5/17/21, indicated R3's left heel open area measured 1.8 cm. x 3 cm. and had mushy, tan slough (dead skin tissue) There was a small amount of serosanguineous drainage, and the peri-wound tissue was fragile.

R3's progress notes dated 5/25/21, at 1:37 p.m. indicated a left heel stage three pressure ulcer that measured 2.5 cm. by 2 cm. The wound had soft tan slough (dead skin tissue) at center which pulled away from the surrounding mushy tissue.

R3's Skin Risk Assessment dated 5/27/21, indicated registered nurse (RN)-K completed a

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 18 | F 686 | | |

skin risk assessment for R3. The skin risk assessment lacked indication R3 had a pressure ulcer.

R3's OT progress note dated 6/1/21, indicated R3 showed increased pushing of himself to the left of his Broda chair. R3 was noted to pull his left foot back against chair footrest/calf pad which was hard. The note indicated staff were instructed to have R3 out of his chair to stretch at least once per day and to apply bilateral foam boots when in his Broda chair due to the extra pressure R3 placed on his feet/heels.

R3's Physical Therapist (PT) note dated 6/2/21, indicated a goal to maintain lower extremity knee range of motion (ROM) to reduce chance of a pressure ulcer and support ability to maintain correct seated posture. The note also indicated R3 was seen for contractures of bilateral lower extremities contributing to risk for skin breakdown.

R3's Skin Care Flow Sheet dated 6/2/21, indicated a wound on R3's left heel opened on 4/29/21. The pressure ulcer (PU) measured 2.5 centimeters (cm.) by 2.5 cm., and had bloody scant (small amount) drainage with a beefy red base. On 5/3/21, the PU measured 2 cm. by 1.5. cm. with no drainage and eschar (dead tissue that sheds or falls of the skin) base. On 5/12/21, the PU measured 1.9 cm. by 2.6 cm. with no drainage and eschar base. On 5/19/21, the PU measured 2.5 cm. by 3.1 cm. with no drainage and eschar base. On 5/26/21, it measured 2.5 cm. by 3 cm. with a scant amount of serosanguineous drainage (thin, like water which is usually light red to pink tinge) and an eschar base. On 6/2/21, the PU measured 2.8 cm. by 2.6

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 19 | F 686 | | |

cm. with scant amount of serosanguineous drainage and an eschar base.

During an observation on 6/2/21, at 7:49 a.m. NA-F and NA-G lowered R3 into his chair using an EZ Lift (mechanical lift) to transfer R3 into a Broda (chair used for positioning and pressure release) chair. R3 stated, "ow, ow." While they lowered R3 into the Broda chair, R3's left and right heel rubbed against the chair pedal. R3 gazed at the back wall and grimaced. NA-G told R3 she was going to fix the position of his leg. NA-G lifted R3's left leg and R3 stated ,"hey, hey." During this observation, R3 had a tan, foam boot on his left and right foot.

During an observation on 6/2/21, at 12:06 p.m. registered nurse (RN)-I measured R3's left heel ulcer. R3's left heel had a bowl-shaped depression which was pink to red in color. RN-I stated R3's left heel pressure ulcer measured 2.8 cm. in length by 2.6 cm. in width and the depth was unknown related to thick, yellow-brown tissue. The edges of the wound base were pink. RN-I also stated since the pressure ulcer opened it had improved.

During an interview on 6/1/21, at 3:25 p.m. PT-I stated she worked with R3 to try to loosen his upper leg and to prevent pressure and tension on his foot. PT-I stated R3 had developed a pressure ulcer on his left heel and it was likely related to R3 getting tighter and putting pressure on his heel. PT-I stated she started to work with R3 on 5/15/21, which was after the stage three pressure wound had developed.

During an interview on 6/2/21, at 7:28 a.m. nursing assistant (NA)-F stated R3 appeared

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 20 | F 686 | | |

more comfortable in a new wheelchair he received on 5/19/21. NA-F stated R3's old chair was too big and R3 would slide down the chair. NA-F stated the wheelchair foot pedals would stop R3 from falling. NA-F stated R3's legs always hit the back of his old wheelchair. NA-F stated she was not aware R3 had a pressure ulcer.

During an interview on 6/2/21, at 8:11 a.m. NA-G stated R3 said, "ow, ow, ow, it hurts" often when she provided cares for R3. NA-G did not think R3 had a pressure ulcer.

During an interview on 6/2/21, at 8:58 a.m. licensed practical nurse (LPN)-C stated she was R3's nurse and did not think he had any pressure ulcers.

During an interview on 6/2/21, at 9:11 a.m. OT-H stated on 3/16/21, R3's family agreed to purchase a new wheelchair for R3. OT-H stated R3 tended to push his heels into the old chair since at least October of 2020. OT-H stated she began caring for R3 2/24/21. OT-H stated R3 could had pushed hard enough and long enough to have caused the pressure ulcer to his left heel. OT-H stated she was not aware of other interventions in place prior to the onset of R3's stage three left heel pressure ulcer besides a cushion on the wheelchair foot pedal. OT-H also stated the interdisciplinary team likely did not think R3 could push so hard to cause a pressure ulcer on his heel.

During an interview on 6/2/21, at 10:13 a.m. registered nurse (RN)-A stated R3 had a stage three pressure ulcer on his left heel which opened on 4/29/21. RN-A stated R3 did a lot of pushing

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 21 | F 686 | | |

and sliding on his heels which could have caused the left heel pressure ulcer. RN-A verified R3's care plan did not reflect his left heel pressure ulcer.

During an interview on 6/2/21, at 1:34 p.m. R3's specialized wound nurse, RN-J stated R3's pressure ulcer was acquired at the facility. RN-J also stated she thought R3's wound was related to rubbing. RN-J stated she was not sure if the pressure ulcer could had been prevented due to R3's severe contraction and how he rubbed R3's legs.

During an interview on 6/2/21, at 3:16 p.m. medical doctor (MD)-C stated every pressure ulcer was preventable. MD-C stated R3 the way R3 sat in his wheelchair looked funny and the wound could had been caused by R3 rubbing his heel against the hard part of the chair. MD-C stated R3 had to rub against something and put pressure on his heel long enough to develop the pressure ulcer. MD-C stated the facility likely did not notice in time to take pressure off R3's heel to prevent the pressure ulcer on R3's heel.

During an interview on 6/2/21, at 2:35 p.m. the director of nursing (DON) stated she was not able to verify if the pressure ulcer was preventable due to R3's constant movement of his heel. The DON stated R3's heel wound was initially a blister type wound which was identified in April or May. The DON also stated her expectation would be for care sheets to indicate if a resident had a wound.

Although R3 was noted to push his heels into his previous Broda chair, interventions which included a heel lift foam boot, a PT evaluation, and new wheelchair were not implemented until

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 22 | F 686 | | |

after R3 developed a pressure ulcer on 4/29/21. R1's Face Sheet dated 6/3/21, indicated R1's diagnoses included Amyotrophic Lateral Sclerosis (a progressive disease that affects the nerve cells in the brain and spinal cord resulting in paralysis), bilateral paralysis, morbid obesity, irritant contact dermatitis.

R1's annual Minimum Data Set (MDS) dated 3/9/21, indicated R1 had intact cognition. The MDS indicated R1 required total assistance with two staff members for all activities of daily living (ADLs). R1 was always incontinent to bladder and bowel. The MDS indicated R1 was at risk for pressure ulcers and had no skin conditions which included moisture associated skin damage (MASD).

R1's Pressure Ulcer/Injury Care Area Assessment (CAAs) dated 3/9/21, indicated R1 had MASD and sometimes allowed staff to reposition her with a wedge.

R1's care plan dated 12/8/19, indicated R1 had an alteration in bowel function. The care plan directed staff to be aware of shearing to R1's buttocks and treat as ordered. Interventions indicated R1 was to be moved in bed by a minimum of two people with a drawsheet, keeping linen free of wrinkles.

