DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces the letter dated August 14, 2024 to reflect correct State Order cycle corrected.

Electronically delivered

February 13, 2025

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

Re: Reinspection Results
Event ID: BR2X12

Dear Administrator:

On June 21, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on May 23, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces the letter dated August 14, 2024 to show change of complaince date and update of remedies.

Electronically delivered
February 13, 2025

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

RE: CCN: 245266
Cycle Start Date: May 23, 2024

Dear Administrator:

On June 4, 2024, we notified you a remedy was imposed. On July 16, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 19, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 19, 2024 did not go into effect. (42 CFR 488.417 (b))

In our letter of July 2, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 18, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 14, 2024

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

RE: CCN: 245266
Cycle Start Date: May 23, 2024

Dear Administrator:

On June 4, 2024, we notified you a remedy was imposed. On August 5, 2024 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 26, 2024.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 19, 2024 be discontinued as of July 26, 2024. (42 CFR 488.417 (b))

In our letter of June 4, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 18, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

An equal opportunity employer.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 14, 2024

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

Re: Reinspection Results
Event ID: BR2X12 and WNOQ12

Dear Administrator:

On June 21, 2024 and August 5, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the surveys completed on May 23, 2024 and June 27, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 4, 2024

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

RE: CCN: 245266
Cycle Start Date: May 23, 2024

Dear Administrator:

On May 23, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 19, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 19, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 19, 2024.

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

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 19, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Benedictine Health Center Of Minneapolis will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 19, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

DEPARTMENT CONTACT

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

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 23, 2024 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or

termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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://forms.web.health.state.mn.us/form/NHDisputeResolution

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,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 4, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: BR2X11

Dear Administrator:

The above facility was surveyed on May 21, 2024, through May 23, 2024, 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:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office: (507) 206-2728

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@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 _____	05/23/2024

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 *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 5/21/24, 5/22/24, and 5/23/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you	2 000		

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 _____	05/23/2024

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

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H52663564C (MN00103082 & MN00103094) and H52663965C (MN00101595) with licensing orders issued at 0900 and 1375. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 2 not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers 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: 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 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess pressure ulcers and provide necessary treatment and services to prevent and/or mitigate the risk of new ulcer development or deterioration resulting in actual harm with the development of a new pressure injury for 1 of 3 residents (R1) reviewed	2 900	Corrected 06/14/2024	6/14/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 3 for pressure ulcers. Findings include: Definitions of pressure ulcer types Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis (middle layer of skin), presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Fat is not visible and deeper tissues are not visible. Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (non-viable usually moist tissue than can be soft and stringy in texture) and/or eschar (dead or devitalized tissue that is usually black and may appear scab-like) may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may occur. Fascia (connective tissues), muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable pressure ulcer. Unstageable Pressure Ulcer: 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. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Deep Tissue Pressure Injury (DTPI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy,	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 4 boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. R1's Minimum Data Set (MDS) dated 4/17/24, indicated R1 admitted to the facility on 4/11/24 from a hospital and had diagnoses including unspecified displaced fracture of first cervical vertebra (broken neck), anemia (lack of healthy red blood cells), septicemia (sepsis), stroke, quadriplegia, respiratory failure, stage 2 pressure ulcer of right buttock, unspecified convulsions, and dependence on ventilator status. R1 was rarely/never understood and rarely/never understood others, had severely impaired cognitive skills for daily decision making, had range of motion limitations in all extremities, and was fully dependent on staff for cares such a mobility in bed, transferring, and hygiene. R1 had an indwelling urinary catheter, was always incontinent of bowel, got 51% or more of total calories through a feeding tube, utilized supplemental oxygen, was on an invasive mechanical ventilator, and needed tracheostomy care. R1's MDS identified him as at risk for developing pressure ulcers and noted one stage 2 pressure ulcer present on admission with treatments of a pressure reducing device for chair and bed, pressure ulcer care, and the application of nonsurgical dressings other than to feet. R1's post-discharge instructions from the discharging facility dated 4/10/24, included "Miami J collar [a cervical collar/brace to stabilize cervical neck injuries] in place due to diagnosis of C1-C4 [cervical vertebra one through four] fracture incomplete quadriplegia." It did not	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 _____	05/23/2024

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BENEDICTINE HEALTH CENTER OF MINNEAP	618 EAST 17TH STREET MINNEAPOLIS, MN 55404

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2 900	Continued From page 5 include orders or instructions regarding management of the collar, note any active wounds, or include orders for wound care. A progress note dated 4/12/24, indicated R1 arrived at the facility the previous evening at 7:38 p.m. and had a cervical collar on as well as "wound on both buttock/coccyx," with left buttock wound measuring 3 centimeters (cm) long by 0.7 cm wide and right buttock wound measuring 2.5 cm long by 1 cm wide. The note included "clean[ed] with NS [normal saline] and foam dressing applied." It lacked comprehensive assessment of both wounds that identified risk factors including decreased mobility, medication that impaired healing, co-morbities, refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition, hydration, pressure points for turning and reposition needs, wound bed characteristics, drainage and pain. R1's Skin Risk Observation with Braden Scale dated 4/12/24, indicated R1 had one of more unhealed pressure injuries at stage 1 or higher. The location(s) of the observed pressure injuries was "buttock R/L [right/left]." R1's Braden Scale for Prediction of Pressure Sore Risk indicated he was at a high risk level. It lacked further assessment of the identified wounds. A provider note by nurse practitioner (NP)-A dated 4/12/24 and 4/16/24, both noted "no skin breakdown." They also noted "Incomplete quadriplegia since 11/2023. Has a collar in place. Plan: will need neuro[logy] follow up with xrays [sic]." R1's provider orders included an order dated 4/16/24, noting "resident has a Miami Jay [sic] collar. Special instructions: NP will address after	2 900		

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2 900	Continued From page 6 review of chart." R1's provider orders included an order dated 4/16/24, for "wound care: sacral area foam dressing every shift until wound nurse assessment." R1's electronic health record (EHR) lacked wound care orders for the sacral wound prior to 4/16/24. R1's Treatment Administration Record (TAR) dated 4/1/24 to 4/30/24, indicated the sacral wound care treatment was first documented as complete on the first shift of the day on 4/16/24. R1's TAR lacked documentation of wound care treatments for the sacral wound prior to 4/16/24. R1's Wound Management Detail Report by the facility's wound nurse dated 4/17/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 2.8 cm long, 2.5 cm wide, and 0.1 cm deep with no exudate (drainage) or odor, was a stage 2, had no undermining or tunneling, irregular wound edges, 100% epithelial tissue, blanchable redness of the skin surrounding the wound, and wound healing status was stable. Comments noted "peri-wound skin fragile." The wound report did not address the pressure ulcer on the left buttock previously identified on left buttock. R1's Care Area Assessment (CAA) for pressure ulcer/injury dated 4/22/24, identified R1's risk factors for pressure ulcer/injury. Extrinsic risk factors included: requires staff assistance to move sufficiently to relive pressure over any one site, confined to a bed or chair all or most of the time, needs special mattress or seat cushion to reduce or relieve pressure, slides down in the bed, and persistently wet (especially from fecal	2 900		

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2 900	Continued From page 7 incontinent, wound drainage, or perspiration). Intrinsic risk factors included: immobility, cognitive loss, incontinence, and poor nutrition. Medication risk factors included opioid medications. Diagnoses or conditions that presented complications or increased risk included: cerebrovascular accident (stroke), paraplegia/quadriplegia, edema, sepsis, pain, and recent decline in functional abilities. Treatments and other factors that caused complications or increased risk included: newly admitted or readmitted, history of healed pressure ulcer/injury, ventilator or respirator, functional limitation in range of motion, head of bed elevated most or all of the time, and devices that can cause pressure (such a oxygen or indwelling catheter tubing, TED (compression) hose, casts, or splints). The analysis of findings noted "admitted [with] pressure ulcer and pressure ulcer risk with contributing factors above. At risk for further clinical declines, increased burden of care, discomfort if this does not heal or further breakdown occurs." R1's Wound Management Detail Report by the facility's wound nurse dated 4/24/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 2.3 cm long, 2 cm wide, and 0.1 cm deep with a light amount of bloody (bright red, thin) exudate, no odor, was a stage 2, had no undermining or tunneling, had wound edges epithelializing flush with the wound base, 100% epithelial tissue, blanchable redness of the skin surrounding the wound that was dry and thin, and wound healing status was improving. Comments noted "Smaller. Peri-wound skin has fragile areas. Hydrocolloid covers [a type of dressing for wounds]."	2 900		

