DEPARTMENT OF HEALTH

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 2, 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 informed you of imposed enforcement remedies.

On June 18, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted immediate jeopardy (Level J), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

On June 14, 2024, the situation of immediate jeopardy to potential health and safety cited at F684 was removed. However, continued non-compliance remains at the lower scope and severity of D.

As a result of the survey findings:

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

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

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.

As we notified you in our letter of June 4, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 19, 2024. However, due to the

extended survey the new NATCEP loss date is June 18, 2024.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Benedictine Health Center Of Minneapolis is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 18, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions

(42 CFR 488.417 (a));

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

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

determination.

APPEAL RIGHTS

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

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/ 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 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.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 2, 2024

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

Re: Event ID: XB2911

Dear Administrator:

The above facility survey was completed on June 18, 2024 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING ______ B. WING ______	C 06/18/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

On 6/13/24, 6/14/24, 6/17/24 and 6/18/24, 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 complaint was reviewed.

H52664417C (MN00104055) with deficiency cited at F684.

The immediate jeopardy began on 5/31/24, at the beginning of the night shift approximately 1:30 a.m. R1's heart rate was 156 bpm (beats per minute), with no action taken by the facility or contact made with the medical provider for direction and at 3:40 a.m. R1 was found unresponsive with no pulse, CPR (cardiac pulmonary resuscitation) was performed, Paramedics arrived at 4:20 a.m., and took over CPR. and R1 was pronounced dead at 4:47 a.m. at the facility. The director of nursing (DON) and administrator were notified of the IJ on 6/14/24, at 4:20 p.m. The IJ was removed on 6/14/24, following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy.

The above findings constituted substandard quality of care, and an extended survey was conducted on 6/17/24, through 6/18/24.

The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 07/05/2024

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 000	Continued From page 1 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 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess and notify provider for change in condition for 1 of 1 resident (R1) reviewed. This resulted in an immediate jeopardy (IJ) situation for R1 when his heart rate (HR) was identified to be 156 bpm (beats per minute), was later found unresponsive with no pulse, CPR (cardiac pulmonary resuscitation) was performed, and he subsequently died at the facility. The immediate jeopardy began on 5/31/24, when at 1:30 a.m. R1's HR was 156 bpm, and no action taken by registered nurse (RN)-A. Then at 3:40 a.m. R1 was found unresponsive with no pulse, CPR was performed, paramedics arrived at 4:20	F 684	Interventions for identified residents: " Resident #1 is no longer a resident of the facility. Medical Record was reviewed and sent to the Quality Assurance committee for process improvement opportunities. Interventions for other residents at risk: " All out of range vital signs for all residents residing in the facility have been pulled and providers notified of the changes in condition. Completed 6/19/24	6/19/24

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F 684	Continued From page 2 a.m., and took over CPR until R1 was pronounced dead at 4:47 a.m. at the facility. The director of nursing (DON) and administrator were notified of the IJ on 6/14/24, at 4:20 p.m. The IJ was removed on 6/14/24, following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. R1's admission Minimum Data Set (MDS) dated 5/29/24, indicated R1 unable to be interviewed for mental/cognition status due to unable to express ideas and wants, rarely or never understood, unable to respond, and had highly impaired vision. MDS indicated R1's diagnoses included respiratory failure, fracture, septicemia (bacteria in the blood stream) and multi-drug resistant organism (MDRO) (a germ that is resistant to any antibiotic). R1 prognosis identified he did not have a chronic condition identified that may have resulted in less than six-month life expectancy. R1 had a tracheostomy (a surgical opening made through the front of the neck and into the windpipe/trachea kept open for breathing) and suctioning, he was dependent on a ventilator (a machine that helped lungs work then unable to breath on your own properly), and oxygen. R1's Baseline Care Plan dated 5/23/24, identified cognition as nonresponsive, non-verbal, and questionable impaired hearing. Staff were expected to suction R1 as needed and oxygen saturation (SaO2) (measures how much oxygen is in your blood) levels to be maintained over 90%. Plan of care directed staff for total resident care: Management of ventilator, tracheostomy, suctioning, cervical collar, nutrition, and tube	F 684	Systemic Changes: " The facility's Resident Examination and Assessment and Change in Condition policy were reviewed with no changes needed at this time as a result of the review. " The nurse who completed this error was interviewed on 6/10/24 and reeducated on 6/11/24 by the DON. He was also reeducated 1:1 by the staff development coordinator on 6/12/24. Staff member has not worked since 6/12/24 and was relieved of his duties on 6/27/24. " Current facility nursing staff, including agency/contract, were re-educated by DON or designee beginning on 6/11/2024 with completion 6/19/24 in relation to: o Resident Examination and Assessment policy which includes when to contact the provider. o Change in Condition Policy which includes assessing (including vital signs) and documentation of assessment. o Change in condition definitions and what to do when a change in condition occurs. o Documentation of Change in conditions including vital signs. o Out of range vital signs- what parameters cause alerts in the EHR and what to do when they are out of range (recheck and notify provider if still outside of parameters). o Clinical Managers have been reeducated on pulling the facility activity report and reviewing the previous days progress notes, changes in condition,	