R1's Skin Care Flow Sheet dated 5/19/21, indicated R1's right buttock wound was 7 centimeters (cm) long by 9 cm wide by 0.1 cm deep. R1's left buttock wound was 8 cm long by 9 cm wide with no depth. R1's gluteal crease wound was 2 cm long by 0.5 cm wide by 0.1 cm deep.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 23 | F 686 | | |

R1's Skin Care Flow Sheet dated 5/26/21, indicated R1's right buttock wound was 11.5 cm long by 11 cm wide by 0.1 cm deep. R1's left buttock wound was 10.5 cm long by 11 cm wide by 0.1 cm deep. R1's gluteal crease wound indicated it was closed.

R1's Skin Care Flow Sheet dated 6/2/21, indicated R1's right buttock wound was 7.5 cm. long by 12.5 cm. wide containing two open areas 0.1 cm. deep. The wound base was mild red, pink and yellow and there was a scab present. The note indicated R1's left buttock wound was 10 cm. long by 11 cm. wide. The note also indicated R1's gluteal crease wound was 6 cm long by 0.3 cm. wide by 0.1 cm. deep.

During an observation and interview on 6/2/21, at 9:48 a.m. NA-M crossed R1's legs then pushed R1's right buttock and shoulder to roll R1 away from her on to R1's left side. This caused R1's buttocks to separate and exposed R1's gluteal crease wound. R1's face was red, she grimaced, and was crying. RN-I was in R1's room and gathered wound dressing supplies, however, did not assist NA-M to reposition R1. NA-M independently repositioned R1 although, R1's care plan required two staff for repositioning. At 10:13 a.m. NA-M put a fitted sheet under R1 and rolled R1 on her back after assisting RN-I with wound care. The sheet was too small for the mattress which caused the sheet to fall down behind R1's shoulders and created folds and creases against R1's back. NA-I also folded a flat sheet, approximately 18 inches wide, and placed it under R1 as a drawsheet. The sheet did not cover R1's back to provide support during repositioning and was visibly creased and bunched under R1's left hip. The fitted sheet and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 686 | Continued From page 24<br>drawsheet were left bunched and creased under R1 when NA-M and RN-I left R1's room.<br><br>During an interview on 6/2/21, at 11:45 a.m. RN-I stated R1 previously was hospitalized and returned to the facility on 4/7/21, and had no open areas on her buttocks. RN-I stated R1 developed wounds which worsened since returning to the facility. RN-I stated NAs' independently repositioned residents who required two staff for repositioning, and it made RN-I, "nervous."<br><br>During an interview on 6/2/21, at 3:02 p.m. the DON stated it would have been inappropriate for an NA to reposition or move R1 alone if a resident's care plan required two staff for bed mobility. The DON further stated the expectation was that the NA's would have followed the care plan and asked for assistance.<br><br>During an interview on 6/3/21, at 9:33 a.m. R1 stated when the staff turned her, they pushed and pulled on her buttocks. R1 stated she felt the skin tear in her gluteal crease.<br><br>During an interview on 6/3/21, at 10:07 a.m. medical doctor (MD)-C stated the skin on R1's buttocks was moist and fragile. MD-C also stated it was possible R1's gluteal crease wound worsened due to staff pushing and pulling R1's buttocks when they rolled her on to her side.<br><br>The facility Prevention and Treatment of Skin Breakdown policy dated 2018, indicated a pressure injury occurs as a result of intent and/or prolonged pressured or pressure in combination with shear. | F 686 | | |
| F 740 SS=D | Behavioral Health Services | F 740 | | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 25<br>CFR(s): 483.40<br><br>§483.40 Behavioral health services.<br>Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to comprehensively assess and implement individualized interventions to meet the psychosocial needs, reduce depression, and increase the quality of life for 1 of 3 (R1) residents reviewed for behavioral health care.<br><br>Findings include<br><br>R1's face sheet dated 6/3/21, indicated R1 had diagnoses that included Amyotrophic Lateral Sclerosis(ALS) (a progressive disease that affects the nerve cells in the brain and spinal cord resulting in paralysis), respiratory failure, bilateral paralysis, anxiety, aphonia (inability to speak), a tracheostomy (a hole made in the neck for a breathing tube) with ventilator dependence (required a machine to breath), anxiety, and depression with insomnia (the inability to sleep).<br><br>R1's annual Minimum Data Set (MDS) dated 3/9/21, indicated R1 had a Brief Interview for Mental Status (BIMS) of 13 with minimal cognitive | F 740 | 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>" Established weekly checking in with nursing staff and psychological services for R-1.<br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br>" Any resident that is significantly challenged with communication with a diagnosis of depression.<br>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?<br>" When the communication/mental health issue is identified, the need will be care planned. Psychological services will be made available. Currently this is weekly for R1. Social services and psychological services will review all residents weekly to identify additional | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 26<br>deficits. The MDS indicated, during the assessment period, R1 was depressed and had trouble sleeping at least one day and felt bad about herself nearly every day. The MDS indicated it was very important for R1 to be involved in her care planning, be informed of current events, and have access to reading materials. R1 required a total assist of two for all activities of daily living (ADLs).<br><br>R1's Care Area Assessment (CAAs) dated 3/9/21, indicated R1 took anti-anxiety, anti-depressant, and narcotic pain medications, and therefore, R1's safety needed to be closely monitored. The CAAs indicated, R1 used a Dynavox computer (an eye gaze-enabled, speech generating device that allowed people who were paralyzed and/or unable to speak, to communicate) to communicate.<br><br>R1's care plan dated 3/5/21, indicated R1 used the Dynavox to communicate, text, and control the television. The care plan indicated R1 was dependent on staff for social stimulation and staff were to provide social interaction visits weekly. The care plan also indicated R1 was depressed, and staff would monitor R1 for changes in mood, behaviors, and psychosocial issues. The care plan indicated R1 would display minimal signs of pain. Interventions included observe R1 for moaning, groaning and/or grimacing. The care plan indicated R1 had depression and should have been observed for refusal to communicate, a discouraged expression and/or crying. The care plan further indicated R1 had difficulty to communicate. Interventions included anticipate R1's needs, provide support, and allow time for R1 to type needs on her Dynavox. The care plan also indicated that because R1's head tilted to the | F 740 | needs and current status<br>" Staff reminded to greet residents on entry into their rooms. Therapeutic touch offered as appropriate. Staff will engage residents in casual conversation and monitoring for signs of depression.<br>" Appropriate touch points will be planned/offered and adjusted as needed per resident□s response. Currently weekly meeting with R1 and manager are in place.<br>4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br>" Staff will receive education regarding communication with residents and approaches to use.<br>" Social Services/designee is responsible for compliance. Weekly audits will be completed 1x/week for 4 weeks across shifts.<br>" The facility administrator and/or designee will monitor touch point audits and results of audits will be reviewed in Quality Council for need of ongoing monitoring. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 27 | F 740 | | |

right, a neck brace and gel pillow would be used to align her head. This allowed R1 to better communicate with the Dynavox. R1's care plan further indicated to position the Dynavox so R1 could see the television.

R1's Mood Interview and Staff Observation report dated 3/8/21, at 10:06 a.m. indicated R1 felt she let others down, depressed or hopeless, and had trouble sleeping, several days out of the two week assessment period. The report indicated R1's Patient Health Questionnaire score (PHQ-9)(to determine presence and severity of depression) was six, indicating mild depression. No staff observations of R1's mood was reported and no further assessments were provided.

R1's Medical doctor (MD) Provider Notes dated 4/8/21, indicated R1 had great sadness and anxiety. The note indicated R1 requested more medications to help her sleep. The note also indicated R1 was on a "fair amount of medications" but responded well to talking to people. The note indicated the provider spent the majority of the visit counseling/coordinating care related to R1's depression, anxiety and despair over her disease process.

R1's MD Provider Note dated 5/7/21, indicated R1 had increased episodes of crying and on-going depression. The note also indicated R1 did not have access to the Dynavox during the assessment. No reason was given or alternate modes of communication used during the assessment. The note indicated R1 would benefit from music and television when feeling down.

R1's Associated Clinic of Psychology (ACP) progress notes dated 4/28/21, indicated R1

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 28 | F 740 | | |

required therapy for ongoing emotional distress.