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2 900	Continued From page 8 R1's care plan for pressure ulcer/injury dated 4/26/24, noted "I have a current pressure ulcer (admitted with) located buttock/sacral area. I am at risk for increased skin integrity issues due to incontinence, immobility, use of equipment and medications, anemia." Goal dated 4/29/24, noted "my pressure ulcer will continue to show sings of healing and no new areas will develop through the review date" with interventions dated 4/26/24 including assisting with repositioning every two to three hours with use of an air mattress for pressure relief and need for head of bed elevated for tube feeding and ease of breathing, nursing assistants (NA's) observing skin and reporting any abnormalities to the nurse, having good skin hygiene and skin to be moisturized as needed if dry, elimination of waste to be addressed in the toileting section of the care plan, monitoring of labs and weight as ordered, pressure redistributing mattress on bed and cushion in chair, proper notifications to be made if wounds change, staff providing adequate nutrition and hydration with nutritional supplements and vitamins as ordered, using pillows between knees and bony prominences to avoid direct contact, and treatments as ordered (see TAR). A provider note by nurse practitioner NP-A dated 4/26/24, noted "no skin breakdown." It also noted "Incomplete quadriplegia since 11/2023. Has a collar in place (wife reports C2 [second cervical vertebra] was not healing and that is why collar was left in place in Arizona [R2 admitted to facility from a hospital in Arizona]). Plan: will need neuro[logy] follow up with xrays [sic] and referral to [local hospital] neurosurgery." A neurosurgery clinic provider note dated 4/30/24, noted R1 was seen for "consideration of weaning of collar" and noted "due to the complexity of the	2 900		

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2 900	Continued From page 9 patient's recent hospital course, would like to review chart in more detail prior to discontinuing collar." Instructions included follow-up on Thursday at 8:30 a.m. and orders placed at the visit were for a computed tomography (CT) scan. R1's Wound Management Detail Report by the facility's wound nurse dated 5/1/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 3 cm long, 6 cm wide, and the depth could not be measured with a moderate amount of serosanguineous (pale red to pink, thin and watery) exudate, no odor, was a stage 3, no undermining or tunneling, had irregular wound edges, was 60% covered by epithelial tissue and 40% covered by slough tissue (dead tissue usually cream or yellow in color), skin surrounding the wound had blanchable redness, and the wound healing status was declining. Comments noted "Larger area of denuded [exposed, damaged] skin." R1's wound was identified as a stage 3 pressure ulcer whereas previous Wound Management Detail Reports from 4/17/24 and 4/24/24 had identified this wound as stage 2. R1's Wound Management Detail Report by the facility's wound nurse dated 5/1/24, included a pressure ulcer with location of "coccyx center; superior" not present on admission with date identified of 5/1/24. The wound was 2.7 cm long, 1.1 cm wide, with depth that could not be measured, no odor or exudate, was a stage 3, had no undermining or tunneling, the wound was 90% covered by slough tissue and 10% covered by epithelization tissue, had well defined wound edges with pink/normal surrounding skin, and the wound healing status was stable. Comments noted "covered with hydrocolloid along with other open area."	2 900		

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2 900	Continued From page 10 R1's skin care plan did not include any revisions upon identification of the worsening pressure ulcer of the right coccyx. Further R1's record did not include a comprehensive assessment of the center superior coccyx wound identified on 5/1/24 that included risk factors including decreased mobility, medication that impaired healing, co-morbities, refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition, hydration, pressure points for turning and reposition needs, and pain. During an interview on 5/23/24 at 1:10 p.m., the assistant director of nursing (ADON) confirmed R1's admission progress note dated 4/12/24 identified sacral pressure ulcers on both the left and right sides with placement of a foam dressing and wound care orders that started on the 16th with the order for a sacral area foam dressing every shift. The ADON stated she did not see any evidence of wound care between 4/12/24 and 4/16/24. She noted that if a resident arrived with wounds but no wound care orders, staff should request orders from the provider and this did not meet her expectation for wound care nor was it in line with standards of care. The ADON identified that a pressure ulcer not being treated had the potential to worsen. The ADON stated comprehensive assessment of wounds were completed by the facility's wound nurse who rounds weekly on Wednesdays. She confirmed that the wound nurse saw R1 on 4/17/24 and documented the right coccyx pressure wound but did not document the second wound previously identified in the 4/12/24 progress note until a visit on 5/1/24 when it was first comprehensively assessed. The ADON stated the wound should have been assessed as soon as it was identified and by the wound nurse when she saw R1 on	2 900		

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2 900	Continued From page 11 4/17/24. The ADON confirmed documentation indicated R1's right coccyx pressure ulcer progressed from a stage 2 wound on 4/24/24 to a stage 3 wound on 5/1/24 and she would want a resident's care plan, orders, and interventions to be updated for a worsening wound and did not have any evidence that interventions were re-assessed for effectiveness when staff identified the wound was worsening. A provider note by nurse practitioner NP-A dated 5/2/24, indicated R1 had a change in condition and NP-A recommended sending him to the hospital for further evaluation and diagnosis. A progress noted dated 5/2/24, indicated R1 was transported to the emergency department via emergency services at approximately 11:30 a.m. A hospital patient care image (photograph) in R1's EHR dated 5/2/24 at 1:42 p.m., depicted a large open wound on the back of the head with description of "mechanical pressure ulcer back of head from c collar [cervical collar]." Additional photographs depicted a foam border dressing with the date 3/18 visible on the front in marker and the back of the dressing with a large amount of bloody drainage, hair, and skin attached after removal from R1's head. A hospital intensive care unit admission note dated 5/2/24 at 1:44 p.m., included "open wounds on his occipital area and coccyx (pictures in chart)." A hospital progress note dated 5/2/24 at 2:03 p.m., noted "patient malodorous, has foam bandage to back of head that is grossly bloody with layers of skin, wound under occiput in same shape and depth of dressing dated 3/18 as in	2 900		

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2 900	Continued From page 12 March 18. Today's date is May 2nd. Unable to currently visualize skin under Miami J. Wound nurse consult placed stat as well." A hospital wound nurse consultation note dated 5/3/24 at 8:10 a.m., identified a pressure injury on the posterior head noted to be unstageable and a pressure injury located on the sacrum with poorly defined/irregular margins noted to be a deep tissue injury. Review of R1's record throughout his admission to the facility prior to transfer to the hospital lacks any documentation of a wound on the posterior head. Nursing Home Incident Report #356410 submitted to the State Agency by the facility dated 5/4/24, noted "resident [R1] was sent to the hospital for evaluation. At the hospital resident was noted having a pressure related ulcer at the back of his head." Nursing Home Incident Report Investigation Report Summary #356410 submitted to the State Agency by the facility dated 5/10/24, noted "staff did not have orders for management of Miami J Collar, and were waiting for [physician]/NP to decide on management." In an interview on 5/23/24 at 7:26 a.m., registered nurse (RN)-D stated R1 had a cervical collar secured with Velcro and they would undo the Velcro to change his tracheostomy ties (a strip of material that goes around someone's neck to assist with securing a tracheostomy tube on the front of the neck). RN-D noted staff did not have an order for the collar and it said in the computer that it would be evaluated by the provider to determine how to manage it. RN-D stated nurses	2 900		

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2 900	Continued From page 13 needed an order to remove the collar to clean the skin underneath and because she saw that the collar was to be evaluated by the provider she thought they would come and do something. RN-D stated she did not know what the manufacturer recommended for management of the Miami J cervical collar. In an interview on 5/23/24 at 8:21 a.m., RN-B stated residents with neck braces admit to the facility with instructions from the doctor about the brace that staff followed. She noted if someone had a brace sometimes they might get a wound, like if the brace is not ever released, if it is tight, or if there is already a wound underneath that needs to be dressed, "so you have to always assess ... you have to see if it is making a wound from the pressure, you have to check the skin." RN-B stated to check the skin nurses could remove the brace if there was an order to do so but, if not, could look and feel inside the space between the back of the head and the brace to assess the skin. RN-B noted that if someone had a brace but no orders she would call the provider to request orders, if someone had a pressure ulcer but no wound care orders she would assess the wound and call the provider to request orders. In an interview on 5/23/24 at 8:53 a.m., RN-C stated "for a resident with a cervical neck brace the first thing is you need to assess the skin under the collar and see what's going on ... you remove it and then put it back on when you're done and check to see if the collar is clean on the inside too." RN-C further stated "if a resident with a collar comes in, it doesn't matter if there is an order or not, you have to assess the skin. If you think it's not safe to remove the collar and do the assessment then you need to let the provider know that you need an order so you can assess."	2 900		

