DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 2, 2023

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

RE: CCN: 245266
Cycle Start Date: January 26, 2023

Dear Administrator:

On March 1, 2023, the Minnesota Department(s) 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.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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March 2, 2023

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

Re: Reinspection Results
Event ID: 3ER312

Dear Administrator:

On March 1, 2023 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 January 26, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 31, 2023

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

RE: CCN: 245266
Cycle Start Date: January 26, 2023

Dear Administrator:

On January 26, 2023, a survey was completed at your facility by the Minnesota Department of Health, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 April 26, 2023 (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 July 26, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered
January 31, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: 3ER311

Dear Administrator:

The above facility was surveyed on January 26, 2023 through January 26, 2023 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	C 01/26/2023

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 1/26/23, a standard abbreviated survey was conducted at your facility. Your facility was found to be not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H52667855C (MN90332)and (MN90351) with a deficiency cited at F585. The following complaint was found to be SUBSTANTIATED without deficiency due to actions taken prior to the survey: H52667664C (MN90203). 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been	F 585		2/20/23

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

Electronically Signed | 02/15/2023

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 585	Continued From page 1 furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 585		

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F 585	Continued From page 2 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency	F 585		

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F 585	Continued From page 3 confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their process to ensure a voiced grievance concerning an unwanted visitor was received, tracked and resolved to satisfaction for 1 of 1 resident (R1) reviewed for grievances. Findings include: R1's quarterly Minimum Data Set (MDS) dated 12/14/22, identified R1 had intact cognition and minimal depression. R1 had no behaviors or rejection of care noted. R1 had diagnoses of bipolar disorder, depression and anxiety. R1's Care Plan dated 9/21/22, identified the following: -Preferences for Customary Routine category identified R1 had not wanted to be disturbed during the night and had not wanted staff to knock on R1's door and enter the room while asleep. Interventions included staff would honor resident's wishes. -Psychosocial Well-Being category identified R1 reported childhood traumatic memories regarding a parent coming into R1's bedroom at night. Interventions included to listen objectively to R1's complaints and validate feelings. During an interview on 1/26/23, at 9:30 a.m. licensed practical nurse (LPN)-A stated she was the nurse working with R1 and was not aware of	F 585	F 585 • R 1 provided the name and address of the individual that he/she does not wish to have contact with via phone or in person. This individual has been contacted via certified mail. • On 2/2/23 the Administrator and Social Service Director reviewed the policies related to resident rights specific to visitation and grievances with those in attendance at Resident Council. • Review of policies specific to the resident rights of visitation and grievances by staff. Policies present on the units and text message sent specific to reviewing and signing acknowledgement of content in addition to verbal reminders. • Random conversations with residents in which the question of whether they have concerns is included along with reminder of their right to voice concerns or grievances. This will be weekly for four weeks and transition to monthly until further direction from QA. • Resident concerns or grievances will be discussed during the weekday management meetings along with plan for investigation follow up and closure. Grievance logs will be reviewed weekly by Administrator or designee to assure	

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F 585	Continued From page 4 any restricted visitors for R1. During an interview on 1/26/23, at 9:43 a.m. R1 stated in mid-December 2022 an unannounced visitor (V)-A from her past entered her room while she was asleep and left a large holiday card in her room. R1 kept the card and showed the card to surveyor. The card envelope had V-A's name and address label and a written note, which R1 stated made her feel "creeped out". The envelope also had a note directing R1 to contact someone, which R1 stated she was no longer in contact with. R1 stated she had reported to several staff a request for V-A to not be allowed back to the facility. R1 stated she was instructed by staff to call V-A and ask him to not return. R1 stated had felt uncomfortable and had not wanted to call V-A but made the call anyway because she was told to. R1 recalled having "a lot of trauma" history and stated V-A's visit re-opened the trauma. Additionally, R1 stated she felt disturbed that V-A entered the room while she was asleep and potentially watched her sleep without her knowledge. R1 stated anyone she was not in contact with was not V-A's concern. R1 stated social services (SS) had not followed up with her after R1 reported this concern. R1 stated because no one followed up, she felt unsafe knowing V-A could potentially come back. During an interview on 1/26/23, at 10:45 a.m. registered nurse (RN)-A stated she was not aware of any restricted visitors for R1. During an interview on 1/26/23, at 10:58 a.m. social services director (SSD) stated she was the only social worker for the building. SSD stated she heard second-hand that R1 had talked to the health unit coordinator (HUC) and R1 had	F 585	completion. Summary information presented at QA meetings for further direction.	