R1's ACP progress note dated 5/12/21, indicated, staff reported R1 continued to make complaints and was tearful. The note indicated R1 became tearful during the session, citing physical loss, vulnerability and not being in control as triggers for R1's depression. Interventions included staff to validate R1's feelings and encourage R1 to share positive experiences.

R1's ACP progress note dated 5/19/21, indicated R1 continued to be tearful and expressed feelings of depression. R1's negative emotions were increased and R1 had difficulty to employing coping skills. The note also indicated positive interactions with staff could enhance R1's mood.

R1's ACP progress note dated 5/26/21, indicated staff reported R1's mental condition had not changed.

During an observation and interview on 6/2/21, at 9:48 a.m. nursing assistant (NA)-M stood alone on R1's right side and used a draw sheet to pull R1 towards her, which caused R1's body to twist and and jerk. NA-M crossed R1's legs and pushed R1 away from her onto R1's left side. The back of R1's right hand landed on the bed, and R1's elbow pointed up in the air. NA-M remained behind R1 and was unable to visualized R1's face or trach tubing. R1 grimaced and her face was red for the duration of the wound and peri care. R1's eyes were open, and drool ran from the left side of R1's mouth. At 10:13 NA-M rolled R1 on to her back. R1's chin quivered, her face was red, and R1 grimaced, and cried. NA-M told R1 "you're okay". NA-M stated "that's what I tell her to calm her down". NA-M stated R1 panicked

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 29 | F 740 | | |

and cried when she was turned and cleaned, which made it difficult to calibrate the Dynavox with R1's eye gaze.

During a continuous observation and interview on 6/2/21, from 1:20 p.m. to 2:07 p.m. NA-J and NA-M transferred R1 to a chair and left the Dynavox facing away from R1. NA-M left the room to find registered nurse (RN)-H to assist to apply R1's neck brace. At 1:34 p.m. RN-H and NA-M entered R1's room to apply R1's neck brace but did not know how. RN-H left the room to get LPN-E to help with the neck brace. R1's brow furrowed and she attempted to mouth words. NA-M could not understand what R1 said and at 1:43 p.m., left to look for the nurses. At 1:48 p.m. RN-H and NA-M entered R1's room. RN-H and NA-M continued to try to align R1 and pushed her head to the left and adjusted the gel pillow around R1's neck. RN-H stated she was not familiar with R1's neck brace. R1 remained upset with a furrowed brow and grimaced and attempted to mouth words. NA-M and RN-H continued to try to adjust the gel pillow and loosely placed the brace around R1's neck. R1 continued to grimace and attempted to communicate her needs. At 1:58 p.m. RN-H asked R1 if she needed to be suctioned. R1 raised her eyebrows to indicate she did. RN-H suctioned R1 twice and R1's face relaxed. At 2:07 p.m. LPN-E entered R1's room and applied R1's neck brace appropriately.

During an interview on 6/2/21, at 10:45 a.m. NA-M stated R1 occasionally got upset about something that happened on the overnight shift and that caused R1 to be "crabby" or not want to talk for a while. NA-M stated it could take R1 "a while to come around in the morning". NA-M also

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 30 | F 740 | | |

stated R1 felt she was being ignored more lately.

During an interview on 6/2/21, at 11:45 a.m. RN-I stated R1 was upset so often and that sometimes the staff didn't respond to R1. RN-I stated it was difficult because R1 couldn't communicate without the Dynavox. RN-I stated she had noticed R 1 quietly sobbed more in the last 3 weeks. RN-1 also stated it was possible R1 experienced pain during wound cares but that had not been thought of or addressed.

During an interview on 6/2/21, at 2:11 p.m. FM-M stated, although R1 was allowed to have visitors again, R1 cried more frequently. FM-M stated R1 was very unhappy because R1 felt staff didn't do their their jobs. FM-M stated R1's family and friends often worried about R1 at night because R1's Dynavox didn't work. FM-M stated R1's family and friends were unable to get a hold of R1 and would call the facility to have staff check on R1 and see if her Dynavox was set up. FM-M stated R1's family and friends worried about R1 at night. FM-M stated R1 and her family were also concerned about retaliation against R1 for expressing concerns.

During an interview on 6/3/21, at 8:35 a.m. LPN-D stated R1 seemed to have increased frustration and sadness recently.

During a continuous observation on 6/3/21, from 8:54 a.m. to 9:25 a.m. NA-I sat in a chair on R1's left side, and faced the television, in the same direction as R1. The TV was at the highest volume setting of 100. R1 attempted to turn the volume down and used the Dynavox but was unable. NA-I continued to face the TV and assisted R1 with breakfast. NA-I did not notice

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 31 | F 740 | | |

R1's inability to control the TV through her computer or offer to assist R1. At 8:57 a.m. MD-C entered R1's room and, unable to speak over the volume of the TV, used the remote to turn the volume down to 47. MD-C stated she would return to assess R1's wounds after breakfast and left. NA-I stated she was allowed to assist R1 with the TV volume but this was the first day NA-I had seen R1's new Dynavox and had not been trained on it. NA-I stated she could have used the TV remote but did not think of it. NA-I continued to assist R1 with breakfast, fed R1 from the side and continued to face the TV. NA-I did not offer R1 choices of the food or drinks she would prefer to eat from R1's plate. NA-I also did not converse or interact with R1 during the meal. NA-I fed large portions of food to R1 which often fell out of R1's mouth onto R1's clothing protector or down R1's right cheek. R1 finished breakfast at 9:25 a.m. NA-I wiped R1's mouth and left cheek, removed clothing protector and left R1's room without wiping the milk or food on R1's right cheek and neck.

During an interview on 6/3/21, at 9:26 a.m. R1 indicated she would like staff to face her and talk to her during meals. R1 also stated it was not unusual for only one NA to roll or reposition her in bed. R1 stated she was uncomfortable the day before when NA-M rolled her and RN-I did wound cares. R1 also stated it made her "cry inside and out" that some staff didn't "have a heart" for their job. R1 stated she "cries a lot, almost every day" about her situation and about the staff because R1 was an LPN and knows how her cares should be done.

During an interview on 6/3/21, 11:04 a.m. NA-I stated "sometimes" the staff interacted with the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 32 | F 740 | | |

residents during meals. NA-I stated there was no reason why NA-I faced the TV and not R1. NA-I stated she tried to give R1 small bites, however, R1 was unable to open her mouth very far so NA-I was able to get more into R1's mouth with larger portions. NA-I stated she wiped away the food that fell out of R1's mouth. NA-I stated she did not see the food and milk that was left on R1's right cheek and neck after breakfast.

During an interview on 6/3/21, at 2:46 p.m. psychologist MD-B stated R1 expressed concerns that staff didn't care about her and was discouraged about the timeliness of concerns being addressed. MD-B stated she wanted the facility to improve their accommodations for R1, particularly with the use of the Dynavox. MD-B stated R1's interactions and relationships with staff were very important to R1. MD-B further stated recommendations were made for staff to be cheery and pleasant towards R1.

During an interview on 6/2/21, at 3:02 p.m. the director of nursing (DON) stated R1 had difficulty accepting her disease process. The DON stated there was concern for how R1 would cope as her disease progressed.

During a follow-up interview on 6/3/21, at 11:14 a.m. the DON stated NAs should engage in conversation with residents during meals. The DON also stated NAs should offer residents a choice of what food and drink the resident would like from their tray. The DON further stated NAs should not watch TV while assisting a resident with their meal unless that was the resident's preference.