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2 900	Continued From page 14 RN-C states if a resident had a pressure ulcer but no wound care orders nurses have to assess it and tell the provider, it was not okay to just leave it, nurses had to ask for orders. In an interview on 5/23/24 at 11:01 a.m., the administrator stated R1 was admitted on 4/11/24 with a Miami J collar and staff immediately realized they did not have orders for the management of the collar. The administrator noted staff contacted the discharging facility and requested orders the next day but did not receive them. He stated R1 had a provider visit on 4/12/24 and nursing requested orders from NP-A, but NP-A and the doctor said they could not give the orders and R1 needed to be referred to neurology for this. He noted a referral was made and appointment scheduled for 4/30/24. The administrator stated that after the referral was made "the question arose of whether we should take the collar off and see the skin under, but the family said that we should not touch the collar because his C2 hadn't healed and it was very dangerous." He stated they waited and at NP at the neurology clinic saw him on 4/30/24 but was not comfortable giving any orders for management of the collar. The administrator noted that the facility had access to the hospital's medical record system and became aware after R1 was transferred to the hospital that hospital staff identified a wound under the Miami J collar. The administrator stated nurses need to do a thorough job in assessing skin and although they did not have orders to move the collar, maybe they should have sent R1 in faster for evaluation of the collar, maybe to the emergency department rather than wait for a neurology appointment. He noted attempts were made to get orders for management of the collar, but doctors were not willing to provide them and the mistake initially	2 900		

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2 900	Continued From page 15 happened when R1 was admitted without complete orders. The administrator stated that accepting a resident for admission with complete orders was a mistake because once the facility accepted the resident they became the facility's responsibility. In an interview on 5/23/24 at 1:10 p.m., the assistant director of nursing (ADON)stated she was not aware during his admission that R1 had a wound on the back of his head. She noted head to toe skin assessments are done on admission but R1's did not identify a head wound. The ADON noted for someone like R1 with skin underneath a medical device she would expect to have orders for management of the device and would expect staff to have an order to remove a cervical collar. She further noted that staff could have at least felt behind the collar to check R1's skin in the absence of orders to remove the collar for skin assessment. In an interview on 5/23/24 at 2:00 p.m., the director of nursing (DON) stated the facility lacked orders for R1's cervical collar she wouldn't dare remove it without having direction which is why NP-A referred R1 to neurosurgery. The DON noted she expected comprehensive skin assessments and getting needed orders to be done within 24 hours of admission. She stated comprehensive assessments of wounds and documentation of all the wound characteristics were needed to track wound healing and should be done within the first couple days after a wound was identified. She confirmed that a wound identified on a Thursday (4/11/24) that was not comprehensively assessed until the following Wednesday (4/17/24) was not in line with her expectations or professional standards of practice. The DON noted that the facility had	2 900		

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2 900	Continued From page 16 been informed in R1's pre-admission assessment that he did not have any wounds but if someone had a wound and no wound care orders staff should initiate wound care per facility protocol and contact the provider for further orders. In an interview on 5/23/24 at 2:39 p.m., NP-A stated for someone with a cervical collar typical standards of care are that the facility would have some orders for it from the discharging facility. She stated typically the facility would have orders directing to leave a collar on for a specific amount of time or to remove it and clean underneath it, but they "didn't have a lot of data from the discharging facility" about R1 and his collar. NP-A noted she referred R1 to neurosurgery to et an x-ray and orders for the collar for specialist to make a recommendation about what to do. She stated expectations for skin assessment with R1 were tough, if staff had asked her if it was okay to remove to collar and look at the skin underneath she probably would have deferred to the physician because the facility did not have good records and they were going off of what family said. NP-A stated staff "probably wanted me to say let's take off the collar and look at the skin, but we never had that specific conversation about looking at the skin. The question was what do we do with the collar and my answer was send him to neurosurgery. I think we all own a piece of this ... I'm a wound care nurse and I turned him over and looked at his bottom but I didn't take the collar off, didn't see the back of his head ... I was aware that we weren't taking the collar off because we agreed neurosurgery needs to evaluate him." NP-A noted that she first saw R1 on 4/12/24 and did not note any skin issues but knew he had a little area on his bottom and states "I recall seeing small areas on his bottom, one comes to mind, but I can't say for sure. They were like	2 900		

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2 900	Continued From page 17 superficial." In an interview on 5/29/24 at 11:50 a.m., the facility's medical director (MD) stated, if a resident admitted with a cervical collar it would always be left on until staff could obtain orders for its management because staff needed doctor's orders to remove a cervical collar. The MD noted R1 did not have orders for management of his Miami J collar on arrival so staff attempted to get orders from the referring hospital, the primary care team, and the neurology clinic. The MD stated the facility did not receive complete information about R1's care needs and somebody had previously put a dressing on a wound underneath the collar but never recorded it for facility staff to see, so they had no knowledge there was an open area or that there was a dressing in place. The MD identified this as a "bad outcome" and noted nursing staff are responsible for skin care once a resident arrives at the facility. The MD stated he did not have a clear timeline for how long a resident could go without orders for a cervical collar before he would expect alternative interventions, like sending the resident to the emergency department. The MD stated he did not have an answer regarding if he would expect nursing staff to consult manufacturer guidelines for a cervical collar. Miami J Patient Care Handbook from manufacturer Ossur copyrighted 2010, includes "C-Spine Precautions: you must be lying flat to remove the collar unless your doctor gives you permission to do this in a sitting position. You will need a second person to help you in order to maintain the proper head, neck, and airway alignment. Position patient with arms to the side, shoulders down and head aligned centrally.	2 900		

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	00960	A. BUILDING: _____ B. WING _____	05/23/2024

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2 900	Continued From page 18 Unless otherwise specified by your doctor: do not remove the collar except to wash under it and change the pads. Keeping your Miami J and the skin beneath clean is an important part of your treatment. Daily cleaning will help to prevent skin irritation." Facility policy titled Prevention and Treatment of Skin Breakdown dated 2018, included "Policy: Resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care." "Treatment of impaired pressure injury and lower extremity ulcers (arterial, venous, neuropathy/diabetic, mixed) If a resident is admitted with impaired skin integrity or a new pressure injury or lower extremity wound developed the licensed nurse implements the following items: 1.) Documentation of the skin impairment is completed in the medical record. Staging of pressure injury is completed as necessary by trained licensed associated. Other lower extremity wounds with [sic] be described a partial thickness loss or full thickness loss. 2.) Standing orders/protocol for skin wound are initiated. 3.) Notify attending provider, resident and resident representative. Attending provider determines wound type and may provide additional orders. 4.) Notify supervisor/designee. 5.) Evaluate current pressure reduction interventions and revise resident centered care plan."	2 900		

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2 900	Continued From page 19 Facility policies an admission orders and skin protocol were requested but not received SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) 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 DON or designee could also review all residents with pressure ulcers to assure the wounds are comprehensively assessed and included in comprehensive person-centered care plans. The DON or designee could conduct audits of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure ulcer development. The DON or designee could also conduct audits of newly residents to ensure skin assessments are accurate and complete and provide staff education on conducting skin assessments. The DON or designee could bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		6/14/24

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21375	Continued From page 20 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBPs) for 2 of 3 (R3 and R4) residents observed for ventilator (machine that breathes for residents) tracheostomy residents, residents who had feeding tubes or indwelling urinary catheters. Findings include: R3's 5-day Minimum Data Set (MDS) dated 4/16/24, indicated R3 was in a persistent vegetative state and had diagnoses of traumatic brain injury, neurogenic bladder, history of multidrug-resistant organism (MRDOs), pneumonia, septicemia, seizure disorder or epilepsy and respiratory failure. R3 was dependent for all activities of daily living (ADLs). R3 had a tracheostomy and with invasive mechanical ventilator and required suctioning. R3 received tube feeding for nutrition and had an indwelling urinary catheter. Review of R3's care plan did not address R3's risk for infection nor interventions for infection prevention that included the use of personal protective equipment (PPE). During continuous observation on 5/23/24 between 11:15 a.m. and 1:10 p.m., the entrance to R3's room did not have signage posted that identified EBP nor a PPE cart outside/inside the room was in his room. R3 was sitting in his room during this time. Nursing assistant (NA)-R and registered nurse (RN)-C entered R3's room to	21375	Corrected 06/14/2024	

