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	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Benedictine Health Center of Minneapolis	618 East 17th Street Minneapolis, MN 55404

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43367 Based on interview and document review, the facility failed to assess and notify provider for change in condition for 1 of 1 resident (R1) reviewed. This resulted in an immediate jeopardy (IJ) situation for R1 when his heart rate (HR) was identified to be 156 bpm (beats per minute), was later found unresponsive with no pulse, CPR (cardiac pulmonary resuscitation) was performed, and he subsequently died at the facility. The immediate jeopardy began on [DATE], when at 1:30 a.m. R1's HR was 156 bpm, and no action taken by registered nurse (RN)-A. Then at 3:40 a.m. R1 was found unresponsive with no pulse, CPR was performed, paramedics arrived at 4:20 a.m., and took over CPR until R1 was pronounced dead at 4:47 a.m. at the facility. The director of nursing (DON) and administrator were notified of the IJ on [DATE], at 4:20 p.m. The IJ was removed on [DATE], following verification of an acceptable removal plan however, noncompliance remained at the lower scope and severity level D, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 unable to be interviewed for mental/cognition status due to unable to express ideas and wants, rarely or never understood, unable to respond, and had highly impaired vision. MDS indicated R1's diagnoses included respiratory failure, fracture, septicemia (bacteria in the blood stream) and multi-drug resistant organism (MDRO) (a germ that is resistant to any antibiotic). R1 prognosis identified he did not have a chronic condition identified that may have resulted in less than six-month life expectancy. R1 had a tracheostomy (a surgical opening made through the front of the neck and into the windpipe/trachea kept open for breathing) and suctioning, he was dependent on a ventilator (a machine that helped lungs work then unable to breath on your own properly), and oxygen. R1's Baseline Care Plan dated [DATE], identified cognition as nonresponsive, non-verbal, and questionable impaired hearing. Staff were expected to suction R1 as needed and oxygen saturation (SaO2) (measures how much oxygen is in your blood) levels to be maintained over 90%. Plan of care directed staff for total resident care: Management of ventilator, tracheostomy, suctioning, cervical collar, nutrition, and tube feeding. Facility Standing Orders dated [DATE], identified Respiratory distress: O2 (oxygen) at 2 to 4 L liters/minute via cannula for up to 30 minutes. Notify physician. Hospital discharge summary and orders dated [DATE], identified: (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Diagnoses: acute (sudden onset) failure of the respiratory system with lack of oxygen [DATE] to [DATE]. -Call provider for: difficulty breathing, headache or visual disturbances. -Call provider for temperature over 100.4. F -Code status: full R1's progress notes (PN) dated from [DATE], through [DATE], identified: -[DATE], at 11:00 p.m. R1's SaO2 95% on room air, and no heart rate identified. -[DATE], at 6:56 a.m. R1's vital signs at 1:00 a.m. BP (blood pressure) ,d+[DATE], T (temperature) 97.9 F (Fahrenheit), SaO2 87%, HR (heart rate/pulse) 107, on room air (RA), R (respirations)16. R1 was started on oxygen 2 L (Liters) per nasal cannula. R1's SaO2 improved to 94%. Second vitals were checked to be BP , d+[DATE], HR 107, T 97.5 F and remained unresponsive throughout to verbal nor sensory stimuli. No sign of pain or distress were observed. -[DATE], at 11:03 p.m. remained unresponsive throughout shift, no body movement, no respiratory distress, or signs/symptoms of pain. Vitals: BP ,d+[DATE], HR 113, T 97.5 F, SaO2 95% on 2 L of oxygen. Second set of vitals: BP ,d+[DATE], HR 114, T 98.6 F, R 15, SaO2 94 to 95% on 2 L oxygen. Suctioned four times with moderate white secretion. -[DATE], at 12:00 p.m. HR 120, R 17 and SaO2 91% on 2 L of oxygen. Breath sounds slightly course, diminished throughout, post suction times three small/pale/thin secretions. -[DATE], at 4:19 p.m. resident restless and vent was alerting for about 30 minutes, but stable now. Vitals: BP ,d+[DATE], 98.1 F, HR 120, R 18, SaO2 93% on 2 L oxygen. Nurse Practitioner (NP)-B was notified day four of no bowel movement, onetime house order for MOM (milk of magnesia) 30 cc and prune juice order for constipation. -[DATE], at 10:59 p.m. no signs of restlessness on shift. Vital signs: BP ,d+[DATE], 98.2 F, HR 111, R 20, SaO2 95% on 2 L oxygen. Resident was being monitored for any changes in status. -[DATE], at 7:36 a.m. vital signs at 12:30 a.m. 98.1 F, HR 111, R 14, BP ,d+[DATE]. Suctioned four times with small to moderate whitish secretions each time. -No progress notes or vital signs documented on [DATE], from 3:06 p.m. to [DATE], at 3:04 p.m. (almost 24 hours). -[DATE], at 3:06 p.m. resident alert and smiled to his mom when communicating with him. Vital signs: BP , d+[DATE], HR 109, 98.1 F, SaO2 94%, and R 14. Vent dependent and on oxygen at 2 L with no shortness of breath. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-[DATE], at 3:04 p.m. remained unresponsive through shift and ventilator dependent. Temperature 100.5 F. Modified the room and wet towel over forehead and under arm placed, non-pharmacology intervention was not effective. Tylenol administered and fever went down to 98.9 F tympanic (ear probe), BP ,d+[DATE], HR 114, SaO2 96% on 2 L oxygen, and R 17. -[DATE], at 6:23 a.m. at about 3:40 a.m. to 3:45 a.m. resident was found unresponsive by writer (RN-A), R1 pulse was checked electronically and manually. Shouted for help and other nurses came in right away, CPR started, and 911 was called. Paramedics arrived about 4:20 a.m. and took over, and at 4:47 a.m. R1 was pronounced dead by the emergency team. At beginning of shift vital signs were T 97.5 F, SaO2 90% with 4 L of O2, HR 156, and observed with bilateral chest rise and fall, breathing unlabored, on ventilator, in bed. Suctioned periodically per need. R1's medical record lacked documentation of vital signs on [DATE], from 3:06 p.m. through [DATE], in progress notes. Additionally, no progress notes were documented since 8:55 a.m. on [DATE], until [DATE], at 6:23 a.m. (almost three days). R1's physician communication/order document dated [DATE], at 3:15 p.m. completed by RN-B identified R1 had no BP [sic] (bowel movement) day four. NP-B ordered and signed on [DATE], at 3:15 p.m. warm MOM (milk of magnesia) 30 cc (cubic centimeters) with one glass of prune juice if no BM on day two. One time order. The communication document did not identify R1 had tachycardia (exceeds the normal resting rate) HR of 120 beats per minute identified in the progress notes. A facility document titled Configure Vital Alerts, printed [DATE], at 12:44 p.m. identified acceptable vital sign ranges (minimum/maximum) set in R1's HER to alert staff when vital signs were out of range: - Pulse 55 to 110 per minute - Respirations 10 to 26 per minute - Temperature 96.0 F to 100.0 F - O2 Saturation 90% to 100% R1's HR readings located in EHR vitals and progress notes from [DATE]-[DATE], identified: [DATE], HR 89, 98, and 98 (EHR vitals) [DATE], HR 107, 107, 112, 98, 113, and 114 (EHR vitals) [DATE], HR 120, 120, and 111 (PN) [DATE], HR 111, and 109 (PN) [DATE], HR 114 (PN) [DATE], through [DATE] HR was not documented. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE], HR 99, 111, and 156 (EHR vitals). R1's medical record's (PN and EHR) indicated HR was identified to be out of acceptable range 10 times between [DATE]-[DATE] with no action taken by the facility or contact made with the Provider for direction. During an interview on [DATE] at 1:15 p.m., registered nurse (RN)-B stated she worked with R1 on [DATE] and verified R1's HR was 120 and the ventilator was alarming a lot, so she had to trouble shoot. RN-B stated R1 was also constipated, and the provider was contacted regarding that concern. RN-B stated the provider was unaware of the 120 HR, and ventilator alarming, and really should have been updated right away. RN-B stated if R1's condition had changed, especially respiratory and vitals abnormal, a provider would have been contacted right away. During an interview on [DATE] at 1:30 p.m., respiratory therapist (RT) stated he noted on [DATE], R1's HR was considered elevated at 120 beats per minute (bpm), and he reported to the nurse on duty. RT stated when a pattern was noted of R1's elevated HR a provider should have been contacted for further direction. During a follow up interview on [DATE] at 10:11 a.m., RT stated on [DATE], R1 was placed on 2 L of oxygen, and on [DATE], R1 was bumped up to 4 L of oxygen by RN-A. RT indicated R1's 156 HR would be the key related to an indicator something was wrong for R1 as he had seen residents go into sepsis with HR 120 to 130, and most likely there was a problem with R1's heart. During an interview on [DATE] at 2:10 p.m., RN-C stated they worked [DATE], when R1's temperature was 100.5 F and HR was 114. RN-C indicated acceptable HR range was identified in the EHR vitals section as 55 to 110 bpm. RN-C administered R1 Tylenol and temperature went down. RN-C indicated they were focused on the temperature and not on his HR. RN-C verified a provider was not contacted since temperature