Facility Wellness policy dated 2017, indicated to

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 740 | Continued From page 33<br>complete a comprehensive assessment with the resident to understand their individual preferences and include day-to-day leisure pursuits, customary routines, and community involvement prior to admission. The policy indicated to ensure adaptive equipment/supplies were available. The policy also indicated to develop and care plan individualized approaches for residents who may display behavioral symptoms and patterns. | F 740 | | |
| F 805 SS=D | Food in Form to Meet Individual Needs<br>CFR(s): 483.60(d)(3)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides-<br><br>§483.60(d)(3) Food prepared in a form designed to meet individual needs.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to communicate swallowing difficulties when a resident showed signs of pocketing their for 1 of 3 residents (R3), who were reviewed for assistance at meals.<br><br>Findings include:<br><br>R3's face sheet dated 6/3/21, indicated diagnoses of dementia, oropharyngeal phase dysphagia (swallowing difficulties from mouth to throat), and cognitive communication deficit.<br><br>R3's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated severe cognitive impairment. R3 required extensive assist to eat. R3 was noted to cough or choke at meals when he ate or swallowed medications. | F 805 | 1. Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?<br>" Residents R-3 that receive assistance with feeding<br><br>2. How will you identify other residents having the potential to be affected by the same deficient practice?<br>" All residents care planned for assistance with feeding due to swallowing issues.<br><br>3. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur? | 7/9/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 805 | Continued From page 34<br><br>R3's care plan dated 1/9/20, indicated R3 required a mechanically altered diet and thickened liquids due to difficulty chewing and swallowing. Staff were to monitor for signs and symptoms of aspiration with a goal to be free from signs of choking and aspiration.<br><br>R3's Speech Therapy Plan of Care Evaluation dated 9/14/16, indicated R3's wife would like R3's diet downgraded if R3 demonstrate fatigue when he chewed mechanical soft texture. This was the most recent evaluation by a speech language pathologist (SLP).<br><br>R3's Nutrition Assessment dated 3/3/21, included a diet order for mechanical soft textures with honey thick liquids. R3 was noted, per nursing documentation on 2/25/21, to cough or choke during meals or when swallowing medications. The assessment indicated R3 required total assistance with meals.<br><br>The facility Nursing Care Worksheet date 5/27/21, indicated R3 required total assist from staff while R3 ate.<br><br>Continuous observation was conducted on 6/2/21, from 8:26 a.m. to 8:50 a.m.<br><br>-at 8:26 a.m. R3 sat in the dining room with his head down and eyes closed. Nursing assistant (NA)-F placed a piece of English muffin into R3's mouth while R3's eyes were closed. R3 chewed on the English muffin with his eyes closed and pushed the partial chewed food into his cheek; there appeared to be a large bulge on the side of R3's right cheek. R3 did not appear to arouse when NA-F spoke to him. NA-F stated, "wake up" | F 805 | " Staff trained to assist residents with eating will ensure residents are wake when feeding and ensure a minimum amount of food is in their mouth when feeding them.<br>" Meal assistants will ensure that the resident has cleared their mount by observation and encourage fluids at the end of the meal.<br><br>4. How will you monitor the corrective action(s) to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?<br>" NARs will receive education around clearing the mouth to prevent pocketing of food.<br>" DON/designee is responsible for compliance. Observation audits will be completed 1x/week for 4 weeks.<br>" The facility administrator and/or designee will monitor the audits are completed and results will be reviewed in Quality Council for need of ongoing monitoring or until substantial compliance is maintained. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 805 | Continued From page 35 | F 805 | | |

and proceeded to put a cup of coffee to R3's mouth but R3's mouth did not open. Eventually R3's mouth opened and a food bolus (mass of food formed in the mouth after thorough chewing and mixing with saliva.) was visible. NA-F assisted R3 with a drink of coffee and the a lump appeared on his right cheek again.

-at 8:42 a.m. NA-F tapped R3 on the arm and assisted with a bite of hard-boiled egg. R3 chewed the egg on his left side of his mouth and moved the egg bolus to his right cheek. R3's eyes were closed, and his mouth opened which exposed the partially chewed egg. NA-F tried to arouse R3. R3 chewed on the egg again, moved the food bolus to his cheek again and closed his eyes. NA-F put a glass of orange juice to R3's lips which R3 partially opened his mouth but did not take a sip; instead, R3 chewed on the food in his cheek. NA-F stated, "wake up" and R3 opened his eyes and then closed them again. R3 continued to chew on the food in his mouth. NA-F put juice to R3's mouth and he took a sip. While R3 drank he licked his lips and partially chewed white egg was visible inside his mouth. As NA-F continued to assist R3 to drink, R3 grimaced. NA-F continued to bring malt-o-meal to R3's mouth and when R3 opened his mouth, food fell out onto his shirt protector and chin. NA-F continued to bring food to R3's mouth but R3's mouth was barely opened. NA-F asked R3 to open his mouth and R3 took a small bite. R3's eyes remained closed, and his mouth open.

-at approximately 8:50 a.m. R3's head dropped, and mouth opened; honey thick milk fell out of R3's mouth. NA-F grabbed a spoon to wipe it away and placed the milk back into R3's mouth.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 805 | Continued From page 36 | F 805 | | |

During an interview on 6/2/21, at 8:52 a.m. NA-F stated R3 was usually sleepy during breakfast and at other meals too. NA-F stated when R3 was tired he usually put food to the side of his mouth.

During an interview on 6/2/21, at 11:02 a.m. speech language pathologist (SLP)-G stated R3 was last seen by a SLP in 2016. SLP-G also stated nursing had not communicated to her that R3 pocketed (holding food in mouth without swallowing) his food at meals when he was tired.

During an interview on 6/2/21, at 11:51 a.m. licensed practical nurse (LPN)-C stated if a resident was noted to pocket food at meals she would need to notify the provider and SLP-G to evaluate for safety.

During an interview on 6/2/21, at 12:38 p.m. NA-H stated she would not continue to feed a resident if a resident appeared to fall asleep. NA-H also stated she would inform the nurse if a resident put food in his cheek (pocket) at meals.

During an interview on 6/2/21, at 12:40 p.m. NA-F verified R3 pocketed his food at the morning meal on 6/2/21. NA-F also stated she did not tell the nurse as R3 was "ok" when NA-F prompted him and R2 wanted to continue to eat.

During an interview on 6/2/21, at 1:20 p.m. registered dietitian (RD)-F stated aides were to tell a nurse or reach out to SLP-G when a resident appeared to pocket their food at meals. RD-F also stated pocketing was a sign of a swallowing difficulty which could lead to choking.

During an interview on 6/2/21, at 1:34 p.m. the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245266 | A. BUILDING _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BENEDICTINE HEALTH CENTER OF MINNEAPOLIS** | **618 EAST 17TH STREET MINNEAPOLIS, MN 55404** |

| (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 805 | Continued From page 37<br>director of nursing (DON) verified it was her expectation for a nursing aide to communicate to the resident's nurse when an issue was noted with swallowing at meals.<br><br>A facility policy on when to communicate to SLP was requested but not provided. | F 805 | | |

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
June 21, 2021

Administrator
Benedictine Health Center Of Minneapolis
618 East 17th Street
Minneapolis, MN 55404

Re: State Nursing Home Licensing Orders
Event ID: ZKMH11

Dear Administrator:

The above facility was surveyed on June 1, 2021 through June 3, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

Susan Frericks, Unit Supervisor
Metro D District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
PO Box 64990
St. Paul MN 55164-0900
Email: susan.frericks@state.mn.us
Mobile: (218) 368-4467

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
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 |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>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.<br><br>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.<br><br>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.<br><br>INITIAL COMMENTS:<br>On 6/1/21, to 6/3/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT to be 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 | 2 000 | 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 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 | Continued From page 1<br>be completed.<br><br>The following complaint were found to be SUBSTANTIATED:<br><br>H5266090C (MN00056808) with a licensing orders issued at 0265, 1435, and 0900<br>H5266091C (MN00068159), however, no licensing orders were issued.<br>H5266092C (MN00073232) with a licensing orders issued at 0900 and 1810.<br><br>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.<br>You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached<br><br>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 | 2 000 | 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.<br>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.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 | Continued From page 2<br>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.<br><br>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 | WILL APPEAR ON EACH PAGE. | |
| 2 265 | MN Rule 4658.0085 Notification of Chg in Resident Health Status<br><br>A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for:<br><br>A. an accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; | 2 265 | | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 265 | Continued From page 3<br><br>C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment;<br><br>D. a decision to transfer or discharge the resident from the nursing home; or<br><br>E. expected and unexpected resident deaths.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the facility failed to notify a resident representative of a new pressure injury for 1 of 3 residents (R3) who had a state three pressure ulcer.<br><br>Findings include:<br><br>R3's Face Sheet dated 6/3/21, indicated R3's diagnoses included hemiplegia (paralysis of one side of the body), dementia, left knee contracture, and spasticity (condition in which muscles stiffen or tighten).<br><br>R3's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R3 had a severe cognitive impairment. R3 was at risk for development of pressure ulcers.<br><br>R3's progress notes dated 5/3/21, at 11:19 a.m. indicated R3 had a new left heel, unstageable pressure ulcer which appeared. The wound measured 2 centimeters (cm.) by 1.5 cm. with hard eschar and no drainage.<br><br>R3's progress notes dated 5/25/21, at 1:37 p.m. indicated R3 had a left heel stage three pressure | 2 265 | Corrected | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 265 | Continued From page 4 | 2 265 | | |

ulcer which measured 2.5 cm. by 2 cm. The wound had soft tan slough (dead skin tissue) at center which pulled away from the surrounding mushy tissue.