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21375	Continued From page 21 perform care tasks that included, bathing, suctions of tracheostomy, urinary catheter cares and wound dressing changes. Neither staff members were observed using gowns during these activities. R4's quarterly MDS dated 2/27/24, indicated R4's cognition was not assessed however, the annual MDS dated 11/28/23, indicated R4 had severely impaired cognition. R4's MDS dated 2/27/24, identified R4 had diagnoses of high blood pressure, neurogenic bladder, diabetes, aphasia, problems swallowing), hemiplegia/hemiparesis (paralyzed on side), seizure disorder or epilepsy and respiratory failure. R4 was dependent for all ADLs. R4 had tracheostomy with invasive mechanical ventilator and required suctioning. R4 received tube feeding for nutrition and had an indwelling catheter. Review of R4's care plan did not address R3's risk for infection nor interventions for infection prevention that included the use of PPE. During an observation on 5/23/24 at 1:36 p.m., RN-E and NA-S performed cares for R4 which included tracheostomy suctioning, indwelling urinary catheter cares, including emptying the urine collection bag, peri care and wound dressing changes without wearing gowns. During an interview on 5/23/24 at 2:07 p.m., RN-E stated staff never wore gowns for catheter cares, ventilator and tracheostomy cares, and during wound cares unless resident's were on contact precautions. RN-E was not aware of what EBP were and when they should be implemented. During an interview on 5/23/24 at 2:09 p.m., RN-C was not aware of what EBP were and when	21375		

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21375	Continued From page 22 they should be implemented. RN-C stated the staff would only use gowns with contact precautions. During an interview on 5/23/24 at 2:33 p.m., assistant director of nursing (ADON) indicated the facility was in the process of implementing EBP's. During an interview on 5/23/24 at 3:03 p.m., nurse practitioner (NP)-A was not aware of when EBP should be implemented. During an interview on 3/22/24 at 11:48 a.m., Administrator stated residents with implanted medical devices, would need EBP's. These have not been set up and the facility was in the process of implementation these regulations. Review of facility policy dated 2019, titled "Enhanced Barrier Precautions", -purpose was to be a strategy in nursing homes to decrease transmission of center for disease control (CDC)- targets and other important MRDOs. Resident at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing change will be required to use EBP. -Policy table on when to use EBPs to be used with all residents with any of the following.... Indwelling medical devices (e.g., urinary catheters, feeding tubes, tracheostomy/ventilator), regardless of MDRO colonization status. Required personal protective equipment (PPE), gown, gloves prior to high contact care activity. Face protection may also be needed if performing activity with risk of splash or spray. -General considerations when using EBPs indicated 4.) post clear signage on the door or wall outside resident room indicating the type of	21375		

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21375	Continued From page 23 precautions and required PPE. 5.) make PPE available in a designated area outside resident room, 7.) position a trash receptacle inside the resident room and near the exit for the PPE to be discarded prior to exiting the room. 8.) Provide education to staff, residents and visitors as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies and procedures on enhanced barrier precautions and ensure their prompt implementation. The DON or designee could educate all staff on these policies and procedures. The DON or designee could audit to ensure all staff members are aware of and adhering to enhanced barrier precautions and report these findings to their QAPI committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21375		

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F 000	INITIAL COMMENTS On 5/21/24, 5/22/24, and 5/23/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52663564C (MN00103082 & MN00103094) and H52663965C (MN00101595) with deficiencies issued at F609, F610, F686, and F880. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		6/14/24

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

Electronically Signed — 06/07/2024

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

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F 609	Continued From page 1 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report an allegation of abuse to the State Agency (SA) for 1 of 1 resident (R2) reviewed for allegations of abuse. Findings include: A Vulnerable Adult Maltreatment Report submitted to the State Agency on 3/14/24, alleged R2 was physically and emotionally abused by unknown facility staff. The report identified R2 made posts on a social media website including "Benedictine is a violence" and "woman hand head punched cried." R2's Minimum Data Set (MDS) dated 3/19/24, indicated R2 had diagnoses including aphasia, dementia, and cognitive social or emotional deficit following cerebral infarction (stroke). R2 had severely impaired cognitive skills for daily	F 609	F609- Reporting of Alleged Violations Corrective action for resident(s) affected: Alleged abuse of R2 was reported on 5/23/24 at 1817pm. Action as it applies to others: All residents have the potential to be affected, no additional residents identified. Customer Concerns reviewed back 60 days. Systemic Changes: Abuse Prevention Plan Policy was reviewed and remains current. All staff working in the facility are Mandated Reporters and have been reeducated on the Abuse Prevention Plan Policy and the importance of immediate reporting, investigation and intervention. Monitoring for compliance: DON or	

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F 609	Continued From page 2 decision making and physical and verbal behaviors directed at others. R2 sometimes made herself understood and was sometimes able to understand others and required staff assistance with toileting, hygiene, and transferring. The facility's Concern report entry by registered nurse (RN)-A identified a concern dated 3/14/24, and noted RN-A was informed that R2 had "been posting on [social media website] phrases such as 'benedictine violence' and 'woman head punch I cry' ... Writer spoke with DON and administrator, plan to put a camera in [R2's] room after consent signed to confirm that no abuse is taking place." In an interview on 5/23/24 at 9:15 a.m., the administrator stated he had been made aware that R2 was posting words like hitting on a social media website and had an inter-disciplinary team meeting regarding the concern. The administrator stated the team met and decided "we will assume the worst, like maybe somebody is hitting her, maybe she's having rough treatment." The administrator stated if he suspected abuse of a resident had occurred it was his responsibility to immediately report it and start an investigation and the suspicion of abuse had to be reported to the SA within two hours. The administrator noted the statements on the social media website posted by R2 were a problem and if a resident said something that might amount to abuse the facility took it seriously, but he didn't really see R2's writing as cause for suspicion of abuse. In an interview on 5/23/24 at 11:01 a.m., the administrator stated he was going to report the allegations regarding R2 to the SA.	F 609	designee will audit Customer concerns 2x per week to verify accurate reporting of concerns to state agency for 6 weeks. Results will be reported to Quality Assurance Committee to determine the need for further monitoring. Date of compliance: June 14th, 2024 Violation Corrective action for resident(s) affected: Alleged abuse of R2 was reported on 5/23/24 at 1817pm. Thorough investigation was completed including staff, residents and family interviews, and medical record review. Reviewed with unit nursing staff the need to reappproach again after a short time, if she initially refuses or indicates increasing agitation. Approach to care provision needs to be slow and in short phrases when providing information to residents. Action as it applies to others: All residents have the potential to be affected, no additional residents identified. Systemic Changes: Abuse Prevention Plan Policy was reviewed and remains current. Social Services director has been educated on documenting interviews for reportable and non-reportable incident investigations. All staff working in the facility are Mandated Reporters and have been reeducated on the Abuse Prevention Plan Policy and the importance of immediate reporting, thorough investigation and intervention.	

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F 609	Continued From page 3 In an interview on 5/23/243 at 2:00 p.m., the director of nursing (DON) stated with R2's post of "womanhandheadpunchicried" she would be concerned about abuse. The DON stated she did not recall how she became aware of the situation and did not believe it was reported. The DON noted abuse needs to be reported to the SA "fairly immediately" and there was no specific person who filed reports for the facility. Facility policy titled Abuse Prevention Plan with last revision date 7/21/22, included "the community is responsible for reporting suspected abuse, neglect, misappropriation of resident property, and/or financial exploitation in accordance with legal requirements. If the event that caused the suspicion involves abuse or results in serious bodily injury, the individual is required to report the suspicion immediately, but not later than 2 hours after forming the suspicion."	F 609	Monitoring for compliance: DON or designee will audit Customer concerns 2x per week to verify thorough investigation of alleged violations for 6 weeks. Results will be reported to Quality Assurance Committee to determine the need for further monitoring. Date of compliance: June 14th, 2024	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 610		6/14/24

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F 610	Continued From page 4 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct and maintain records of a thorough investigation into an allegation of abuse for 1 of 1 resident (R2) reviewed for allegations of abuse. Findings include: R2's Minimum Data Set (MDS) dated 3/19/24, indicated R2 admitted to the facility on 5/11/23 with diagnoses including aphasia (loss of ability to understand and express speech), dementia, and cognitive social or emotional deficit following cerebral infarction (stroke). R2 had severely impaired cognitive skills for daily decision making and physical and verbal behaviors directed at others. R2 sometimes made herself understood and was sometimes able to understand others and required staff assistance with toileting, hygiene, and transferring. R2's care plan noted R2 was a vulnerable adult and needed assistance to remain safe within the community. The identified goal dated 3/28/24, was "any suspected abuse will be investigated in a timely manor [sic] according to facility policy and procedures" with an intervention dated 5/12/23 of "you will report and investigate any allegations of suspected abuse, neglect, or exploitation." A Vulnerable Adult Maltreatment Report submitted to the State Agency on 3/14/24, alleged	F 610	F610- Investigate/Prevent/Correct Alleged This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. Alleged abuse of R2 was reported on 5/23/24 at 1817 PM. Thorough investigation was completed including staff, residents and family interviews and medical record review. Interventions for ongoing speech therapy to encourage R2 to continue writing and communicating. Caregivers were educated on providing care to R2 and how care may be perceived. Family and significant other encouraged to report any suspicious information this resident may put in her social media platform. All residents have the potential to be affected, no additional residents identified. Abuse Prevention Plan Policy was reviewed and remains current. Social Services Director has been educated on	

