Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces a letter dated August 14, 2024. This letter reflects the separation of the cycle and the correction of the event id of WNOG11.

Electronically delivered

February 18, 2025

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

Re: Reinspection Results
Event ID: WNOQ12

Dear Administrator:

On 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 survey completed on June 27, 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: File

Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces a letter dated August 14, 2024. This letter reflects the separation of the cycle and the correction of the event id of WNOG11.

Electronically Delivered
February 18, 2025

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

RE: CCN: 245266
Cycle Start Date: June 27, 2024

Dear Administrator:

On August 5, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

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: File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces a letter dated July 10, 2024. This letter identifes that a new survey cycle was created with new remedies for event id: WNOQ11.

Electronically delivered
February 18, 2025

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

RE: CCN: 245266
Cycle Start Date: June 27, 2024

Dear Administrator:

On June 27, 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 a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by September 27, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 27, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

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

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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: File

Protecting, Maintaining and Improving the Health of All Minnesotans

This letter replaces a letter dated July 10, 2024.

Electronically delivered
February 18, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: WNOQ11

Dear Administrator:

The above facility was surveyed on June 26, 2024 through June 27, 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:

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

Please feel free to call me with any questions.

Sincerely,

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

cc: 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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

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 27, 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. The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective 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 July 2, 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 18, 2024.

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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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 10, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: WNOQ11

Dear Administrator:

The above facility was surveyed on June 26, 2024 through June 27, 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:

Terri Ament, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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.

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 06/27/2024

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 On 6/26/24 through 6/27/24, 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: H52664983C (MN00104349) with a deficiency cited at F686. 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 686 SS=E	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. 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	F 686		7/26/24

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

Electronically Signed | 07/19/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 686	Continued From page 1 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor the development of pressure ulcers for 4 of 4 residents (R1, R2, R3, R4) reviewed for pressure ulcers. In addition, the facility failed to follow infection control practices during pressure ulcer care for 3 of 4 residents (R2, R3, R4) reviewed for pressure ulcers. Findings include: Definitions of pressure ulcer types according to National Pressure Ulcer Advisory Panel (NPUAP): 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 that 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 the 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, it is an unstageable pressure ulcer.	F 686	F686 E During the survey process it was noted that the facility failed to monitor the development of pressure ulcers and follow infection control practices. R1-Guardian is aware of wound & treatments. Resident has since been enrolled in hospice secondary to an unrelated recent diagnosis. R2-R3 and R4 have had their wounds and treatments assessed, orders and plan of care reviewed by the RN Clinical Manager. All residents who have pressure ulcers have the ability to be affected by this deficient practice. All residents with current pressure ulcers will have their orders reviewed for any additional clarification on the steps needed to perform proper wound care. Education will be provided to all licensed nursing staff on proper wound management and infection control practices while performing wound care by 7/26/24. The facility policy on skin and wound management was reviewed by the facility and will be provided to all licensed nursing staff on or by 7/26/24. To ensure compliance; an audit of wound care and infection control practices will be conducted by the DON, IP or designee on 4 residents per week x 4 weeks and then 2x weekly for 3 months and as needed thereafter; results will be reviewed by quality council for monitoring and assured	

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F 686	Continued From page 2 Stage 4 Pressure Ulcer: Sores that extend below the subcutaneous fat in deep tissues including muscle, tendons, ligaments, cartilage, or bone. This stage presents a high risk of infection. 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. R1's Face Sheet dated 6/26/24 indicated R1 had diagnoses of multiple sclerosis, dementia, functional quadriplegia, and cognitive communication deficit. R1's quarterly Minimum Data Set (MDS) dated 3/27/24, indicated R1 was moderately cognitively impaired and fully dependent on staff for activities of daily living. R1's quarterly MDS dated 6/19/24 indicated R1 had one unstageable pressure ulcer. R1's Wound Management Detail Report dated 6/26/24, indicated a sacral pressure ulcer was first noted on 6/12/24. The wound management detail report contained the wound care nurse's once weekly treatment and documentation. It measured 3.5 centimeters (cm) by 7 cm, depth was unable to be measured and was unstageable. The tissue type was listed as necrotic (death of cells in a tissue) with light exudate (fluid that leaks out of blood vessels into a lesion or area of inflammation). On 6/19/24, it was measured 3.5 cm by 6.5 cm. It was described as unstageable with slough (non-viable usually moist tissue that can be soft and stringy in texture), had a foul odor and irregular wound	F 686	compliance. The DON is responsible for compliance. Facility will achieve substantial compliance by 7/26/24	