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

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F 684	Continued From page 3 feeding. Facility Standing Orders dated 5/23/24, identified Respiratory distress: O2 (oxygen) at 2 to 4 L liters/minute via cannula for up to 30 minutes. Notify physician. Hospital discharge summary and orders dated 4/22/24, identified: -Diagnoses: acute (sudden onset) failure of the respiratory system with lack of oxygen 4/17/24 to 5/22/24. -Call provider for: difficulty breathing, headache or visual disturbances. -Call provider for temperature over 100.4. F -Code status: full R1's progress notes (PN) dated from 5/22/24, through 5/31/24, identified: -5/22/24, at 11:00 p.m. R1's SaO2 95% on room air, and no heart rate identified. -5/23/24, at 6:56 a.m. R1's vital signs at 1:00 a.m. BP (blood pressure) 104/67, T (temperature) 97.9 F (Fahrenheit), SaO2 87%, HR (heart rate/pulse) 107, on room air (RA), R (respirations)16. R1 was started on oxygen 2 L (Liters) per nasal cannula. R1's SaO2 improved to 94%. Second vitals were checked to be BP 107/64, HR 107, T 97.5 F and remained unresponsive throughout to verbal nor sensory stimuli. No sign of pain or distress were observed. -5/23/24, at 11:03 p.m. remained unresponsive	F 684	events and out of range vital signs, verifying follow up on those items and providing education as necessary. This information reported at IDT meetings. " This education has been completed with current staff including agency/contract as of 6/19/24. " Validation of understanding of education was verified by random interviews of staff members conducted by DON or designee. Further 1:1 education will be provided as needed to reinforce understanding of education provided. " Nursing staff were re-educated prior to beginning their next scheduled shift. Completed as of 6/19/24 Ongoing-All new licensed staff will receive this education before working with residents. Random audits of out of range vital sign reports and appropriate follow up twice weekly by DON or designee for 4 weeks, then weekly for 4 weeks. Random interviews of licensed staff to verify understanding of appropriate follow up for out of range vital signs twice weekly by DON or designee for 4 weeks, then weekly for 4 weeks. Report of audits to Quality Council for further direction.	

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F 684	Continued From page 4	F 684		

throughout shift, no body movement, no respiratory distress, or signs/symptoms of pain. Vitals: BP 116/72, HR 113, T 97.5 F, SaO2 95% on 2 L of oxygen. Second set of vitals: BP 121/72, HR 114, T 98.6 F, R 15, SaO2 94 to 95% on 2 L oxygen. Suctioned four times with moderate white secretion.

-5/24/24, at 12:00 p.m. HR 120, R 17 and SaO2 91% on 2 L of oxygen. Breath sounds slightly course, diminished throughout, post suction times three small/pale/thin secretions.

-5/24/24, at 4:19 p.m. resident restless and vent was alerting for about 30 minutes, but stable now. Vitals: BP 111/64, 98.1 F, HR 120, R 18, SaO2 93% on 2 L oxygen. Nurse Practitioner (NP)-B was notified day four of no bowel movement, onetime house order for MOM (milk of magnesia) 30 cc and prune juice order for constipation.