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F 610	Continued From page 5 R2 was physically and emotionally abused by unknown facility staff. The report identified R2 made posts on a social media website including "Benedictine is a violence" and "woman hand head punched cried." The facility's Concern report entry by registered nurse (RN)-A identified a concern dated 3/14/24, and noted RN-A was informed that R2 had "been posting on [social media website] phrases such as 'benedictine violence' and 'woman head punch I cry.'" Documentation noted "Writer did skin assessment and found no signs of bruising or redness noted to resident's body. Writer spoke with DON and administrator, plan to put a camera in [R2's] room after consent signed to confirm that no abuse is taking place and keep resident safe ... Resident remains safe in care given by floor staff, monitoring consent forms signed, camera to be placed in room, staff to be investigated." Findings were identified as "A complete exam was done on resident with no findings of any harm or injuries. SS [social services] interviewed fellow resident on 2nd floor regarding cares provided to all resident on the 2nd floor by all staff including aids and nurses" and "nothing found supports resident was harmed in any way." The report lacked specific documentation regarding interviews with R2, other residents, or staff. A progress note dated 3/15/24, by RN-A noted "writer did skin assessment and found no signs of bruising or redness noted to resident's body. Writer spoke with DON and administrator, plan to put a camera in [R2's] room after consent signed to confirm that no abuse is taking place and keep resident safe ... writer called [R2's family member (FM)-A] back, [FM-A] updated on plan ... forms	F 610	documenting interviews for reportable and non-reportable incident investigations. All staff working in the facility are Mandated Reporters and have been reeducated on the Abuse Prevention Policy and the importance of reporting, thorough investigation and intervention. Daily resident concerns will be discussed at IDT by Social worker. DON or designee will audit customer concerns 2x per week to verify thorough investigation of alleged violations for 6 weeks. Results will be reported to Quality Assurance Committee to determine the need for further monitoring.	

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F 610	Continued From page 6 placed in [R2's] room for [FM-A] to go over." In an interview on 5/22/24 at 10:07 a.m., FM-A stated they had heard the facility was going to do an internal investigation into the social media posts but wasn't sure what happened with that. FM-A noted they had spoken with the facility about putting cameras in R2's room but decided against it and then things kind of "fizzled out," the facility did not reach back out and say what else they would do or what the result of their investigation was. In an interview on 5/22/24 at 11:44 a.m., director of social services (SS)-A stated she remembered hearing something about the social media website posts and "I know they [facility staff] did some investigating, I'm trying to remember what it was. I think they determined it wasn't accurate, what she was saying." SS-A noted other staff would know more about the incident. In an interview on 5/23/24 at 9:15 a.m., the administrator stated he had been made aware that R2 was posting words like hitting on a social media website and had an inter-disciplinary team (IDT) meeting regarding the concern. The administrator stated the team met and decided "we will assume the worst, like maybe somebody is hitting her, maybe she's having rough treatment." The administrator stated if he suspected abuse of a resident had occurred it was his responsibility to immediately report it and start an investigation. He stated there was previously a nurse manager, RN-A, who assisted with the investigation into R2's postings. The administrator noted RN-A spoke to R2 immediately to ask her if she was safe and if anyone was hurting her and did a head-to-toe	F 610		

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F 610	Continued From page 7 skin assessment with no findings. The administrator noted at the IDT meeting the IDT decided to put a camera inside of R2's room but R2's family and partner did not want this or sign the consent forms, so no camera was placed. The administrator indicated staff decided to keep watching R2 and monitoring her behaviors and what she said. He stated RN-A was supposed to document what she investigated in a progress note and concern report and document the interview of R2. He identified the documentation as incomplete. The administrator stated he thought the social worker interviewed other residents to see if they felt safe but information about what the interviews were, who was interviewed, and if staff were interviewed was missing. In an interview on 5/23/24 at 1:08 p.m., SS-A stated she spoke to some residents on R2's floor after she found out about the posts but "many on the floor are vegetative." SS-A identified four residents she thought she spoke to and stated she did not think she documented the interviews. She stated she did not interview staff, she thought the administrator was going to talk to staff. Documentation of resident and/or staff interviews was requested, but not received. An alternative form of safety assessment for "vegetative" residents was not noted. In an interview on 5/23/243 at 2:00 p.m., the director of nursing (DON) stated with R2's post of "womanhandheadpunchicried" she would be concerned about abuse. The DON stated she did not recall how she became aware of the situation. She stated "the nurse manager for that unit [RN-A] was going to follow up and she did some brief initial follow up and had been given direction	F 610		

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F 610	Continued From page 8 that this needs to be investigated. I think it was on a Friday and then on Sunday she ended her employment with us ... I can't tell you exactly what she investigated, can't say if it was thorough." Facility policy titled Abuse Prevention Plan with last revision date 7/21/22, included "Investigation of incidents and allegations: a.) All accident and incidents as well as allegations of abuse, neglect, misappropriation of resident property, and/or financial exploitation will be thoroughly investigated by the Director of Social Services, Director of Nursing, or their appropriate designees ...; b.) Measures will be taken to identify the source of the alleged abuse and prevent future incidents; c.) Investigative packets will be utilized to systematically direct the team through the investigative process; d.) Any evidence gathered will be handled with caution to ensure no tampering, destruction, or alteration occurs. Facility staff conducting the investigation will take care to only share information about the incident or investigation with other staff who have a professional 'need to know;' e.) Identify and interview all who might have knowledge of the incident including the alleged victim, perpetrator, witnesses or others who may have had related contact with the alleged perpetrator, related to the incident in question; f.) The focus of the investigation is to determine the extent, cause and future prevention with thorough documentation of the investigative process completed."	F 610		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		6/14/24

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F 686	Continued From page 9 Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess pressure ulcers and provide necessary treatment and services to prevent and/or mitigate the risk of new ulcer development or deterioration resulting in actual harm with the development of a new pressure injury for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings include: Definitions of pressure ulcer types Stage 2 Pressure Ulcer: Partial-thickness loss of skin with exposed dermis (middle layer of skin), presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister. Fat is not visible and deeper tissues are not visible. Stage 3 Pressure Ulcer: Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough (non-viable usually moist tissue than can be soft and stringy in texture) and/or eschar (dead or	F 686	F686- Treatment/Svcs to Prevent/Heal Pressure Ulcer Corrective action for resident(s) affected: R1 no longer resides at the facility. Medical record will be reviewed through the Quality Assurance committee for process improvement opportunities. Action as it applies to others: All residents reviewed to ensure orders are present for management of applied devices and wounds. All residents reviewed to ensure that comprehensive wound assessments have been completed on all residents with wounds and are care planned appropriately. Systemic Changes: Prevention and Treatment of Skin Breakdown Policy was reviewed and remains current. Nursing leadership, including the nurse completing wound rounds, has been reeducated on completing comprehensive wound assessments including risk factors,	

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F 686	Continued From page 10 devitalized tissue that is usually black and may appear scab-like) may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may occur. Fascia (connective tissues), muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the wound bed, it is an Unstageable pressure ulcer. Unstageable Pressure Ulcer: 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. If the slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Deep Tissue Pressure Injury (DTPI): Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. R1's Minimum Data Set (MDS) dated 4/17/24, indicated R1 admitted to the facility on 4/11/24 from a hospital and had diagnoses including unspecified displaced fracture of first cervical vertebra (broken neck), anemia (lack of healthy red blood cells), septicemia (sepsis), stroke, quadriplegia, respiratory failure, stage 2 pressure ulcer of right buttock, unspecified convulsions, and dependence on ventilator status. R1 was rarely/never understood and rarely/never	F 686	completing wound assessments every 7 days and the expectation of assessment on admission or readmission. Monitoring and documentation of wounds with treatments/dressing changes. All nursing staff have been reeducated on completing skin assessments, provider notification of new, worsening or stalled areas and obtaining and implementing treatment orders. A new column has been added to the admission intake sheet to indicate if there are any medical devices present such as a cervical collar to obtain orders for management prior to admitting to facility. Monitoring for compliance: DON or designee will audit all new admissions with a Miami J, cervical collar, splints, braces or wounds for 8 weeks to verify orders are in place, comprehensive skin/wound assessment has been completed and care plan is updated. DON or designee will complete 3 random wound audits per week for 8 weeks to verify comprehensive assessment, provider notification and current treatment orders are in place. Results will be reported to Quality Assurance Committee to determine the need for further monitoring. Date of compliance: June 14th, 2024	