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F 686	Continued From page 3	F 686		

edges. The healing status was listed as declining. The comment section indicated the nurse practitioner was updated about the odor and thicker slough.

R1's skin assessments were documented in Nursing Orders Flowsheet Administration History from 6/1/24 through 6/21/24. The Flowsheet indicated an order, "Skin assessment done on bath day" was completed as ordered. On 6/1/24 nurse notes under the order indicated there was open skin on R1's coccyx. On 6/4/24, another nurse's note indicated an old wound on the coccyx was open, foam dressing was applied. No measurements or other observation details were included in these assessments.

R1's wound observations were also documented in Nursing Orders Flowsheet Administration History from 6/1/24 through 6/21/24. The order, "Document wound appearance Monday, Wednesday, Friday. To include odor, amount of drainage type, and wound edges" was started on 6/17/24.
-On 6/17/24 the wound observation was documented as no odor, no drainage amount, no drainage type, no wound edges. Charted late because of patient care.
-On 6/19/24 the wound observation was documented as yes odor, light drainage amount, serous drainage type, irregular wound edges. There was no order to specifically monitor the sacral pressure ulcer prior to 6/17/24.

R1's Wound Care Order as ordered by the nurse practitioner (NP)-A on 6/7/24 directed, "Duoderm (hydrocolloid dressing for management of light to moderately exudating wounds) to sacral wound on Monday, Wednesday, Friday." The order was

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F 686	Continued From page 4 started and first documented on 6/10/24. The order lacked further directions and there was no wound order in R1's electronic health record (EHR) prior to 6/10/24. Nurses began signing off on the wound care order on 6/10/24. On 6/26/24 at 9:14 a.m., R1's family member (FM)-A was interviewed. FM-A stated he was not notified of R1's pressure ulcer until 6/20/24 when he was at the facility before R1 was transferred to the hospital. He didn't think the pressure ulcer should have gotten to the point of infection requiring R1 to go the hospital and have surgery to clean the wound and receive IV antibiotics. On 6/27/24 at 8:47 a.m., RN-D was interviewed. RN-D stated when she was informed of the wound it was something that had happened previously. When asked why it took so long to receive orders for the pressure ulcer, she thought the pressure ulcer was found on 6/7/24 because a nursing assistant noticed there was a dressing on it. The nursing assistant told the nurse and the nurse contacted the nurse practitioner for wound care orders. She was unsure who put the dressing on the wound before there was orders for it. A new pressure ulcer should receive treatment right away. The person who found the wound or the nurse manager would be responsible for contacting the family. R1's pressure ulcer care order could have included instructions on how to clean the wound and what to clean it with. R1 was not feeling herself the day that she went to the hospital, she was not sure if there were specific signs or symptoms of a urinary tract infection. Washcloths would not be acceptable and medical tape should be applied directly to the resident once removed from the roll. Hand sanitizer should be used before and	F 686		

