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	06/27/2024

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

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337 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. 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 [DATE], indicated R1 was moderately cognitively impaired and fully dependent on staff for activities of daily living. R1's quarterly MDS dated [DATE] indicated R1 had one unstageable pressure ulcer. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. R2's significant change MDS dated [DATE], indicated R2 was severely cognitively impaired and was fully dependent on staff for activities of daily living. R2's discharge MDS dated [DATE], 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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 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 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE], indicated R3 was severely cognitively impaired and was fully dependent on staff for activities of daily living. R3's discharge MDS dated [DATE], indicated R3 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 [DATE], 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 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-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. 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 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. (continued on next page)

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	06/27/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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.