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F 686	Continued From page 11 understood others, had severely impaired cognitive skills for daily decision making, had range of motion limitations in all extremities, and was fully dependent on staff for cares such a mobility in bed, transferring, and hygiene. R1 had an indwelling urinary catheter, was always incontinent of bowel, got 51% or more of total calories through a feeding tube, utilized supplemental oxygen, was on an invasive mechanical ventilator, and needed tracheostomy care. R1's MDS identified him as at risk for developing pressure ulcers and noted one stage 2 pressure ulcer present on admission with treatments of a pressure reducing device for chair and bed, pressure ulcer care, and the application of nonsurgical dressings other than to feet. R1's post-discharge instructions from the discharging facility dated 4/10/24, included "Miami J collar [a cervical collar/brace to stabilize cervical neck injuries] in place due to diagnosis of C1-C4 [cervical vertebra one through four] fracture incomplete quadriplegia." It did not include orders or instructions regarding management of the collar, note any active wounds, or include orders for wound care. A progress note dated 4/12/24, indicated R1 arrived at the facility the previous evening at 7:38 p.m. and had a cervical collar on as well as "wound on both buttock/coccyx," with left buttock wound measuring 3 centimeters (cm) long by 0.7 cm wide and right buttock wound measuring 2.5 cm long by 1 cm wide. The note included "clean[ed] with NS [normal saline] and foam dressing applied." It lacked comprehensive assessment of both wounds that identified risk factors including decreased mobility, medication that impaired healing, co-morbities,	F 686		

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F 686	Continued From page 12 refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition, hydration, pressure points for turning and reposition needs, wound bed characteristics, drainage and pain. R1's Skin Risk Observation with Braden Scale dated 4/12/24, indicated R1 had one of more unhealed pressure injuries at stage 1 or higher. The location(s) of the observed pressure injuries was "buttock R/L [right/left]." R1's Braden Scale for Prediction of Pressure Sore Risk indicated he was at a high risk level. It lacked further assessment of the identified wounds. A provider note by nurse practitioner (NP)-A dated 4/12/24 and 4/16/24, both noted "no skin breakdown." They also noted "Incomplete quadriplegia since 11/2023. Has a collar in place. Plan: will need neuro[logy] follow up with xrays [sic]." R1's provider orders included an order dated 4/16/24, noting "resident has a Miami Jay [sic] collar. Special instructions: NP will address after review of chart." R1's provider orders included an order dated 4/16/24, for "wound care: sacral area foam dressing every shift until wound nurse assessment." R1's electronic health record (EHR) lacked wound care orders for the sacral wound prior to 4/16/24. R1's Treatment Administration Record (TAR) dated 4/1/24 to 4/30/24, indicated the sacral wound care treatment was first documented as complete on the first shift of the day on 4/16/24. R1's TAR lacked documentation of wound care treatments for the sacral wound prior to 4/16/24.	F 686		

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F 686	Continued From page 13 R1's Wound Management Detail Report by the facility's wound nurse dated 4/17/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 2.8 cm long, 2.5 cm wide, and 0.1 cm deep with no exudate (drainage) or odor, was a stage 2, had no undermining or tunneling, irregular wound edges, 100% epithelial tissue, blanchable redness of the skin surrounding the wound, and wound healing status was stable. Comments noted "peri-wound skin fragile." The wound report did not address the pressure ulcer on the left buttock previously identified on left buttock. R1's Care Area Assessment (CAA) for pressure ulcer/injury dated 4/22/24, identified R1's risk factors for pressure ulcer/injury. Extrinsic risk factors included: requires staff assistance to move sufficiently to relive pressure over any one site, confined to a bed or chair all or most of the time, needs special mattress or seat cushion to reduce or relieve pressure, slides down in the bed, and persistently wet (especially from fecal incontinent, wound drainage, or perspiration). Intrinsic risk factors included: immobility, cognitive loss, incontinence, and poor nutrition. Medication risk factors included opioid medications. Diagnoses or conditions that presented complications or increased risk included: cerebrovascular accident (stroke), paraplegia/quadriplegia, edema, sepsis, pain, and recent decline in functional abilities. Treatments and other factors that caused complications or increased risk included: newly admitted or readmitted, history of healed pressure ulcer/injury, ventilator or respirator, functional limitation in range of motion, head of bed	F 686		

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F 686	Continued From page 14 elevated most or all of the time, and devices that can cause pressure (such a oxygen or indwelling catheter tubing, TED (compression) hose, casts, or splints). The analysis of findings noted "admitted [with] pressure ulcer and pressure ulcer risk with contributing factors above. At risk for further clinical declines, increased burden of care, discomfort if this does not heal or further breakdown occurs." R1's Wound Management Detail Report by the facility's wound nurse dated 4/24/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 2.3 cm long, 2 cm wide, and 0.1 cm deep with a light amount of bloody (bright red, thin) exudate, no odor, was a stage 2, had no undermining or tunneling, had wound edges epithelializing flush with the wound base, 100% epithelial tissue, blanchable redness of the skin surrounding the wound that was dry and thin, and wound healing status was improving. Comments noted "Smaller. Peri-wound skin has fragile areas. Hydrocolloid covers [a type of dressing for wounds]." R1's care plan for pressure ulcer/injury dated 4/26/24, noted "I have a current pressure ulcer (admitted with) located buttock/sacral area. I am at risk for increased skin integrity issues due to incontinence, immobility, use of equipment and medications, anemia." Goal dated 4/29/24, noted "my pressure ulcer will continue to show sings of healing and no new areas will develop through the review date" with interventions dated 4/26/24 including assisting with repositioning every two to three hours with use of an air mattress for pressure relief and need for head of bed elevated for tube feeding and ease of breathing, nursing	F 686		

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F 686	Continued From page 15 assistants (NA's) observing skin and reporting any abnormalities to the nurse, having good skin hygiene and skin to be moisturized as needed if dry, elimination of waste to be addressed in the toileting section of the care plan, monitoring of labs and weight as ordered, pressure redistributing mattress on bed and cushion in chair, proper notifications to be made if wounds change, staff providing adequate nutrition and hydration with nutritional supplements and vitamins as ordered, using pillows between knees and bony prominences to avoid direct contact, and treatments as ordered (see TAR). A provider note by nurse practitioner NP-A dated 4/26/24, noted "no skin breakdown." It also noted "Incomplete quadriplegia since 11/2023. Has a collar in place (wife reports C2 [second cervical vertebra] was not healing and that is why collar was left in place in Arizona [R2 admitted to facility from a hospital in Arizona]). Plan: will need neuro[logy] follow up with xrays [sic] and referral to [local hospital] neurosurgery." A neurosurgery clinic provider note dated 4/30/24, noted R1 was seen for "consideration of weaning of collar" and noted "due to the complexity of the patient's recent hospital course, would like to review chart in more detail prior to discontinuing collar." Instructions included follow-up on Thursday at 8:30 a.m. and orders placed at the visit were for a computed tomography (CT) scan. R1's Wound Management Detail Report by the facility's wound nurse dated 5/1/24, included a pressure ulcer right of coccyx present on admission with date identified of 4/17/24. The wound was 3 cm long, 6 cm wide, and the depth could not be measured with a moderate amount	F 686		

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F 686	Continued From page 16 of serosanguineous (pale red to pink, thin and watery) exudate, no odor, was a stage 3, no undermining or tunneling, had irregular wound edges, was 60% covered by epithelial tissue and 40% covered by slough tissue (dead tissue usually cream or yellow in color), skin surrounding the wound had blanchable redness, and the wound healing status was declining. Comments noted "Larger area of denuded [exposed, damaged] skin." R1's wound was identified as a stage 3 pressure ulcer whereas previous Wound Management Detail Reports from 4/17/24 and 4/24/24 had identified this wound as stage 2. R1's Wound Management Detail Report by the facility's wound nurse dated 5/1/24, included a pressure ulcer with location of "coccyx center; superior" not present on admission with date identified of 5/1/24. The wound was 2.7 cm long, 1.1 cm wide, with depth that could not be measured, no odor or exudate, was a stage 3, had no undermining or tunneling, the wound was 90% covered by slough tissue and 10% covered by epithelization tissue, had well defined wound edges with pink/normal surrounding skin, and the wound healing status was stable. Comments noted "covered with hydrocolloid along with other open area." R1's skin care plan did not include any revisions upon identification of the worsening pressure ulcer of the right coccyx. Further R1's record did not include a comprehensive assessment of the center superior coccyx wound identified on 5/1/24 that included risk factors including decreased mobility, medication that impaired healing, co-morbities, refusals/rejection of care and treatment, cognitive status, incontinence status, nutrition, hydration, pressure points for turning	F 686		