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F 686	Continued From page 5 after care was provided to a resident. On 6/27/24 at 9:07 a.m., RN-E (the facility's infection preventionist) was interviewed. Regarding the progression of R1's pressure ulcer development, she stated around 6/7/24, a nursing assistant told a nurse there was a dressing that needed to be changed. The nurse did not see dressing change orders for R1 in the EHR, so they placed a call to the provider to obtain wound care orders. The orders should have been entered into the EHR on 6/7/24 and not 6/10/24. She verified FM-A was not notified of the new pressure ulcer until 6/20/24. When asked about the wound care order, she stated she thought there was a description "about what they were supposed to do with it" but was unable to provide any additional details. She was unable to verify if R1 had any signs or symptoms of a urinary tract infection before her hospitalization. Tap water and washcloths would not be acceptable for wound care, washcloths are harsh, and disposable items should be used instead. Hand hygiene should be completed before and after gloving. Residents should have their own wound care supplies in their room, if a nurse does bring in a pair of scissors, it should be cleaned before and after use. Medical tape should not have been put on furniture in the room. Normal saline bottles should be thrown away 72 hours after opening, should be signed and dated. Staff should not use normal saline bottles if it was not dated. R2's Face Sheet dated 6/26/24, indicated R2 had diagnoses of persistent vegetative state, dependence on ventilator status, osteomyelitis, pressure ulcer of sacral region Stage 4, pressure ulcer of left hip unstageable, and pressure ulcer of right hip unstageable.	F 686		

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F 686	Continued From page 6 R2's significant change MDS dated 6/10/24, indicated R2 was severely cognitively impaired and was fully dependent on staff for activities of daily living. R2's discharge MDS dated 6/12/24, indicated he had one Stage 4 pressure ulcer and two unstageable ulcers. R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order "L Buttock: Cleanse normal saline; apply wound gel to slough in base; cover with foam dressing. Change twice a day." The order was active from 6/6/24 through 6/13/24. It was documented that the wound care order was administered twice a day from 6/6/24 through 6/13/24. No nurses notes were documented. R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "L hip wound: pack with mesalt. Cover with army battle dressing twice a day/" The order was active from 6/20/24 through 6/26/24 and was documented as administered twice a day. No nurses notes were documented. R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "R bony hip: apply foam adhesive dressing daily until healed." The order was active from 6/6/24 through 6/13/24. No nurses notes were documented. R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Sacral wound: cleanse with normal saline, pack lightly with mesalt; cover with large foam adhesive twice daily." The order was active from 6/6/24 through 6/13/24 and was	F 686		

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F 686	Continued From page 7 administered as ordered, there were no nurses notes. R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Wound care to left buttock: cleanse with normal saline. Apply wound gel to slough base. Cover with foam dressing." The order was active from 6/17/24 through 6/21/24 and was administered as ordered, there were no nurses notes. R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Wound care to left ischial + sacral: apply 4x4 mesalt opened up and lightly packed cover with army battle dressing, change three times a day." The order was active from 6/21/24 through 6/16/24. A nurses note from 6/23/24 directed "Wound care done by night nurse." R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Wound care to right buttock: cleanse with normal saline. Apply wound gel at slough base, cover with foam border. date and initial." The order was active from 6/17/24 through 6/21/24 and was administered as ordered. There were no nurses notes. R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Wound care to right ischial: apply open mesalt and foam adhesive change daily." The order was active from 6/22/24 through 6/26/24. A nurses note from 6/23/24 stated "Wound care done by night nurse."	F 686		

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F 686	Continued From page 8 R2's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Wound care to sacrum: cleanse with normal saline. Pack with mesalt. Cover with foam dressing, date and initial." The order was active from 6/17/24 through 6/21/24 and was administered as ordered. There were no nurses notes. R2's wound care was documented in the treatment administration from 6/1/24 through 6/26/24. From 6/17/24 to 6/26/24 R2 had the order "Document coccyx wound appearance daily. To include odor, amount of drainage, drainage type and wound edges. -6/17/24 it was documented as no odor, large drainage amount, bloody drainage type, irregular edges -6/18/24 it was documented as no odor, moderate drainage amount, serous drainage type, irregular wound edges -6/19/24 it was documented as no odor, light drainage amount, serosanguinous drainage type, irregular wound edges -6/20/24 it was documented as no odor, small drainage amount, bloody drainage type, irregular wound edges -6/21/24 it was documented as no odor, small drainage amount, serosanguinous drainage type, irregular wound edges -6/22/24 it was documented as no odor, yes drainage amount, serosanguinous drainage type, irregular wound edges -6/23/24 it was documented as a nurses initials, no details about the wound -6/24/24 it was documented as no odor, large amount drainage amount, serosanguinous drainage type, irregular wound edges -6/25/24 it was documented as no odor, large	F 686		