During an interview on 6/2/21, at 9:41 a.m. R3's guardian, family member (FM)-K stated she was not aware R3 had a pressure ulcer or any skin issues. FM-K stated she relied on the facility to keep her informed of R3's health since they were not able to see him regularly.

During an interview on 6/2/21, at 10:13 a.m. registered nurse (RN)-A confirmed R3 had a pressure ulcer on his heel. RN-A was not sure if R3's representative was notified of the pressure ulcer. RN-A stated documentation of notification should have been in a progress note. RN-A verified there was no documentation to support if FM-K was notified. RN-A stated R3's representative should had been updated when the pressure ulcer opened on 4/29/21.

During an interview on 6/2/21, at 11:51 a.m. licensed practical nurse (LPN)-C stated when a pressure ulcer was found she was to notify a resident's guardian/family.

During an interview on 6/2/21, at 2:35 p.m. the director of nursing (DON) verified it was her expectation for a resident representative to be informed when a resident obtains a pressure ulcer and communicated the progression of the pressure ulcer.

The facility Change in Condition policy 2018, directed when there is a significant change in condition a licensed nursing associate was to consult the provider and notify the resident and resident representative.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 265 | Continued From page 5<br><br>SUGGESTED METHOD OF CORRECTION: The administrator or designee could implement policies and procedures related to commuincation on a change in condition requirements. The quality assessment and assurance committee could perform random audits to ensure compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) days | 2 265 | | |
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan and/or implement interventions to prevent the development of | 2 900 | Corrected | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 6<br>pressure ulcers for 2 of 3 residents (R3, R1) who were identified to have pressure related injuries.<br><br>Findings include:<br><br>The National Pressure Injury Advisory Panel defined pressure injury ulcer descriptions as follows:<br><br>Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) should only be removed after careful clinical consideration and consultation with the resident 's physician, or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. If the anatomical depth of the tissue damage involved can be determined, then the reclassified stage should be assigned. The pressure ulcer does not have to be completely debrided or free of all slough or eschar for reclassification of stage to occur.<br><br>Stage 3: Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 7 | 2 900 | | |

R3's Face Sheet dated 6/3/21, indicated R3 had diagnoses which included hemiplegia (paralysis of one side of the body), dementia, stiffness of left knee, left knee contracture, and spasticity (condition in which muscles stiffen or tighten).

R3's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R3 had a severe cognitive impairment. R3 required extensive assistance of staff for bed mobility. R3 was totally dependent on staff for transfers and locomotion. R3 had an impairment on one side of his lower extremity, was at risk for pressure ulcers, and used a wheelchair for mobility.

Review of R3's Physician Orders indicated the following:
- On 2/23/21, occupational therapy (OT) was to evaluate and treat R3's positioning, neck, and hip.
- On 5/3/21, R3 was to wear a heel lift foam boot for seven hours three times per day.
- On 5/8/21, physical therapy (PT) was to evaluate and treat for shearing and friction on R3's leg.

R3's care plan dated 6/1/21, lacked indication of a pressure ulcer.

R3's nursing care worksheet dated 5/27/21, lacked indication R3 had a pressure ulcer on his left heel.

R3's treatment administration record (TAR) dated 6/3/21, indicated R3 had a specialty Broda chair, "with straps across the thigh" to keep R3 in a functional position. The order was open ended and began on 8/1/18.

R3's OT progress note dated 2/24/21, indicated

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 8<br><br>R3's Broda chair (wheelchair) had a foot elevator feature which did not function consistently. The OT progress note further indicated R3's Broda chair needed some padding replacement.<br><br>Nurse practitioner (NP)-E progress note dated 4/29/21, indicated R3 complained of pain in his left leg. The progress note further indicated the cause of pain in R3's left leg was positional in appearance.<br><br>R3's progress notes dated 5/3/21, at 11:19 a.m. indicated a new left heel, unstageable pressure ulcer was caused by R3 moving his leg. The would measured 2 centimeters (cm.) by 1.5 cm. and had hard eschar (dead tissue) with no drainage.<br><br>R3's progress notes dated 5/11/21, at 1:29 p.m. indicated a left Achilles heel pressure ulcer was unstageable due to eschar. The wound measured 2 cm. x 1.5 cm. and had no drainage. The eschar slightly softened with the use of Hydrocolloid (gel forming agent).<br><br>NP-E's progress note dated 5/12/21, indicated R3 had left leg pain a couple weeks ago and developed a pressure ulcer on his left heel. The progress note also indicated prevention measures were in-place which included heel boots and a referral to PT and OT for a positioning evaluation.<br>R3's progress notes dated 5/13/21, at 1:06 p.m. indicated R3 was seen by OT for positioning in his chair due to an unstageable pressure ulcer which was discovered on his left heel. PT was to evaluate range of motion in R3's left leg.<br><br>R3's progress notes dated 5/17/21, indicated R3's left heel open area measured 1.8 cm. x 3 cm. and | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 9 | 2 900 | | |

had mushy, tan slough (dead skin tissue) There was a small amount of serosanguineous drainage, and the peri-wound tissue was fragile.

R3's progress notes dated 5/25/21, at 1:37 p.m. indicated a left heel stage three pressure ulcer that measured 2.5 cm. by 2 cm. The wound had soft tan slough (dead skin tissue) at center which pulled away from the surrounding mushy tissue.

R3's Skin Risk Assessment dated 5/27/21, indicated registered nurse (RN)-K completed a skin risk assessment for R3. The skin risk assessment lacked indication R3 had a pressure ulcer.

R3's OT progress note dated 6/1/21, indicated R3 showed increased pushing of himself to the left of his Broda chair. R3 was noted to pull his left foot back against chair footrest/calf pad which was hard. The note indicated staff were instructed to have R3 out of his chair to stretch at least once per day and to apply bilateral foam boots when in his Broda chair due to the extra pressure R3 placed on his feet/heels.

R3's Physical Therapist (PT) note dated 6/2/21, indicated a goal to maintain lower extremity knee range of motion (ROM) to reduce chance of a pressure ulcer and support ability to maintain correct seated posture. The note also indicated R3 was seen for contractures of bilateral lower extremities contributing to risk for skin breakdown.

R3's Skin Care Flow Sheet dated 6/2/21, indicated a wound on R3's left heel opened on 4/29/21. The pressure ulcer (PU) measured 2.5 centimeters (cm.) by 2.5 cm., and had bloody scant (small amount) drainage with a beefy red

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 10 | 2 900 | | |

base. On 5/3/21, the PU measured 2 cm. by 1.5. cm. with no drainage and eschar (dead tissue that sheds or falls of the skin) base. On 5/12/21, the PU measured 1.9 cm. by 2.6 cm. with no drainage and eschar base. On 5/19/21, the PU measured 2.5 cm. by 3.1 cm. with no drainage and eschar base. On 5/26/21, it measured 2.5 cm. by 3 cm. with a scant amount of serosanguineous drainage (thin, like water which is usually light red to pink tinge) and an eschar base. On 6/2/21, the PU measured 2.8 cm. by 2.6 cm. with scant amount of serosanguineous drainage and an eschar base.