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F 686	Continued From page 17 and reposition needs, and pain. During an interview on 5/23/24 at 1:10 p.m., the assistant director of nursing (ADON) confirmed R1's admission progress note dated 4/12/24 identified sacral pressure ulcers on both the left and right sides with placement of a foam dressing and wound care orders that started on the 16th with the order for a sacral area foam dressing every shift. The ADON stated she did not see any evidence of wound care between 4/12/24 and 4/16/24. She noted that if a resident arrived with wounds but no wound care orders, staff should request orders from the provider and this did not meet her expectation for wound care nor was it in line with standards of care. The ADON identified that a pressure ulcer not being treated had the potential to worsen. The ADON stated comprehensive assessment of wounds were completed by the facility's wound nurse who rounds weekly on Wednesdays. She confirmed that the wound nurse saw R1 on 4/17/24 and documented the right coccyx pressure wound but did not document the second wound previously identified in the 4/12/24 progress note until a visit on 5/1/24 when it was first comprehensively assessed. The ADON stated the wound should have been assessed as soon as it was identified and by the wound nurse when she saw R1 on 4/17/24. The ADON confirmed documentation indicated R1's right coccyx pressure ulcer progressed from a stage 2 wound on 4/24/24 to a stage 3 wound on 5/1/24 and she would want a resident's care plan, orders, and interventions to be updated for a worsening wound and did not have any evidence that interventions were re-assessed for effectiveness when staff identified the wound was worsening.	F 686		

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F 686	Continued From page 18	F 686		

A provider note by nurse practitioner NP-A dated 5/2/24, indicated R1 had a change in condition and NP-A recommended sending him to the hospital for further evaluation and diagnosis.

A progress noted dated 5/2/24, indicated R1 was transported to the emergency department via emergency services at approximately 11:30 a.m.

A hospital patient care image (photograph) in R1's EHR dated 5/2/24 at 1:42 p.m., depicted a large open wound on the back of the head with description of "mechanical pressure ulcer back of head from c collar [cervical collar]." Additional photographs depicted a foam border dressing with the date 3/18 visible on the front in marker and the back of the dressing with a large amount of bloody drainage, hair, and skin attached after removal from R1's head.

A hospital intensive care unit admission note dated 5/2/24 at 1:44 p.m., included "open wounds on his occipital area and coccyx (pictures in chart)."

A hospital progress note dated 5/2/24 at 2:03 p.m., noted "patient malodorous, has foam bandage to back of head that is grossly bloody with layers of skin, wound under occiput in same shape and depth of dressing dated 3/18 as in March 18. Today's date is May 2nd. Unable to currently visualize skin under Miami J. Wound nurse consult placed stat as well."

A hospital wound nurse consultation note dated 5/3/24 at 8:10 a.m., identified a pressure injury on the posterior head noted to be unstageable and a pressure injury located on the sacrum with poorly defined/irregular margins noted to be a deep

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F 686	Continued From page 19 tissue injury. Review of R1's record throughout his admission to the facility prior to transfer to the hospital lacks any documentation of a wound on the posterior head. Nursing Home Incident Report #356410 submitted to the State Agency by the facility dated 5/4/24, noted "resident [R1] was sent to the hospital for evaluation. At the hospital resident was noted having a pressure related ulcer at the back of his head." Nursing Home Incident Report Investigation Report Summary #356410 submitted to the State Agency by the facility dated 5/10/24, noted "staff did not have orders for management of Miami J Collar, and were waiting for [physician]/NP to decide on management." In an interview on 5/23/24 at 7:26 a.m., registered nurse (RN)-D stated R1 had a cervical collar secured with Velcro and they would undo the Velcro to change his tracheostomy ties (a strip of material that goes around someone's neck to assist with securing a tracheostomy tube on the front of the neck). RN-D noted staff did not have an order for the collar and it said in the computer that it would be evaluated by the provider to determine how to manage it. RN-D stated nurses needed an order to remove the collar to clean the skin underneath and because she saw that the collar was to be evaluated by the provider she thought they would come and do something. RN-D stated she did not know what the manufacturer recommended for management of the Miami J cervical collar.	F 686		

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F 686	Continued From page 20 In an interview on 5/23/24 at 8:21 a.m., RN-B stated residents with neck braces admit to the facility with instructions from the doctor about the brace that staff followed. She noted if someone had a brace sometimes they might get a wound, like if the brace is not ever released, if it is tight, or if there is already a wound underneath that needs to be dressed, "so you have to always assess ... you have to see if it is making a wound from the pressure, you have to check the skin." RN-B stated to check the skin nurses could remove the brace if there was an order to do so but, if not, could look and feel inside the space between the back of the head and the brace to assess the skin. RN-B noted that if someone had a brace but no orders she would call the provider to request orders, if someone had a pressure ulcer but no wound care orders she would assess the wound and call the provider to request orders. In an interview on 5/23/24 at 8:53 a.m., RN-C stated "for a resident with a cervical neck brace the first thing is you need to assess the skin under the collar and see what's going on ... you remove it and then put it back on when you're done and check to see if the collar is clean on the inside too." RN-C further stated "if a resident with a collar comes in, it doesn't matter if there is an order or not, you have to assess the skin. If you think it's not safe to remove the collar and do the assessment then you need to let the provider know that you need an order so you can assess." RN-C states if a resident had a pressure ulcer but no wound care orders nurses have to assess it and tell the provider, it was not okay to just leave it, nurses had to ask for orders. In an interview on 5/23/24 at 11:01 a.m., the administrator stated R1 was admitted on 4/11/24	F 686		

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F 686	Continued From page 21 with a Miami J collar and staff immediately realized they did not have orders for the management of the collar. The administrator noted staff contacted the discharging facility and requested orders the next day but did not receive them. He stated R1 had a provider visit on 4/12/24 and nursing requested orders from NP-A, but NP-A and the doctor said they could not give the orders and R1 needed to be referred to neurology for this. He noted a referral was made and appointment scheduled for 4/30/24. The administrator stated that after the referral was made "the question arose of whether we should take the collar off and see the skin under, but the family said that we should not touch the collar because his C2 hadn't healed and it was very dangerous." He stated they waited and at NP at the neurology clinic saw him on 4/30/24 but was not comfortable giving any orders for management of the collar. The administrator noted that the facility had access to the hospital's medical record system and became aware after R1 was transferred to the hospital that hospital staff identified a wound under the Miami J collar. The administrator stated nurses need to do a thorough job in assessing skin and although they did not have orders to move the collar, maybe they should have sent R1 in faster for evaluation of the collar, maybe to the emergency department rather than wait for a neurology appointment. He noted attempts were made to get orders for management of the collar, but doctors were not willing to provide them and the mistake initially happened when R1 was admitted without complete orders. The administrator stated that accepting a resident for admission with complete orders was a mistake because once the facility accepted the resident they became the facility's responsibility.	F 686		

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F 686	Continued From page 22 In an interview on 5/23/24 at 1:10 p.m., the assistant director of nursing (ADON)stated she was not aware during his admission that R1 had a wound on the back of his head. She noted head to toe skin assessments are done on admission but R1's did not identify a head wound. The ADON noted for someone like R1 with skin underneath a medical device she would expect to have orders for management of the device and would expect staff to have an order to remove a cervical collar. She further noted that staff could have at least felt behind the collar to check R1's skin in the absence of orders to remove the collar for skin assessment. In an interview on 5/23/24 at 2:00 p.m., the director of nursing (DON) stated the facility lacked orders for R1's cervical collar she wouldn't dare remove it without having direction which is why NP-A referred R1 to neurosurgery. The DON noted she expected comprehensive skin assessments and getting needed orders to be done within 24 hours of admission. She stated comprehensive assessments of wounds and documentation of all the wound characteristics were needed to track wound healing and should be done within the first couple days after a wound was identified. She confirmed that a wound identified on a Thursday (4/11/24) that was not comprehensively assessed until the following Wednesday (4/17/24) was not in line with her expectations or professional standards of practice. The DON noted that the facility had been informed in R1's pre-admission assessment that he did not have any wounds but if someone had a wound and no wound care orders staff should initiate wound care per facility protocol and contact the provider for further orders.	F 686		