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F 686	Continued From page 9 amount drainage amount, sanguinous drainage type, irregular wound edges -6/26/24 it was documented as no odor, moderate drainage amount, serosanguious drainage type, irregular wound edges R2's wound care was documented in the treatment administration from 6/1/24 through 6/26/24. From 6/17/24 through 6/26/24, R2 had the order "Document left buttock wound appearance daily. To include odor, amount of drainage, drainage type and wound edges. -6/17/24 it was documented as no odor, moderate drainage amount, serosanguinous drainage type, irregular wound edges. -6/18/24 it was documented as no odor, moderate drainage amount, serous drainage type, irregular wound edges -6/19/24 it was documented as no odor, light drainage amount, serosanguinous drainage type, irregular wound edges -6/20/24 it was documented as no odor, light drainage amount, serosanguinous drainage type, irregular wound edges -6/21/24 it was documented as no odor, small drainage amount, serosanguinous drainage type, irregular wound edges -6/22/24 it was documented as no odor, small drainage amount, serosanguinous drainage type, irregular wound edges -6/23/24 it was documented as a nurses initials, no details about the wound -6/24/24 it was documented as no odor, large amount drainage amount, serosanguinous drainage type, irregular wound edges -6/25/24 it was documented as no odor, large amount drainage amount, sanguinous drainage type, irregular wound edges -6/26/24 it was documented as no odor,	F 686		

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F 686	Continued From page 10 moderate drainage amount, serosanguious drainage type, irregular wound edges R2's wound care was documented in the treatment administration from 6/1/24 through 6/26/24. From 6/17/24 through 6/26/24, R2 had the order "Document right buttock wound appearance daily. To include odor, amount of drainage, drainage type and wound edges. -6/17/24 it was documented as no odor, moderate drainage amount, serosanguinous drainage type, irregular wound edges. -6/18/24 it was documented as no odor, moderate drainage amount, serous drainage type, irregular wound edges -6/19/24 it was documented as no odor, light drainage amount, serosanguinous drainage type, irregular wound edges -6/20/24 it was documented as no odor, light drainage amount, serosanguinous drainage type, irregular wound edges -6/21/24 it was documented as no odor, small drainage amount, serosanguinous drainage type, irregular wound edges -6/22/24 it was documented as no odor, small drainage amount, serosanguinous drainage type, irregular wound edges -6/23/24 it was documented as a nurses initials, no details about the wound -6/24/24 it was documented as no odor, large amount drainage amount, serosanguinous drainage type, irregular wound edges -6/25/24 it was documented as no odor, large amount drainage amount, sanguinous drainage type, irregular wound edges -6/26/24 it was documented as no odor, light drainage amount, serosanguious drainage type, well-defined wound edges	F 686		

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F 686	Continued From page 11 On 6/26/24 at 10:07 a.m., registered nurse (RN)-A, who was also the facility's designated wound care nurse was observed providing wound cares for R2. RN-B, who was the nurse manager on the floor, provided assistance with repositioning R2. RN-A removed the old dressings and changed her gloves, but did not perform hand hygiene prior to donning clean gloves. RN-A cleansed R2's coccyx wound with a washcloth which was in the room prior to RN-A entering the room to provide services. The washcloth had been on R2's bedside table next to gastrostomy tube feeding supplies. A nursing assistant (NA) entered the room to provide assistance. RN-A applied the new dressing and began to prepare the tape to secure the dressing. RN-A put four long strips of tape onto the top of R2's chair before putting applying to the new dressing on R2's coccyx wound. RN-A changed her gloves when RN-B reminded her to complete hand hygiene for every glove change. RN-A then completed hand hygiene with hand sanitizer during each glove change following the reminder. R2 was repositioned to have buttock's pressure ulcer cleaned and redressed. RN-B suggested using a sterile gauze instead of a washcloth to clean the wound. RN-A used a split 4x4 inch gauze. RN-A finished measuring the wound and took a scissors out of her pocket to cut the dressing to the ordered size. R3's Face Sheet dated 6/26/24, indicated R3 had diagnoses of pressure ulcer of sacral region Stage 4, and dependence on ventilator. R3's admission MDS dated 6/4/24, indicated R3 was severely cognitively impaired and was fully dependent on staff for activities of daily living. R3's discharge MDS dated 6/10/24, indicated R3	F 686		