-5/24/24, at 10:59 p.m. no signs of restlessness on shift. Vital signs: BP 109/68, 98.2 F, HR 111, R 20, SaO2 95% on 2 L oxygen. Resident was being monitored for any changes in status.

-5/25/24, at 7:36 a.m. vital signs at 12:30 a.m. 98.1 F, HR 111, R 14, BP 98/62. Suctioned four times with small to moderate whitish secretions each time.

-No progress notes or vital signs documented on 5/25/24, from 3:06 p.m. to 5/26/24, at 3:04 p.m. (almost 24 hours).

-5/25/24, at 3:06 p.m. resident alert and smiled to his mom when communicating with him. Vital signs: BP 99/62, HR 109, 98.1 F, SaO2 94%, and R 14. Vent dependent and on oxygen at 2 L with

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

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F 684		F 684		

Continued From page 5
no shortness of breath.

-5/26/24, at 3:04 p.m. remained unresponsive through shift and ventilator dependent. Temperature 100.5 F. Modified the room and wet towel over forehead and under arm placed, non-pharmacology intervention was not effective. Tylenol administered and fever went down to 98.9 F tympanic (ear probe), BP 97/57, HR 114, SaO2 96% on 2 L oxygen, and R 17.

-5/31/24, at 6:23 a.m. at about 3:40 a.m. to 3:45 a.m. resident was found unresponsive by writer (RN-A), R1 pulse was checked electronically and manually. Shouted for help and other nurses came in right away, CPR started, and 911 was called. Paramedics arrived about 4:20 a.m. and took over, and at 4:47 a.m. R1 was pronounced dead by the emergency team. At beginning of shift vital signs were T 97.5 F, SaO2 90% with 4 L of O2, HR 156, and observed with bilateral chest rise and fall, breathing unlabored, on ventilator, in bed. Suctioned periodically per need.

R1's medical record lacked documentation of vital signs on 5/26/24, from 3:06 p.m. through 5/30/24, in progress notes. Additionally, no progress notes were documented since 8:55 a.m. on 5/28/24, until 5/31/24, at 6:23 a.m. (almost three days).

R1's physician communication/order document dated 5/24/24, at 3:15 p.m. completed by RN-B identified R1 had no BP [sic] (bowel movement) day four. NP-B ordered and signed on 5/24/24, at 3:15 p.m. warm MOM (milk of magnesia) 30 cc (cubic centimeters) with one glass of prune juice if no BM on day two. One time order. The communication document did not identify R1 had tachycardia (exceeds the normal resting rate) HR

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of 120 beats per minute identified in the progress notes.

A facility document titled Configure Vital Alerts, printed 6/14/24, at 12:44 p.m. identified acceptable vital sign ranges (minimum/maximum) set in R1's HER to alert staff when vital signs were out of range:
- Pulse 55 to 110 per minute
- Respirations 10 to 26 per minute
- Temperature 96.0 F to 100.0 F
- O2 Saturation 90% to 100%

R1's HR readings located in EHR vitals and progress notes from 5/22/24-5/30/24, identified:

5/22/24, HR 89, 98, and 98 (EHR vitals)

5/23/24, HR 107, 107, 112, 98, 113, and 114 (EHR vitals)

5/24/24, HR 120, 120, and 111 (PN)

5/25/24, HR 111, and 109 (PN)

5/26/24, HR 114 (PN)

5/27/24, through 5/29/24 HR was not documented.

5/30/24, HR 99, 111, and 156 (EHR vitals).

R1's medical record's (PN and EHR) indicated HR was identified to be out of acceptable range 10 times between 5/22/24-5/30/24 with no action taken by the facility or contact made with the Provider for direction.