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F 686	Continued From page 23 In an interview on 5/23/24 at 2:39 p.m., NP-A stated for someone with a cervical collar typical standards of care are that the facility would have some orders for it from the discharging facility. She stated typically the facility would have orders directing to leave a collar on for a specific amount of time or to remove it and clean underneath it, but they "didn't have a lot of data from the discharging facility" about R1 and his collar. NP-A noted she referred R1 to neurosurgery to et an x-ray and orders for the collar for specialist to make a recommendation about what to do. She stated expectations for skin assessment with R1 were tough, if staff had asked her if it was okay to remove to collar and look at the skin underneath she probably would have deferred to the physician because the facility did not have good records and they were going off of what family said. NP-A stated staff "probably wanted me to say let's take off the collar and look at the skin, but we never had that specific conversation about looking at the skin. The question was what do we do with the collar and my answer was send him to neurosurgery. I think we all own a piece of this ... I'm a wound care nurse and I turned him over and looked at his bottom but I didn't take the collar off, didn't see the back of his head ... I was aware that we weren't taking the collar off because we agreed neurosurgery needs to evaluate him." NP-A noted that she first saw R1 on 4/12/24 and did not note any skin issues but knew he had a little area on his bottom and states "I recall seeing small areas on his bottom, one comes to mind, but I can't say for sure. They were like superficial." In an interview on 5/29/24 at 11:50 a.m., the facility's medical director (MD) stated, if a resident	F 686		

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F 686	Continued From page 24 admitted with a cervical collar it would always be left on until staff could obtain orders for its management because staff needed doctor's orders to remove a cervical collar. The MD noted R1 did not have orders for management of his Miami J collar on arrival so staff attempted to get orders from the referring hospital, the primary care team, and the neurology clinic. The MD stated the facility did not receive complete information about R1's care needs and somebody had previously put a dressing on a wound underneath the collar but never recorded it for facility staff to see, so they had no knowledge there was an open area or that there was a dressing in place. The MD identified this as a "bad outcome" and noted nursing staff are responsible for skin care once a resident arrives at the facility. The MD stated he did not have a clear timeline for how long a resident could go without orders for a cervical collar before he would expect alternative interventions, like sending the resident to the emergency department. The MD stated he did not have an answer regarding if he would expect nursing staff to consult manufacturer guidelines for a cervical collar. Miami J Patient Care Handbook from manufacturer Ossur copyrighted 2010, includes "C-Spine Precautions: you must be lying flat to remove the collar unless your doctor gives you permission to do this in a sitting position. You will need a second person to help you in order to maintain the proper head, neck, and airway alignment. Position patient with arms to the side, shoulders down and head aligned centrally. Unless otherwise specified by your doctor: do not remove the collar except to wash under it and change the pads. Keeping your Miami J and the	F 686		

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F 686	Continued From page 25 skin beneath clean is an important part of your treatment. Daily cleaning will help to prevent skin irritation." Facility policy titled Prevention and Treatment of Skin Breakdown dated 2018, included "Policy: Resident skin integrity is assessed upon admission and weekly thereafter. A skin risk assessment is completed upon admission and weekly for 4 weeks upon significant change, and quarterly thereafter. Those residents at an increased risk for impaired skin integrity are provided preventative measures to reduce the potential for skin breakdown. Those residents' who experience a break in skin integrity or wounds are provided care and service to heal the skin according to professional standards of care." "Treatment of impaired pressure injury and lower extremity ulcers (arterial, venous, neuropathy/diabetic, mixed) If a resident is admitted with impaired skin integrity or a new pressure injury or lower extremity wound developed the licensed nurse implements the following items: 1.) Documentation of the skin impairment is completed in the medical record. Staging of pressure injury is completed as necessary by trained licensed associated. Other lower extremity wounds with [sic] be described a partial thickness loss or full thickness loss. 2.) Standing orders/protocol for skin wound are initiated. 3.) Notify attending provider, resident and resident representative. Attending provider determines wound type and may provide additional orders. 4.) Notify supervisor/designee. 5.) Evaluate current pressure reduction interventions and revise resident centered care plan." Facility policies an admission orders and skin	F 686		

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F 686	Continued From page 26 protocol were requested but not received.	F 686		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		6/14/24

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F 880	Continued From page 27 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement enhanced barrier precautions (EBPs) for 2 of 3 (R3 and R4) residents observed for ventilator (machine that breathes for residents) tracheostomy residents, residents who had feeding tubes or indwelling urinary catheters.	F 880	F880- Infection Prevention & Control Corrective action for resident(s) affected: Enhanced Barrier Precautions were initiated for R3 and R4 on 6/3/24. Action as it applies to others: All residents were reviewed to determine the need for	

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F 880	Continued From page 28 Findings include: R3's 5-day Minimum Data Set (MDS) dated 4/16/24, indicated R3 was in a persistent vegetative state and had diagnoses of traumatic brain injury, neurogenic bladder, history of multidrug-resistant organism (MRDOs), pneumonia, septicemia, seizure disorder or epilepsy and respiratory failure. R3 was dependent for all activities of daily living (ADLs). R3 had a tracheostomy and with invasive mechanical ventilator and required suctioning. R3 received tube feeding for nutrition and had an indwelling urinary catheter. Review of R3's care plan did not address R3's risk for infection nor interventions for infection prevention that included the use of personal protective equipment (PPE). During continuous observation on 5/23/24 between 11:15 a.m. and 1:10 p.m., the entrance to R3's room did not have signage posted that identified EBP nor a PPE cart outside/inside the room was in his room. R3 was lying in his room during this time. Nursing assistant (NA)-R and registered nurse (RN)-C entered R3's room to perform care tasks that included, bathing, suctioning of tracheostomy, urinary catheter cares and wound dressing changes. Neither staff members were observed using gowns during these activities. R4's quarterly MDS dated 2/27/24, indicated R4's cognition was not assessed however, the annual MDS dated 11/28/23, indicated R4 had severely impaired cognition. R4's MDS dated 2/27/24, identified R4 had diagnoses of high blood pressure, neurogenic bladder, diabetes, aphasia,	F 880	Enhanced Barrier Precautions and precautions were initiated if indicated. Systemic Changes: Enhanced Barrier Precaution Policy was reviewed and remains current. All staff have been educated on Enhanced Barrier Precautions, indications for use and the procedure for donning/doffing personal protective equipment. EBP will be initiated when a residents care needs change as per policy. Monitoring for compliance: DON or designee will audit new admissions/readmissions to ensure Enhanced Barrier precautions are initiated where indicated for 6 weeks. DON or designee will audit staff compliance with enhanced barrier precautions 3x per week for 6 weeks, audits will include all shifts. Results will be reported to Quality Assurance Committee to determine the need for further monitoring. Date of compliance: June 14th, 2024	

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F 880	Continued From page 29 problems swallowing), hemiplegia/hemiparesis (paralyzed on side), seizure disorder or epilepsy and respiratory failure. R4 was dependent for all ADLs. R4 had tracheostomy with invasive mechanical ventilator and required suctioning. R4 received tube feeding for nutrition and had an indwelling catheter. Review of R4's care plan did not address R3's risk for infection nor interventions for infection prevention that included the use of PPE. During an observation on 5/23/24 at 1:36 p.m., RN-E and NA-S performed cares for R4 which included tracheostomy suctioning, indwelling urinary catheter cares, including emptying the urine collection bag, peri care and wound dressing changes without wearing gowns. During an interview on 5/23/24 at 2:07 p.m., RN-E stated staff never wore gowns for catheter cares, ventilator and tracheostomy cares, and during wound cares unless resident's were on contact precautions. RN-E was not aware of what EBP were and when they should be implemented. During an interview on 5/23/24 at 2:09 p.m., RN-C was not aware of what EBP were and when they should be implemented. RN-C stated the staff would only use gowns with contact precautions. During an interview on 5/23/24 at 2:33 p.m., assistant director of nursing (ADON) indicated the facility was in the process of implementing EBP's. During an interview on 5/23/24 at 3:03 p.m., nurse practitioner (NP)-A was not aware of when EBP should be implemented.	F 880		

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 05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 30 During an interview on 3/22/24 at 11:48 a.m., Administrator stated residents with implanted medical devices, would need EBP's. These have not been set up and the facility was in the process of implementation these regulations. Review of facility policy dated 2019, titled "Enhanced Barrier Precautions", -purpose was to be a strategy in nursing homes to decrease transmission of center for disease control (CDC)- targets and other important MRDOs. Resident at risk for MDROs, specifically those with an indwelling medical device and/or chronic wounds requiring a dressing change will be required to use EBP. -Policy table on when to use EBPs to be used with all residents with any of the following.... Indwelling medical devices (e.g., urinary catheters, feeding tubes, tracheostomy/ventilator), regardless of MDRO colonization status. Required personal protective equipment (PPE), gown, gloves prior to high contact care activity. Face protection may also be needed if performing activity with risk of splash or spray. -General considerations when using EBPs indicated 4.) post clear signage on the door or wall outside resident room indicating the type of precautions and required PPE. 5.) make PPE available in a designated area outside resident room, 7.) position a trash receptacle inside the resident room and near the exit for the PPE to be discarded prior to exiting the room. 8.) Provide education to staff, residents and visitors as needed.	F 880		