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F 686	Continued From page 12 had one Stage 4 pressure ulcer. R3's active Wound Care Order started 6/22/24, directed, "Sacral wound: apply mesalt loose packed (sodium chloride dressing to stimulate the cleansing of discharging wounds) into wound, cover with foam dressing change daily." R3's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Coccyx wound: apply calcium alginate four times a day, lighten pack cover with army battle dressing pad." The order was active 6/6/24 through 6/24/24. A nurses note from 6/24/24 stated item was not available. R3's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Coccyx wound: cleanse normal saline. Use mesalt sheet to lightly pack (on base and in undermining areas.) Cover with army battle dressing pad. Secure with tape daily." The order was active 5/29/24 through 6/06/24, there were no nurses notes. R3's Wound Management Detail report from 6/1/24 through 6/26/24 documented the following pressure ulcer history. -On 5/29/24 a pressure ulcer on the coccyx was identified. -On 5/29/24 it was documented as unstageable, 3.5 centimeters of undermining. Length was 7 centimeters, width was 6.5 centimeters, depth was 2.5 centimeters. It had light exudate. -On 6/5/24 it was documented as unstageable, with 2.6 centimeters of undermining. Length was 7.5 centimeters, width was 6 centimeters and, depth was 2.6 centimeters. It had moderate, serosanguinous exudate.	F 686		

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

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F 686	Continued From page 13 -On 6/12/24 it was documented as unstageable with undermining at 9 o'clock 1.3 centimeters. Length was 7.5 centimeters, width was 6 centimeters, depth was 3.3 centimeters. -On 6/19/24 it was documented that the pressure ulcer was undermining at 2 o'clock: 3 centimeters. At 9 o'clock 1.6 centimeters. It was a Stage 3 pressure ulcer with well defined wound edges, 95% covered by granulation tissue, and 5% covered by slough tissue. It had erythema, was blanchable with light exudate. Length was 7.5 centimeters and width was 5.5 centimeters, depth was 2.5 centimeters. -On 6/26/24 it was documented as a stable wound with no classification of the wound. Length was 7 centimeters, width was 5 centimeters, depth was 2.5 centimeters. Light, serosanguinous exudate was present. -On 6/5/24 a pressure ulcer on the left calf, lateral posterior was identified. -On 6/5/24 it was documented there was an intact scab, covered with foam dressing to protect. Residents heel boots were on. Length was 1.4 centimeters, width was 0.8 centimeters, no depth. The wound was stage one, closed and 100% covered by epithelialization tissues. It's status was listed as improving. No exudate, odor, undermining, no tunneling, no wound vac. -On 6/12/24 it was documented there was an intact scab. Stage 2 pressure ulcer with edge epitheliazing flush with wound base. Length was 1.4 centimeters, width was 0.9 centimeters, no depth. Status was listed as stable. No exudate, odor, undermining, no tunneling, no wound vac. -On 6/12/24 it was documented there was an intact scab. Stage 2 pressure ulcer with edge epitheliazing flush with wound base. Length was 1.4 centimeters, width was 0.9 centimeters, no	F 686		