During an observation on 6/2/21, at 7:49 a.m. NA-F and NA-G lowered R3 into his chair using an EZ Lift (mechanical lift) to transfer R3 into a Broda (chair used for positioning and pressure release) chair. R3 stated, "ow, ow." While they lowered R3 into the Broda chair, R3's left and right heel rubbed against the chair pedal. R3 gazed at the back wall and grimaced. NA-G told R3 she was going to fix the position of his leg. NA-G lifted R3's left leg and R3 stated ,"hey, hey." During this observation, R3 had a tan, foam boot on his left and right foot.

During an observation on 6/2/21, at 12:06 p.m. registered nurse (RN)-I measured R3's left heel ulcer. R3's left heel had a bowl-shaped depression which was pink to red in color. RN-I stated R3's left heel pressure ulcer measured 2.8 cm. in length by 2.6 cm. in width and the depth was unknown related to thick, yellow-brown tissue. The edges of the wound base were pink. RN-I also stated since the pressure ulcer opened it had improved.

During an interview on 6/1/21, at 3:25 p.m. PT-I stated she worked with R3 to try to loosen his

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 11 | 2 900 | | |

upper leg and to prevent pressure and tension on his foot. PT-I stated R3 had developed a pressure ulcer on his left heel and it was likely related to R3 getting tighter and putting pressure on his heel. PT-I stated she started to work with R3 on 5/15/21, which was after the stage three pressure wound had developed.

During an interview on 6/2/21, at 7:28 a.m. nursing assistant (NA)-F stated R3 appeared more comfortable in a new wheelchair he received on 5/19/21. NA-F stated R3's old chair was too big and R3 would slide down the chair. NA-F stated the wheelchair foot pedals would stop R3 from falling. NA-F stated R3's legs always hit the back of his old wheelchair. NA-F stated she was not aware R3 had a pressure ulcer.

During an interview on 6/2/21, at 8:11 a.m. NA-G stated R3 said, "ow, ow, ow, it hurts" often when she provided cares for R3. NA-G did not think R3 had a pressure ulcer.

During an interview on 6/2/21, at 8:58 a.m. licensed practical nurse (LPN)-C stated she was R3's nurse and did not think he had any pressure ulcers.

During an interview on 6/2/21, at 9:11 a.m. OT-H stated on 3/16/21, R3's family agreed to purchase a new wheelchair for R3. OT-H stated R3 tended to push his heels into the old chair since at least October of 2020. OT-H stated she began caring for R3 2/24/21. OT-H stated R3 could had pushed hard enough and long enough to have caused the pressure ulcer to his left heel. OT-H stated she was not aware of other interventions in place prior to the onset of R3's stage three left heel pressure ulcer besides a cushion on the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 12 | 2 900 | | |

wheelchair foot pedal. OT-H also stated the interdisciplinary team likely did not think R3 could push so hard to cause a pressure ulcer on his heel.

During an interview on 6/2/21, at 10:13 a.m. registered nurse (RN)-A stated R3 had a stage three pressure ulcer on his left heel which opened on 4/29/21. RN-A stated R3 did a lot of pushing and sliding on his heels which could have caused the left heel pressure ulcer. RN-A verified R3's care plan did not reflect his left heel pressure ulcer.

During an interview on 6/2/21, at 1:34 p.m. R3's specialized wound nurse, RN-J stated R3's pressure ulcer was acquired at the facility. RN-J also stated she thought R3's wound was related to rubbing. RN-J stated she was not sure if the pressure ulcer could had been prevented due to R3's severe contraction and how he rubbed R3's legs.

During an interview on 6/2/21, at 3:16 p.m. medical doctor (MD)-C stated every pressure ulcer was preventable. MD-C stated R3 the way R3 sat in his wheelchair looked funny and the wound could had been caused by R3 rubbing his heel against the hard part of the chair. MD-C stated R3 had to rub against something and put pressure on his heel long enough to develop the pressure ulcer. MD-C stated the facility likely did not notice in time to take pressure off R3's heel to prevent the pressure ulcer on R3's heel.

During an interview on 6/2/21, at 2:35 p.m. the director of nursing (DON) stated she was not able to verify if the pressure ulcer was preventable due to R3's constant movement of his heel. The DON stated R3's heel wound was initially a blister type

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 13<br>wound which was identified in April or May. The DON also stated her expectation would be for care sheets to indicate if a resident had a wound.<br><br>Although R3 was noted to push his heels into his previous Broda chair, interventions which included a heel lift foam boot, a PT evaluation, and new wheelchair were not implemented until after R3 developed a pressure ulcer on 4/29/21.<br><br>R1's Face Sheet dated 6/3/21, indicated R1's diagnoses included Amyotrophic Lateral Sclerosis (a progressive disease that affects the nerve cells in the brain and spinal cord resulting in paralysis), bilateral paralysis, morbid obesity, irritant contact dermatitis.<br><br>R1's annual Minimum Data Set (MDS) dated 3/9/21, indicated R1 had intact cognition. The MDS indicated R1 required total assistance with two staff members for all activities of daily living (ADLs). R1 was always incontinent to bladder and bowel. The MDS indicated R1 was at risk for pressure ulcers and had no skin conditions which included moisture associated skin damage (MASD).<br><br>R1's Pressure Ulcer/Injury Care Area Assessment (CAAs) dated 3/9/21, indicated R1 had MASD and sometimes allowed staff to reposition her with a wedge.<br><br>R1's care plan dated 12/8/19, indicated R1 had an alteration in bowel function. The care plan directed staff to be aware of shearing to R1's buttocks and treat as ordered. Interventions indicated R1 was to be moved in bed by a minimum of two people with a drawsheet, keeping linen free of wrinkles. | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 14<br><br>R1's Skin Care Flow Sheet dated 5/19/21, indicated R1's right buttock wound was 7 centimeters (cm) long by 9 cm wide by 0.1 cm deep. R1's left buttock wound was 8 cm long by 9 cm wide with no depth. R1's gluteal crease wound was 2 cm long by 0.5 cm wide by 0.1 cm deep.<br><br>R1's Skin Care Flow Sheet dated 5/26/21, indicated R1's right buttock wound was 11.5 cm long by 11 cm wide by 0.1 cm deep. R1's left buttock wound was 10.5 cm long by 11 cm wide by 0.1 cm deep. R1's gluteal crease wound indicated it was closed.<br><br>R1's Skin Care Flow Sheet dated 6/2/21, indicated R1's right buttock wound was 7.5 cm. long by 12.5 cm. wide containing two open areas 0.1 cm. deep. The wound base was mild red, pink and yellow and there was a scab present. The note indicated R1's left buttock wound was 10 cm. long by 11 cm. wide. The note also indicated R1's gluteal crease wound was 6 cm long by 0.3 cm. wide by 0.1 cm. deep.<br><br>During an observation and interview on 6/2/21, at 9:48 a.m. NA-M crossed R1's legs then pushed R1's right buttock and shoulder to roll R1 away from her on to R1's left side. This caused R1's buttocks to separate and exposed R1's gluteal crease wound. R1's face was red, she grimaced, and was crying. RN-I was in R1's room and gathered wound dressing supplies, however, did not assist NA-M to reposition R1. NA-M independently repositioned R1 although, R1's care plan required two staff for repositioning. At 10:13 a.m. NA-M put a fitted sheet under R1 and rolled R1 on her back after assisting RN-I with wound care. The sheet was too small for the mattress which caused the sheet to fall down | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 15 | 2 900 | | |

behind R1's shoulders and created folds and creases against R1's back. NA-I also folded a flat sheet, approximately 18 inches wide, and placed it under R1 as a drawsheet. The sheet did not cover R1's back to provide support during repositioning and was visibly creased and bunched under R1's left hip. The fitted sheet and drawsheet were left bunched and creased under R1 when NA-M and RN-I left R1's room.