During an interview on 6/13/24 at 1:15 p.m.,

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F 684	Continued From page 7 registered nurse (RN)-B stated she worked with R1 on 5/24/24 and verified R1's HR was 120 and the ventilator was alarming a lot, so she had to trouble shoot. RN-B stated R1 was also constipated, and the provider was contacted regarding that concern. RN-B stated the provider was unaware of the 120 HR, and ventilator alarming, and really should have been updated right away. RN-B stated if R1's condition had changed, especially respiratory and vitals abnormal, a provider would have been contacted right away. During an interview on 6/13/24 at 1:30 p.m., respiratory therapist (RT) stated he noted on 5/24/24, R1's HR was considered elevated at 120 beats per minute (bpm), and he reported to the nurse on duty. RT stated when a pattern was noted of R1's elevated HR a provider should have been contacted for further direction. During a follow up interview on 6/14/24 at 10:11 a.m., RT stated on 5/23/24, R1 was placed on 2 L of oxygen, and on 5/31/24, R1 was bumped up to 4 L of oxygen by RN-A. RT indicated R1's 156 HR would be the key related to an indicator something was wrong for R1 as he had seen residents go into sepsis with HR 120 to 130, and most likely there was a problem with R1's heart. During an interview on 6/13/24 at 2:10 p.m., RN-C stated they worked 5/26/24, when R1's temperature was 100.5 F and HR was 114. RN-C indicated acceptable HR range was identified in the EHR vitals section as 55 to 110 bpm. RN-C administered R1 Tylenol and temperature went down. RN-C indicated they were focused on the temperature and not on his HR. RN-C verified a provider was not contacted since temperature	F 684		

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when down.

During an interview on 6/13/24 at 2:53 p.m., admissions nurse RN-H stated nursing staff were expected to contact a provider with any change in condition such as temperature/fever, elevated HR, change in BP, and respiratory/oxygen status, and RN-H verified she would have expected staff to contact the provider when the HR was elevated especially up to 156. RN-H indicated a problem was identified prior to R1's death, and the provider was not notified of R1's elevated HR. RN-H stated she believed if a provider would been contacted for direction/orders it could have changed the outcome for R1. RN-H also stated the nurse would be expected to reach out to the provider for tighter parameters when they started to elevate outside of the norm, no matter what time of day, the provider should have been called and parameters would have helped.

During a telephone interview on 6/13/24 at 4:10 p.m., primary medical provider (PMD) stated no notifications were made to her regarding R1's change in status. PMD verified staff were expected to contact provider for any significant change in clinical status such as a HR outside parameters and had a sense the resident was not doing well. PMD indicated R1 was non-responsive and had a head injury which would affect the range of vitals collected. PMD stated vitals were important when you had to rely more heavily on other data for a resident who is non-responsive.

During a telephone interview on 6/13/24 at 5:17 p.m., RN-A stated they worked the night shift on 2nd floor which started at 11:00 p.m. RN-A stated he received report at 11:30 p.m., organized

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F 684	Continued From page 9 things, then counted medications with previous shift. Then at approximately 12:00 a.m. RN-A stated he saw four residents prior to entering R1's room at about 1:30 a.m. RN-A stated he was in R1's room for approximately 20 minutes total, adding R1's oxygen level was low at 88% on 2 L O2 and HR was 156, that was when he noted the oxygen tank registered zero/empty. He was unsure how long it had been empty, and he replaced it with a full one. RN-A stated he increased oxygen up to 4 L and oxygen level improved but was unable to indicate how much it improved during interview. RN-A stated he completed R1's water flush through feeding tube, dressing change, and HR went down "somewhat, to 122 to 140 per minute" (not recorded in EHR or PN). RN-A stated R1's vitals fluctuated so he monitored them for a short time, felt R1 was stable, then left the room to check on four other residents. RN-A stated around 2:40 a.m. he entered R1's room again and HR was 118 (not recorded in EHR or PN) and SaO2 had gone back down again to 88%. RN-A stated seemed like something was wrong and called RN-E into the room. RN-A stated along with RN-E checked a HR manually and unable to find one. RN-A stated R1's was warm to the touch when he called out his name, rubbed his shoulders, completed a sternal rub (a firm rub on the flat bone in the middle of the chest to provoke pain or stimulus meant to provoke a response), and no reaction noted, then started CPR. RN-A called for another nurse, RN-D, who called 911 and a code in the facility. RN-A indicted during CPR they checked for HR and noted to be 98 to 110 and SaO2 up to 100%. RN-A stated at 4:20 a.m. emergency personnel arrived and took over CPR for approximately 20 minutes, R1 was pronounced dead at 4:40 a.m. RN-A stated the	F 684		