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F 686	Continued From page 14 depth. Status was listed as stable. No exudate, odor, undermining, no tunneling, no wound vac. -On 6/19/24 it was documented there was an intact scab. It was listed as closed/resurfaced with well defined wound edges and stable. Length was 1.4 centimeters, width was 0.8 centimeters, no depth. -On 6/26/24 it was documented that the scab was removed by the nurse practitioner. The wound was healed and discontinued. On 6/26/24 at 10:43 a.m., RN-A was observed providing wound care for R3. RN-A donned proper personal protective equipment (PPE) and began providing wound care to R3. RN-B entered the room to provide assistance. An open half full normal saline bottle was noted on R3's bedside table. The bottle was not dated when it was opened. The prescribed gel tube was not in the room. RN-A left the room to obtain the gel. RN-B reminded RN-A to remove her PPE when leaving the room, and RN-A doffed her PPE. RN-A returned with the prescribed gel, and donned gloves after using hand sanitizer. RN-A opened the gel tube and dropped the cap. After finishing wound care, RN-A picked up the cap and rinsed it in the sink, dried it with a paper towel and placed it back on the tube. R3 was repositioned to provide wound care for his right scapula. RN-A used a 4x4 inch split gauze with normal saline from the opened and unlabeled normal saline bottle to cleanse the wound. Next, the sacral wound care was completed. RN-A used a 4x4 inch split gauze with the same unlabeled normal saline to cleanse the wound. RN-A opened a package of Tegaderm. RN-B questioned RN-A if that was the correct order and if the nurse practitioner had recently changed the order. RN-A did not verify the order following this, RN-A	F 686		

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F 686	Continued From page 15 continued to apply Tegaderm to the sacral wound. RN-A placed strips of medical tape onto the side of the bedside table before applying to R3's dressing and skin. RN-A accidentally threw the cap for the normal saline bottle away. RN-A placed a new gauze on top of the normal saline bottle before leaving the room. R4's Face Sheet dated 6/26/24, indicated R4 had diagnoses of dementia, and unspecified open wound of right buttock. R4's quarterly MDS dated 6/11/24, indicated R4 was severely cognitively impaired and was fully dependent on staff for activities of daily living. The MDS indicated R4 had no pressure ulcers. R4's wound care order in the treatment administration record from 6/1/24 through 6/26/24 included the order, "Okay to apply skin prep to posterior thigh open area until healed." The order was active from 5/24/24 through 6/26/24. There were no nurses notes. R4's Wound Management Detail report from 6/1/24 through 6/26/24 documented the following pressure ulcer history. -On 5/22/24 there was a right posterior upper thigh abrasion. A note indicated the doctor stated it was an abrasion from briefs that were too small. -On 5/22/24 it was documented as a Stage 2 pressure ulcer with serosanguinous exudate. Length was 0.3 centimeters, width was 4 centimeters and depth was 0.1 centimeters. -On 5/29/24 it was documented as a Stage 2 pressure ulcer with erythema. Length was 0.2 centimeters, width was 0.5 centimeters, depth was 0.05 centimeters. -On 6/5/24 it was documented as improving with	F 686		

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F 686	Continued From page 16 100% of wound covered with epithelial tissue. Length was 0.2 centimeters, width was 0.6 centimeters, depth was 0.1 centimeters. -On 6/12/24 it was documented as a Stage 2 pressure ulcer with irregular wound edges. Length was 0.7 centimeters, width was 1 centimeter, depth was 0.1 centimeter. -On 6/19/24 it was documented as stable with 80% of the base having slough. Length was 0.4 centimeters and width was 1 centimeter. -On 6/26/24 it was documented as improving. Length was 0.3 centimeters and width was 0.9 centimeters. -On 6/12/23 there was a left posterior upper thigh abrasion identified. -On 6/12/24 it was documented as pink and stable. Length was 0.5 centimeters and width was 0.8 centimeters. -On 6/19/24 it was documented as stable and red. Length was 0.8 centimeters, width was 0.8 centimeters, depth was 0.1 centimeters. -On 6/26/24 it was documented as improving and smaller. Length was 0.2 centimeters, width was 0.3 centimeters. On 6/26/24 at 11:16 a.m., RN-A and RN-B entered R4's room to provide wound care after donning PPE. RN-A mentioned not having gauze in the room, doffed PPE to gather proper supplies and returned to don PPE. During the wound care, RN-A wet a gauze with tap water to cleanse the wound. RN-B asked if she needed normal saline and left to obtain normal saline. RN-B returned with two normal saline syringes and RN-A cleansed the wound with a new gauze wetted with one of the normal saline syringes. On 6/26/24 at 11:32 a.m., RN-A was interviewed.	F 686		