During an interview on 6/2/21, at 11:45 a.m. RN-I stated R1 previously was hospitalized and returned to the facility on 4/7/21, and had no open areas on her buttocks. RN-I stated R1 developed wounds which worsened since returning to the facility. RN-I stated NAs' independently repositioned residents who required two staff for repositioning, and it made RN-I, "nervous."

During an interview on 6/2/21, at 3:02 p.m. the DON stated it would have been inappropriate for an NA to reposition or move R1 alone if a resident's care plan required two staff for bed mobility. The DON further stated the expectation was that the NA's would have followed the care plan and asked for assistance.

During an interview on 6/3/21, at 9:33 a.m. R1 stated when the staff turned her, they pushed and pulled on her buttocks. R1 stated she felt the skin tear in her gluteal crease.

During an interview on 6/3/21, at 10:07 a.m. medical doctor (MD)-C stated the skin on R1's buttocks was moist and fragile. MD-C also stated it was possible R1's gluteal crease wound worsened due to staff pushing and pulling R1's buttocks when they rolled her on to her side.

The facility Prevention and Treatment of Skin

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 2 900 | Continued From page 16<br>Breakdown policy dated 2018, indicated a pressure injury occurs as a result of intent and/or prolonged pressured or pressure in combination with shear.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 900 | | |
| 21435 | MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General<br><br>Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. | 21435 | | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21435 | Continued From page 17<br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide meaningful activities for 1 of 3 residents (R2) reviewed for activities.<br>Finding include:<br>R2's Face Sheet dated 6/3/21, indicated diagnoses of anoxic brain damage and visual loss.<br>R2's quarterly Minimum Data Set dated 4/1/21, indicated severe cognitive impairment and minimal risk for depression. R2 sometimes adequately responded to simple, direct communication to make self understood or to understand others. The MDS had no indication of daily or activity preferences. The MDS indicated R2 was totally dependent on staff for transfers and locomotion on unit. R2 had an impairment on both sides of his upper and lower extremities.<br>R2's Physician Orders Report dated 5/26/21, indicated to be up in a Broda chair as tolerated and to lay down after lunch. R2 was to be up in his Broda chair after breakfast at 10:30 a.m., back to bed after lunch and back up for dinner around 4:00 p.m.<br>R2's care plan dated 10/9/20, had no indication of R2's specific activities preferences. Interventions came from family; R2 enjoyed action movies, animals, game shows and one on one socialization.<br>R2's significant change Activity Assessment dated 1/7/21, indicated R2 enjoyed bingo, board games, and cards. R2's music preference included religious, gospel, oldies, R&B,and BB King. R2 enjoyed the outdoors, scenic drives, shopping, parties and special events. R2 needed assistance to and from programs. The assessment also indicated R2 required assistance at programs, encouragement and one to ones. R2 preferred | 21435 | Corrected | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21435 | Continued From page 18 | 21435 | | |

one to ones and preferred his own room. Finally, the assessment indicated R2's family was supportive and involved.
R2's Individual Attendance Record for May 2021, indicated R2 was in his room with television/radio sensory each day in May except on 5/4/21. The record indicated R2 received one staff visit on 5/1/21, and one family/friend visit on 5/6/21.
R2's One on One Visits Form dated 6/1/21, indicated on 4/8/21, staff gave R2 some water and fixed his pillow, turned the radio on and had small talk. On 3/16/21, R2 requested water; activities (A)-B held the straw while R2 drank water. There was no other indication of one on one visits provided to R2 for March 2021, April 2021, May 2021 or June 2021.
During an observation on 6/1/21, at 8:55 a.m. R2 laid in his bed and the television was on.
During an observation on 6/1/21, at 11:11 a.m. R2 laid in his bed while A-B hung the activities calendar on his wall. A-B left the room and did not explain to R2 what the calendar said.
During an observation on 6/1/21, at 2:09 p.m. R2 laid in his bed and the television was on.
During an interview on 6/1/21, at 9:20 a.m. nursing assistant (NA)-B stated R2 did not usually get out of his bed when she worked with him and was unsure when R2 got out of bed.
During an interview and observation on 6/1/21, at 9:30 a.m. R2 stated he liked to go outside but was not able to and did not know why. R2 further stated he told staff but nothing had happened. R2 also stated he liked to listen to BB-King, Blues and R & B but it was rare if he could. R2 had a smile on his face and his eye brows raised when he reported what he liked to do.
During an interview on 6/1/21, at 10:52 a.m. registered nurse (RN)-B stated he was not sure what R2 liked to do.
During an interview on on 6/1/21, at 11:11 a.m.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21435 | Continued From page 19<br><br>A-B stated R2 was blind and did not go to activities in the building. R2 stayed in his bed and watched television often, as they had to rely on nursing to get him out of bed. A-B also stated staff provided one on one visits when they would go into his room to provide cares or give water during the day.<br>During an interview on 6/1/21, at 11:16 a.m. NA-C stated R2 did not get to go to group activities in the building and was not sure why.<br>During an interview on 6/1/21, at 11:43 a.m. A-A stated they did not bring R2 to group activities due to R2's lack of endurance to sit up. A-A additionally stated most activities would be hard for him due to his visual impairment. A-A verified the care plan did not indicate R2's specific activity preferences. A-A also stated she got R2's activity preference from the family due to his past cognition and should re-approach him. A-A stated prior to COVID-19, she made cue cards for staff to know a resident's activity preferences but she had not made them recently.<br>During an interview and observation on 6/1/21, at 11:53 a.m. A-B stated they had an attendance binder. A-B took out the binder and said R2's activities included one staff visit where the activities calendar was hung in R2's room. A-B also pointed out and stated that R2 had one activity noted in April on 4/8/21, which stated staff gave R2 some water, fixed his pillow and turned on the radio for him. Also, A-B stated there were not other indications of activities provided for April 2021, besides television/radio.<br>During an interview on 6/1/21, at 12:35 p.m. NA-D stated she would look at a resident's care sheet to see what their activities preference were. R2's care sheet did not provide this information.<br>During an interview on 6/1/21, at 12:28 p.m. R2 stated he could not read what activities were on the calendar since he was blind. When asked, R2 | 21435 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21435 | Continued From page 20 | 21435 | | |

stated he was often bored. The calendar was read to him and R2 stated he would be interested to attend bingo or cookies and café in the morning.
During an interview on 6/1/21, at 1:45 p.m. RN-B was not aware of what R2 enjoyed doing or if he attended activity programs. RN-B also stated R2 may enjoy coffee with other residents as he liked to talk or have someone read to him. RN-B stated he did not read the activities calendar to R2.
During an interview on 6/3/21, at 8:28 a.m. family member (FM)-J stated she had been concerned of R2's mental and physical health as he was not active and was isolated in his room. FM-J also stated she offered to bring in CD's when R2 was first admitted but had not heard back if he had a CD player or not. FM-J stated she visited often and R2 was always in bed with the television on. FM-J further stated if R2 was in his wheelchair she would like to take him outside or somewhere in the building but he was always in his bed.
During an interview on 6/3/21, at 8:56 a.m. NA-E stated she was not aware of what R2 liked. NA-E also stated staff would talk to him when they brought him water or did cares but was not aware of any other activities he had.
During an interview and observation on 6/3/21, at 9:01 a.m. licensed practical nurse (LPN)-A stated R2 kept to himself and usually watched television. LPN-A also stated he thought R2 liked to watch the news and listen to country music but went to ask R2 to confirm as he was not sure. LPN-A asked R2 what he liked to do and R2 said he would like to go outside or listen to the Blues, BB King or R&B. LPN-A searched R2's room and stated their was no CD or tape he could find in R2's room to play R2's music preferences. LPN-B also stated activities usually worked with R2 for his social needs.
During an interview on 6/3/21, at 9:22 a.m. A-A