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F 585	Continued From page 5 requested a visitor not be allowed back. SSD stated she had not followed up with R1 because SSD had not thought it was a big deal at the time. The SSD stated facility staff had a portal to log grievances and concerns. The SS stated there were no current grievances on file for R1. The SSD also stated if guardians or residents wanted certain visitors to be restricted there was a list of restricted visitors at the main entrance. During an observation on 1/26/23, at 11:10 a.m. with the SSD, the restricted visitor's log was reviewed at the front desk and no one was listed as restricted from visiting R1. During an interview on 1/26/23, at 11:10 a.m. the front desk receptionist (RC) stated she was not aware of any restricted visitors for R1 and would refer to the list of restricted visitors that was currently posted. RC stated the entrance door was always locked and visitors had to be let in by someone on the inside. RC stated there was always someone at the front desk. During the day time it was a receptionist, and at night a security guard. RC stated after being "buzzed in" visitors signed into the visitor log and if they were on the restricted visitor list, would not be allowed in. During an interview on 1/26/23, at 11:23 a.m. the director of nursing (DON) stated R1 and the physical therapist (PT) came in to talk to the DON on an unknown date in December 2022. The DON stated R1 said V-A, a visitor, had been in R1's room while R1 was asleep and R1 had requested that V-A not be allowed to come back in the facility. The DON stated she told R1 to call V-A and tell him not to come back. The DON stated R1 said she did not wanted to call V-A but did anyway. The DON stated to R1, during that	F 585		

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F 585	Continued From page 6 same visit, R1 should follow up with social services (SS) the next day since SS was not in the building at the time. The DON stated she had no documentation of R1's concern and had not offered to post V-A's name on the restricted visitors list at the front desk. During an interview on 1/26/23, at 11:26 a.m. the health unit coordinator (HUC) stated in mid-December 2022, R1 came to the nurses station and was really "worked up". The HUC stated she had never seen R1 so worked up before. The HUC stated R1 said a visitor had come in and R1 requested the visitor not be allowed to come back. The HUC said she remembered the day this visitor arrived and had called the SS on behalf of R1 to let SS know about the incident. The HUC said she was not aware of any follow up. During a review of the facility's visitor sign-in sheet, V-A was listed on 12/16/22, to visit R1, checked in at 12:25 p.m. and checked out 12:45 p.m. During an interview on 1/26/23, at 12:03 p.m. the PT stated R1 said during a therapy session in mid-December 2022 R1 had recalled a visitor that R1 had not wanted to come back to the facility again. The PT stated they went directly to the DON's office since SSD was off that day. The PT stated the DON had advised R1 to wait until tomorrow and talk to SSD. The PT stated the DON had also advised R1 to call the visitor and let him know a visit was no longer wanted. During an interview on 1/26/23, at 1:26 p.m. the administrator stated he was not aware of R1's concern for the unwanted visitor. The	F 585		

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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

(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 585	Continued From page 7 administrator stated any staff could log a concern or grievance on behalf of a resident and it had not happened in this case. The administrator stated concerns should be logged so they could be followed up on. During an interview on 1/26/23, at 1:56 p.m. the business office manager (BOM) stated R1 had also talked to her in December 2022 about V-A. The BOM stated R1 said that V-A made R1 uncomfortable and R1 said had not wanted V-A to visit again. The BOM stated she had not logged a grievance on behalf of R1's concern and stated SSD would be responsible for following up on concerns or grievances. The facility's policy titled Concerns, Grievances dated 9/17/19, identified the following: 1. A resident had the right to voice grievances and concerns. The term "voice concerns" was not limited to a formal written grievance process but could include a resident's verbalized concerns to staff 2. When a resident, representative, visitor or family voiced a concern to a staff member, the staff member would complete a concern form and forward the form to SS in a confidential manner 3. SS or designee would screen the concern forms, assign the concern to an associate accountable for the work area called out on the concern form, and the staff responsible would acknowledge receipt of the concern with the resident within 24 hours (or the next working day) and documents the acknowledgement 4. The staff person responsible would investigate, resolve the issue and respond back to the customer within 5 business days and documents the action. Resident satisfaction with the resolution and handling of the concerns is	F 585		

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 01/26/2023

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F 585	Continued From page 8 obtained 5. All written grievance decisions would include the date the grievance was received, a summary statement, the steps taken to investigate, a summary of investigative findings, a statement as to whether the grievance was confirmed or not confirmed and any correction action taken, and the date the written decision was issued 6. The SS lead was the grievance officer.	F 585		