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HR of 156 was not normal for R1, after the water flush was given via feeding tube the HR came down somewhat, believed he was stable, so no need to call a provider. RN-A stated he had concerns about the elevated HR and that was the reason why he went back to R1's room and checked on him after he saw the other four residents. RN-A stated when he realized R1's SaO2 level had dropped back down to 88%, he called another nurse for assistance. RN-A indicated R1's baseline vitals could have been figured out through time but was unsure as to what they should have been. RN-A verified there was no need to notify a doctor right away and the outcome most likely would have not changed. RN-A verified he was educated on change of condition and importance of notification to provider.

During an interview on 6/14/24 at 10:35 a.m., floor manager RN-F stated when R1 was admitted with HR 89 and tried establishing a baseline but struggled because his HR was overworking and something was going on with him. RN-F stated staff were expected to have documented in EHR nurses progress notes and vitals section, and contact the provider when HR started to elevate. RN-F also stated R1's temperature was elevated over 100.4 F while at the facility and provider should have been notified at that time also. RN-F verified R1's transfer order from the hospital to facility: call provider for temperature over 100.4 F, was not entered into his orders.

During an interview on 6/14/24 at 12:24 p.m., director of nursing (DON) stated on 6/10/24, she reviewed R1's medical records and noted the elevated heart rate. The following morning, she

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F 684	Continued From page 11 spoke with the administrator about a concern related to the registered nurse (RN)-A not acting or when R1's heart was elevated. DON verified she had filed an incident report with the state on Tuesday morning 6/11/24. DON stated parameters for vitals are the same for all residents and pre-set up in the EHR and determined by the facility's health system. DON indicated we had the ability to obtain specific and separate ranges for each resident. DON verified she had given that task to the floor manager and planned on obtaining parameters in the future from the providers. DON stated on 6/10/24, met with RN-A, completed interview, requested a written document that indicated understanding of what happened on the night shift 5/30/24, through 5/31/24. DON stated she flat out told RN-A he was wrong with what he chose to do that night and expected him to respond and act to the situation, contact the provider, and take responsibility for his actions. DON stated R1's elevated HR could have potentially been an indication of infection and possibly sepsis due to an alteration in condition. DON stated the nurse would have been expected to monitor the HR frequently especially since it became elevated. DON verified R1 was non-responsive and therefore the vital signs would have been pretty important information used to assess him, he was unable to verbally respond and unable to show signs of pain or discomfort. DON verified the transfer order from the hospital to the facility on 5/22/24, call provider if temp was over 100.4 F. was not entered into R1's EHR and should have been. DON also verified there was lack of documentation by the nursing staff for R1 in the EHR. DON stated RN-A should have responded and contacted the provider services with a change in condition.	F 684		

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During a telephone interview on 6/14/24 at 2:38 p.m., medical director (MD) stated R1's HR 156 was considered a very abnormal vital sign and should have urgently been called in to a provider that evening. MD stated this incident was identified as a change in condition. MD also stated this group of residents, about 13 to 14 (tracheotomy's and some on ventilators) with various needs, were terribly sick, and occasionally became tachycardiac (a HR over 100 beats per minute). MD stated residents with tachycardia may not cause any symptoms but sometimes a warning of a medical condition that required medical attention. MD stated residents on ventilators showed signs of anxiousness and respiratory infections, and in this case RN-A was unable to recognize it was a change in condition. MD indicated RN-A did not meet the nursing standards of care. MD stated nursing was expected to notify and provider when the temperature became two points above the baseline, HR above 110, and respirations above 20 per minute. MD also indicated when a resident was on supplemental oxygen, SaO2 was below 90% along with a rapid heart rate and did not return to normal range, RN-A would have been expected to document findings, and provider should have been contacted. MD stated RN-A's documentation was considered incomplete/inadequate, did not reflect his thought process, and lacked insight as to what happened that night. MD verified a change noted in R1's vitals required a provider be called to diagnose, intervene, and revise the treatment plan. MD stated R1's situation was out of the nurse's scope of practice and was not the facility policy for an individual nurse to have made those decisions.

