

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Benedictine Health Center of Minneapolis		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49337</p> <p>Based on observation, interview, and document review, the facility failed to respond timely to ventilator alarms for 3 of 3 (R2, R3, R4) residents observed for ventilators.</p> <p>Findings include:</p> <p>R2's undated Face Sheet indicated diagnoses of chronic respiratory failure, heart failure, chronic obstructive pulmonary disease, persistent vegetative state, dependence on a respirator status, and personal history of sudden cardiac arrest.</p> <p>R2's quarterly Minimum Data Set (MDS) dated [DATE] indicated he was severely cognitively impaired, and required total dependence for all cares and activities of daily living (ADLs).</p> <p>R2's care plan dated 10/30/24 indicated R2 was ventilator dependent and interventions included to answer vent alarms promptly.</p> <p>R3's undated Face Sheet indicated diagnoses of chronic respiratory failure, dependence on respirator status, encounter for attention to tracheostomy (a surgical opening into the neck to create an airway), persistent vegetative state, and chronic obstructive pulmonary disease.</p> <p>R3's quarterly MDS dated [DATE] indicated he was severely cognitively impaired, and required total dependence for all cares and ADLs.</p> <p>R3's care plan dated 10/30/24 indicated R3 was ventilator dependent and interventions included to answer vent alarms promptly.</p> <p>R4's undated Face Sheet indicated diagnoses of acute respiratory failure with hypoxia (low oxygen levels), encounter for attention to tracheostomy, and dependence on respirator status.</p> <p>R4's quarterly MDS dated [DATE] indicated he was severely cognitively impaired and required total dependence for all cares and activities of daily living.</p> <p>R4's care plan dated 10/31/24 indicated R4 was ventilator dependent and interventions included to answer vent alarms promptly.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/30/24 at 11:38 a.m., the ventilator unit was observed. A ventilator alarm was audible and was determined to be R2's ventilator sounding the high-pressure alarm. R2's ventilator continued to alarm every 30 to 45 seconds. At 11:49 a.m., registered nurse (RN)-A entered R2's room and assessed the ventilator alarm. RN-A provided in-line tracheal suctioning, and silenced the high-pressure alarm. R2 had a large amount of water condensation in the circuit tubing (tubing that connects the ventilator to the patient), causing the tubing to shake and move back and forth. RN-A did not empty the tubing. RN-A exited R2's room. At 12:05 p.m., R2's tubing continued to have excess condensation and bubbling of the water in the tube, which was audible from outside his room. R2 did not appear to be in any distress. At 12:19 p.m., RN-B entered R2's room and emptied the condensation from the circuit tubing into the trash can, and provided in-line tracheal suctioning.</p> <p>On 10/30/24 at 2:41 p.m., R3's ventilator alarm went off. The ventilator was checked and showed a high-pressure alarm. The high-pressure alarm continued to go off every 30 seconds to a minute. R3 did not appear to be in any distress. At 2:50 p.m., RN-B entered R3's room and provided in-line tracheal suctioning. The high-pressure alarm was resolved.</p> <p>On 10/30/24 at 3:00 p.m., RN-B stated all staff on the floor are responsible for helping to answer ventilator alarms. When asked if there was enough staff available to respond to the ventilator alarms, she said it depends on the day. RN-B stated ventilator alarms should be answered right away. Low pressure alarms could indicate a leak or a disconnect. High pressure alarms could indicate increased secretions, water in the circuit or the resident is having pain.</p> <p>On 10/31/24 at 8:31 a.m., RN-C stated when a ventilator was beeping, staff should go to the room to check on the resident. High pressure alarms could indicate a mucus plug, water in the tubing, pain or that the resident is repositioning.</p> <p>On 10/31/24 at 8:52 a.m., R4's ventilator alarm went off. The alarm indicated disc-sens (an issue with one of the sense lines). RN-D was in another room next to R4's room. At 8:55 a.m., R4's ventilator alarm continued to go off. RN-D entered the hallway, wiped down patient equipment and opened the med cart. R4's alarm continued to go off once about every minute. At 9:18 a.m., R4's ventilator alarm had still not been assessed by staff. R4 did not appear to be in any distress.</p> <p>On 10/31/24 at 9:19 a.m., RN-D stated staff must go in the resident's room to look at the ventilator to know what type of alarm was going off. Circuit tubing should be emptied of water as needed. When there was too much water in the circuit, there could be a disc-sense alarm because of the water pressure. When resident care plans indicated to answer ventilator alarms promptly, that meant right away. Ventilator alarms which resolved on their own should still be assessed.</p> <p>On 10/31/24 at 10:06 a.m., RN-A stated on busy days, nurses will answer the ventilator alarm that had been ringing the longest. Sometimes when nurses are in a patient room with the door closed, they can't hear the other resident's alarms. The only way for staff to know what type of alarm was going off was to go look at the resident's ventilator. A high-pressure alarm could indicate an obstruction. The disc-sense alarm means something was wrong with the sensor tubing, and it could mean something was not hooked up properly.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/31/24 at 10:37 a.m., the director of nursing (DON) stated staff would need to check the ventilator to determine what alarm was going off. Circuit tubing should be emptied when staff see that it was filling up with water. The ventilator could continue to alarm if the circuit tubing was not emptied. When asked what answering alarms promptly meant in the care plans, the DON stated she could not provide a definitive answer. She also stated she could not speak to how long alarms should ring before they were answered.</p> <p>A policy pertaining to answering ventilator alarms was requested but not provided.</p>		