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21435 | Continued From page 21 | 21435 | | |

verified R2 did not participate in any activities and his participation would be difficult since R2 could not see and needed a one to one. A-A also stated the facility did not have any Blues, BB-King, or R&B music to play for him besides the one facility Ipad which was used for all residents in the building. A-A verified the activities department has not met the expectation to stimulate and meet R2's needs.
During an interview on 6/3/21, at 10:18 a.m. the director of nursing (DON) verified she would expect the facility to have done more for R2. The DON stated she would have expected R2 to have some music he enjoyed or more activities to keep him entertained.
The facility Wellness policy undated, indicated to involve each resident in an ongoing program of activities that is designed to appeal to their interest and would be reflected in the residents individualized person-centered care plan. Each resident's activity program should have been individualized meeting their interests and needs with the residents desired outcomes, including one to ones. Activities referred to any endeavor other than routine activities of daily living (ADL)'s which was intended to enhance the sense of well-being. These included but were not limited to activities that promoted self-esteem, pleasure, comfort, education, creativity, success, and independence.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, activities director or designee, could engage the interdisciplinary team (IDT) to ensure residents in the facility were provided meaningful activities to meet their interests and include activities on evenings and weekends. Activities selected should be resident-centered. The administrator or designee could seek advice from resident council

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21435 | Continued From page 22<br>on likes and dislikes of types and kinds of activities offered in the facility. Activities should incorporate the resident's interests, hobbies and cultural preferences, integral to maintaining and/or improving a resident's physical, mental, and psychosocial well-being and independence and promote self-esteem, pleasure, comfort, education, creativity, success, and independence. ADL-related activities, such as manicures or pedicures, hair styling, and makeovers, may be considered part of the activities program. Activities selected should be individualized and customized based on the resident's previous lifestyle (occupation, family, hobbies), preferences and comforts. Activities should not be confined to a department, but rather may involve all staff interacting with residents. Activities could be non-structured. The administrator or designee could ensure any activities supplied to residents in this manner be care-planned and documented in the residents ' medical record and audited. The results of those audits should be taken to QAPI to determine compliance or the need for continued monitoring.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21435 | | |
| 21810 | MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights<br><br>Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. | 21810 | | 7/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21810 | Continued From page 23<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure necessary equipment for communication, and a call light, were continuously operational and available for 1 of 3 residents (R1) reviewed for accommodation of resident needs.<br><br>Findings include:<br><br>R1's face sheet dated 6/3/21, indicated R1 had diagnoses that included Amyotrophic Lateral Sclerosis (ALS) (a progressive disease that affects the nerve cells in the brain and spinal cord resulting in paralysis), respiratory failure, bilateral paralysis, anxiety, aphonia (inability to speak), and a tracheostomy (a hole made in the neck for a breathing tube) with ventilator dependence (required a machine to breathe).<br><br>R1's annual Minimum Data Set (MDS) dated 3/9/21, indicated R1 had a Brief Interview for Mental Status (BIMS) of 13 with minimal cognitive deficits. The MDS indicated R1 was a total assist of two staff for all activities of daily living (ADLs).<br><br>R1's care plan dated 3/22/21, indicated R1 used a Dynavox computer (an eye gaze-enabled, speech generating device that allowed people who were paralyzed and/or unable to speak, to communicate) to communicate needs to staff. R1's care plan indicated during a care conference on 1/22/20, the provider and R1 determined the Dynavox was the only successful call light for R1. The care plan indicated R1's needs must be anticipated by staff due to R1's very | 21810 | corrected | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21810 | Continued From page 24 | 21810 | | |

limited/inability to communicate. The care plan also indicated R1 had increased care needs related to ALS. Interventions included staff to set up the Dynavox before staff left the room to enable R1 to call for help.

The Nursing Assistant Worksheet dated 5/26/21, indicated R1's call light was the Dynavox and to ensure it was set up.

R1's provider note dated 5/7/21, indicated R1 did not have access to the Dynavox during the provider's visit. No explanation or use of alternative means of communication was documented.

During an interview on 6/1/21, at 9:00 a.m. R1 stated she was often unable to call for help because the Dynavox did not work or was not calibrated and she sometimes waited hours for staff to check on her.

During an observation and interview on 6/1/21, at 9:09 a.m. registered nurse (RN)-E entered R1's room and stated R1 received a new Dynavox the previous week, but staff were unable to connect R1's phone to the system which would have allowed R1 to text and call her family. RN-E stated the staff could not connect the new Dynavox to R1's TV or the Internet so R1 still used the old Dynavox. RN-E stated the Dynavox required R1 to be positioned upright, in front of the monitor so the device could track both of R1's retinas. RN-E stated the computer had to be recalibrated every time R1 was repositioned or moved during cares. RN-E stated R1 could activate the alarm on the Dynavox to call for assistance; however, if the Dynavox was not calibrated, R1 could not call for help. RN-E indicated they would check on R1 "more often"

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21810 | Continued From page 25<br>because R1 was not able to use the call light.<br><br>During an interview on 6/1/21, at 10:28 a.m. nursing assistant (NA)-K stated R1 usually needed help with the old Dynavox because it would not stay calibrated. NA-K stated she tried to connect R1's phone to the new Dynavox but was unable to.<br><br>During an observation on 6/2/21, at 8:22 a.m. NA-M entered R1's room and asked R1 if she could wait to be changed for another 10 minutes. R1 indicated the Dynavox did not work well and attempted to recalibrate it with her eye gaze.<br><br>During an interview on 6/2/21, at 10:45 a.m. NA-M stated she was float staff and worked with R1 once or twice a month. NA-M stated she was unable to read R1's lips and needed the Dynavox to be able to communicate with her.<br><br>During an interview on 6/2/21, at 2:11 p.m. family member (FM)-M stated R1's family and friends often worried about R1 at night because R1's Dynavox did not work. FM-M stated R1's family and friends were unable to get a hold of R1 and would call the facility to have staff check on R1 and if her Dynavox was set up.<br><br>During an observation on 6/2/21, at 2:35 p.m. FM-M visited in R1's room. R1 sat in a chair with the Dynavox positioned in front of her face. The Dynavox did not register R1's eye movements and therefore, R1 was not able to communicate. R1 attempted to activate the alarm/call light on the Dynavox monitor with her eye gaze but was unable to. FM-M left the room to find staff to assist R1 to re-position and recalibrate the Dynavox. At 2:40 p.m. NA-M entered R1's room and, after multiple attempts to recalibrate the | 21810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21810 | Continued From page 26<br>Dynavox, NA-M chose to restart the system.<br><br>During an observation and interview on 6/3/21, at 8:45 a.m. NA-I assisted R1 with breakfast in R1's room. The volume on the TV was on the loudest setting of 100. R1 attempted to turn the volume down using the Dynavox but was unsuccessful. NA-I did not attempt to assist R1. At 8:57 a.m. medical doctor (MD)-C entered R1's room and, unable to speak over the volume of the TV, used the remote to turn the volume down to 47. NA-I stated she was allowed to assist R1 with the TV volume but had not been formally trained on the Dynavox and that was the first day NA-I had seen the new device.<br><br>During an interview on 6/3/21, at 2:46 p.m. R1's psychologist (MD)-B stated she taught herself how to use the Dynavox computer so she could better communicate with R1. MD-B stated the Dynavox did not work when she visited R1 the previous day and MD-B had to reposition R1 and the Dynavox before she could recalibrate it, which allowed R1 to communicate. MD-B stated the staff should have improved their efforts to accommodate R1 to set up the Dynavox properly. MD-B stated she did not recall the other residents who used a Dynavox having as many issues with their devices.<br><br>During an interview on 6/2/21, at 3:02 p.m. the director of nursing (DON) stated she thought the staff were trained on the Dynavox but was not certain who did provided the training or how often. The DON stated R1 was unable to hold herself upright and it made it difficult for R1 to use the Dynavox.<br><br>SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could | 21810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00960 | A. BUILDING: _____ B. WING _____ | C 06/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BENEDICTINE HEALTH CENTER OF MINNEAP | 618 EAST 17TH STREET MINNEAPOLIS, MN 55404 |

| (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 |
|---|---|---|---|---|
| 21810 | Continued From page 27<br>develop, review, and /or revise policies and procedures to ensure all residents have their call lights within reach or function appropriately. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21810 | | |