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During a telephone interview on 6/17/24 at 1:15 a.m., RN-E verified she had worked the night shift on 5/30/24, through 5/31/24. RN-E stated around 3:00 a.m. RN-A had informed her he was unable to get R1's SaO2 reading and knew something was wrong. RN-E stated we entered R1's room together and R1 was very pale, checked manually for a pulse, no pulse felt, and immediately started CPR. RN-E verified was not informed prior to this incident about a change in condition or elevated HR by RN-A. RN-E stated we are expected to go by the resident's normal ranges and if out of the normal range, check orders for interventions, then contact the provider no matter what time of day or night it was. RN-E stated R1 had a tachycardia (abnormal high HR), would have suspected sepsis, provider should have been notified, and most likely sent out via ambulance.

During a telephone interview on 6/17/24 at 2:22 p.m., RN-D stated they worked the night shift on 5/30/24 through morning of 5/31/24. RN-D stated they were not assigned to R1 however around 3:00 am to 3:30 a.m. RN-E came running down the hallway and said something was wrong with R1. RN-D and RN-E both entered R1's room together and RN-D noticed his face was grayish in color, and where the plates used to be in his head, was more sunk in, and he did not really look like himself. RN-D along with RN-A manually checked for HR together, no HR, then started CPR immediately. RN-D verified RN-A had not informed him any time prior to his death about abnormal vitals or concerns about a change in condition. RN-D stated nursing would be expected to call provider when a change was noted in condition such as elevated HR, especially in the 150's, a decision would be made by the provider as to new orders and/or whether

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F 684	Continued From page 14 to send him in by ambulance to ED. Facility policy titled Nursing Services undated, identified thorough resident examination and assessment will capture any abnormalities in health status, physical function, or an acute change of condition. Notify the provider of any abnormalities such as, but not limited to abnormal vital signs, labored breathing, breath sounds that are not clear, or cough, productive or nonproductive. Document physical exam in the HER. Facility policy titled Change in Condition last reviewed 6/11/24, identified care and services was to be provided based upon the current needs of the resident under the direction of the attending provider. When a significant change in the resident's physical, mental, or psychosocial status is identified by the licensed nurse, or when there is need to alter treatment significantly, consult with the attending provider, implement orders for treatment and appropriate monitoring as directed. The licensed nurse was expected to assess for significant change in the resident's condition noted through direct observation, interview, or report from other staff. Obtain a set of vital signs and repeat as needed or ordered. Document symptoms, assessment, observations, resident/resident representative, and medical provider notification. If unable to contact physician, contact the medical director as appropriate. The IJ which began on 5/31/24, was removed on 6/14/24, when the facility successfully implemented a removal plan which included: All nursing staff on duty including agency/contract nursing staff will be re-educated by DON or	F 684		

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F 684	Continued From page 15 designee beginning on 6/11/2024 in relation to: change in condition definitions and what to do when a change in condition occurs, documentation of change in conditions including vital signs, out of range vital signs, what parameters cause alerts in the EHR, and recheck and notify provider if outside of parameters. Nursing staff will be educated prior to beginning their next scheduled shift, time clock notifications in place, education emailed out to staff not currently present, and charge of building notified to verify completion of staff during their shift. This education will continue until completed with current nursing staff including agency/contract. Validation of understanding of education will be verified by random interviews of staff members conducted by DON or designee. Further 1:1 education will be provided as needed to reinforce understanding of education provided. The policy and procedure for change in condition and documentation of out of range vital signs and follow up with provider all have been reviewed. On 6/17/24, between 8:30 a.m. and 3:30 p.m. interviews with DON, nursing staff, and management verified the facility had a plan in place and check off system to assure all staff would be educated prior to working their next shift.	F 684		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/13/24, 6/14/24, 6/17/24 and 6/18/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed:	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/05/24

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2 000	Continued From page 1 H52664417C (MN00104055) with no licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		