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F 686	Continued From page 17 RN-A stated hand hygiene should be completed between every glove change before PPE is put on and after care is completed. The normal saline water bottles are good for seven days after they are opened, she stated she personally does not need them labeled. She used washcloths to clean the wound because there was no gauze available. She also stated she would prefer residents had their own scissors in their rooms, but she had to use her own scissors. She was not sure if R1's family had been notified about her wound or not. She was surprised by the fast progression of the wound, when she saw it for the first time it already had slough. She noticed there started to be an odor, she documented the odor and said the nurse practitioner ordered the treatment, but the nurse practitioner might have been on vacation. On 6/26/24 at 11:41 a.m., RN-B was interviewed and stated every time there's a glove change, hand sanitizer needs to be applied. Every time a staff takes their hands away from the patients, a glove change with hand sanitizer should be completed. Wash cloths should not be used for wound care, the facility did have regular gauze and not split gauze to use for wound care. Each patient should have their own scissors in their room. She was working on getting each resident a bin to keep wound care supplies in their room. When a nurse enters the room, they should have everything they need. She was concerned about a nurse using scissors from their scrub pocket. She expected nurses to pull up each resident's order to see what has changed before performing cares to avoid mistakes. Normal saline bottles can be used up to 72 hours after opening. On 6/26/24 at 2:07 p.m., the hospital registered	F 686		

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F 686	Continued From page 18 nurse (RN)-F who was assigned to R1 on 6/26/24 was interviewed. The RN-F stated R1 still had an open wound that required twice a day wet to dry dressing changes with packing. R1 had stopped intravenous antibiotics and was taking oral antibiotics at the time of the interview. The pressure ulcer was documented as foul smelling and was a sign of her sepsis. On 6/26/24 at 2:22 p.m., the regional nursing director, RN-C stated she would expect clean scissors to be in each resident's room. The use of hand sanitizer or handwashing should be completed during every glove change. Gauze should be used for cleaning wounds, not washcloths. Tap water would not be acceptable to clean wounds with unless it is in the order, otherwise normal saline or wound cleanser should be used. Wound care orders typically clarify what to clean the wound with if the wound should be pat dry and if there are secondary dressings. Staff can't control what providers order, but can clarify with the provider. On 6/27/24 at 10:40 a.m., nurse practitioner (NP)-A was interviewed. NP-A stated washcloths were acceptable to use because they can be used for wound care at home or to clean out stool from the wound. The residents at the facility have chronic wounds that are already infected. Sterile gauze is not necessary unless it's a surgical wound and tap water would be acceptable. Hand sanitizer between every glove change is not required and it would be impossible to get gloves back on after completing hand hygiene. All residents have bandage scissors in their rooms, but an alcohol swab could be used to clean the scissors between patients. She would not have included additional details for the wound care	F 686		

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F 686	Continued From page 19 order because, "I don't write detailed orders." Wound care cleaning was normally already understood by staff, and the standard was nurses cleanse the wound, apply skin prep, and put the dressing on. On 6/27/24 at 11:46 a.m., the director of nursing (DON) was interviewed. When asked if the orders for wound care and pressure ulcer monitoring should have been entered into the resident's EHR faster, the DON responded they are doing training on change of condition. It wouldn't hurt to have more directions in the wound care orders, and they are working on scheduling training for wound care. She would expect staff to change their gloves and then clean their hands. Tap water should only be used if there was an order and washcloths were not acceptable. Scissors should stay in the resident's room; nurses should not take them out of their pockets. Normal saline was usable up to 72 hours after being opened. The facility policy Change in Condition last reviewed 10/2023, directed when a significant change in the resident's physical status, the licensed nursing associate notifies the resident representative. The facility policy Hand Hygiene effective 2017, directed times to perform hand hygiene includes before and after direct resident contact, before and after any invasive procedure, after handling used linens, and after removing gloves. A policy on pressure ulcers was requested but not provided.	F 686		