when down. During an interview on [DATE] at 2:53 p.m., admissions nurse RN-H stated nursing staff were expected to contact a provider with any change in condition such as temperature/fever, elevated HR, change in BP, and respiratory/oxygen status, and RN-H verified she would have expected staff to contact the provider when the HR was elevated especially up to 156. RN-H indicated a problem was identified prior to R1's death, and the provider was not notified of R1's elevated HR. RN-H stated she believed if a provider would been contacted for direction/orders it could have changed the outcome for R1. RN-H also stated the nurse would be expected to reach out to the provider for tighter parameters when they started to elevate outside of the norm, no matter what time of day, the provider should have been called and parameters would have helped. During a telephone interview on [DATE] at 4:10 p.m., primary medical provider (PMD) stated no notifications were made to her regarding R1's change in status. PMD verified staff were expected to contact provider for any significant change in clinical status such as a HR outside parameters and had a sense the resident was not doing well. PMD indicated R1 was non-responsive and had a head injury which would affect the range of vitals collected. PMD stated vitals were important when you had to rely more heavily on other data for a resident who is non-responsive. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 5:17 p.m., RN-A stated they worked the night shift on 2nd floor which started at 11:00 p.m. RN-A stated he received report at 11:30 p.m., organized things, then counted medications with previous shift. Then at approximately 12:00 a.m. RN-A stated he saw four residents prior to entering R1's room at about 1:30 a.m. RN-A stated he was in R1's room for approximately 20 minutes total, adding R1's oxygen level was low at 88% on 2 L O2 and HR was 156, that was when he noted the oxygen tank registered zero/empty. He was unsure how long it had been empty, and he replaced it with a full one. RN-A stated he increased oxygen up to 4 L and oxygen level improved but was unable to indicate how much it improved during interview. RN-A stated he completed R1's water flush through feeding tube, dressing change, and HR went down somewhat, to 122 to 140 per minute (not recorded in EHR or PN). RN-A stated R1's vitals fluctuated so he monitored them for a short time, felt R1 was stable, then left the room to check on four other residents. RN-A stated around 2:40 a.m. he entered R1's room again and HR was 118 (not recorded in EHR or PN) and SaO2 had gone back down again to 88%. RN-A stated seemed like something was wrong and called RN-E into the room. RN-A stated along with RN-E checked a HR manually and unable to find one. RN-A stated R1's was warm to the touch when he called out his name, rubbed his shoulders, completed a sternal rub (a firm rub on the flat bone in the middle of the chest to provoke pain or stimulus meant to provoke a response), and no reaction noted, then started CPR. RN-A called for another nurse, RN-D, who called 911 and a code in the facility. RN-A indicted during CPR they checked for HR and noted to be 98 to 110 and SaO2 up to 100%. RN-A stated at 4:20 a.m. emergency personnel arrived and took over CPR for approximately 20 minutes, R1 was pronounced dead at 4:40 a.m. RN-A stated the HR of 156 was not normal for R1, after the water flush was given via feeding tube the HR came down somewhat, believed he was stable, so no need to call a provider. RN-A stated he had concerns about the elevated HR and that was the reason why he went back to R1's room and checked on him after he saw the other four residents. RN-A stated when he realized R1's SaO2 level had dropped back down to 88%, he called another nurse for assistance. RN-A indicated R1's baseline vitals could have been figured out through time but was unsure as to what they should have been. RN-A verified there was no need to notify a doctor right away and the outcome most likely would have not changed. RN-A verified he was educated on change of condition and importance of notification to provider. During an interview on [DATE] at 10:35 a.m., floor manager RN-F stated when R1 was admitted with HR 89 and tried establishing a baseline but struggled because his HR was overworking and something was going on with him. RN-F stated staff were expected to have documented in EHR nurses progress notes and vitals section, and contact the provider when HR started to elevate. RN-F also stated R1's temperature was elevated over 100.4 F while at the facility and provider should have been notified at that time also. RN-F verified R1's transfer order from the hospital to facility: call provider for temperature over 100.4 F, was not entered into his orders. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 12:24 p.m., director of nursing (DON) stated on [DATE], she reviewed R1's medical records and noted the elevated heart rate. The following morning, she spoke with the administrator about a concern related to the registered nurse (RN)-A not acting or when R1's heart was elevated. DON verified she had filed an incident report with the state on Tuesday morning [DATE]. DON stated parameters for vitals are the same for all residents and pre-set up in the EHR and determined by the facility's health system. DON indicated we had the ability to obtain specific and separate ranges for each resident. DON verified she had given that task to the floor manager and planned on obtaining parameters in the future from the providers. DON stated on [DATE], met with RN-A, completed interview, requested a written document that indicated understanding of what happened on the night shift [DATE], through [DATE]. DON stated she flat out told RN-A he was wrong with what he chose to do that night and expected him to respond and act to the situation, contact the provider, and take responsibility for his actions. DON stated R1's elevated HR could have potentially been an indication of infection and possibly sepsis due to an alteration in condition. DON stated the nurse would have been expected to monitor the HR frequently especially since it became elevated. DON verified R1 was non-responsive and therefore the vital signs would have been pretty important information used to assess him, he was unable to verbally respond and unable to show signs of pain or discomfort. DON verified the transfer order from the hospital to the facility on [DATE], call provider if temp was over 100.4 F. was not entered into R1's EHR and should have been. DON also verified there was lack of documentation by the nursing staff for R1 in the EHR. DON stated RN-A should have responded and contacted the provider services with a change in condition. During a telephone interview on [DATE] at 2:38 p.m., medical director (MD) stated R1's HR 156 was considered a very abnormal vital sign and should have urgently been called in to a provider that evening. MD stated this incident was identified as a change in condition. MD also stated this group of residents, about 13 to 14 (tracheotomy's and some on ventilators) with various needs, were terribly sick, and occasionally became tachycardiac (a HR over 100 beats per minute). MD stated residents with tachycardia may not cause any symptoms but sometimes a warning of a medical condition that required medical attention. MD stated residents on ventilators showed signs of anxiousness and respiratory infections, and in this case RN-A was unable to recognize it was a change in condition. MD indicated RN-A did not meet the nursing standards of care. MD stated nursing was expected to notify and provider when the temperature became two points above the baseline, HR above 110, and respirations above 20 per minute. MD also indicated when a resident was on supplemental oxygen, SaO2 was below 90% along with a rapid heart rate and did not return to normal range, RN-A would have been expected to document findings, and provider should have been contacted. MD stated RN-A's documentation was considered incomplete/inadequate, did not reflect his thought process, and lacked insight as to what happened that night. MD verified a change noted in R1's vitals required a provider be called to diagnose, intervene, and revise the treatment plan. MD stated R1's situation was out of the nurse's scope of practice and was not the facility policy for an individual nurse to have made those decisions. During a telephone interview on [DATE] at 1:15 a.m., RN-E verified she had worked the night shift on [DATE], through [DATE]. RN-E stated around 3:00 a.m. RN-A had informed her he was unable to get R1's SaO2 reading and knew something was wrong. RN-E stated we entered R1's room together and R1 was very pale, checked manually for a pulse, no pulse felt, and immediately started CPR. RN-E verified was not informed prior to this incident about a change in condition or elevated HR by RN-A. RN-E stated we are expected to go by the resident's normal ranges and if out of the normal range, check orders for interventions, then contact the provider no matter what time of day or night it was. RN-E stated R1 had a tachycardia (abnormal high HR), would have suspected sepsis, provider should have been notified, and most likely sent out via ambulance. (continued on next page)

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