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	01/16/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on interview and document review, the facility failed to ensure the resident and/or resident representative participated in care conferences for the planning process and development of interventions for 1 of 1 residents (R36) reviewed for participation of care planning. Findings include: According to the Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated October 2023, the RAI is used to, assist staff with evaluating goal achievement and revising care plans accordingly by enabling the nurse home to track changes in the resident's status. The RAI, establishes a course of action with input from the resident (resident's family and/or guardian or other legally authorized representative), resident's physician and interdisciplinary team that moves a resident toward resident-specific goals utilizing individual resident strengths and interdisciplinary expertise. The Assessment Reference Date (ARD) refers to the specific endpoint for the observation period in the MDS assessment process and is federally mandated to be completed on admission, quarterly (every 92 days), annually, with a significant change in status (SCSA), and on discharge. R36's quarterly Minimum Data Set (MDS) dated [DATE] identified R36 with severe cognitive impairment, was dependent on staff for personal hygiene, toileting, showers/bathes, dressing upper and lower body and turning in bed. In addition, R36 with diagnoses of Alzheimer's, dementia, hemiplegia affecting right dominant side, and malnutrition. R36's electronic medical record (EMR) indicated the MDS assessments were documented and submitted on the following dates: - 1/3/24 - quarterly - 3/27/24- quarterly - 6/26/24- quarterly - 7/21/24 - SCSA (significant change) - 10/16/24- quarterly (continued on next page)

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

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	01/16/2025

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care Conferences were documented on 1/17/24, 4/9/24, and 7/17/24 following discharge from hospice services. The EMR lacked evidence of a care conference being done after 7/21/24. During interview with the registered nurse/infection control preventionist (ICPC) on 1/14/25 at 12:10 p.m., ICPC stated, we do it [care conferences] when the ARD is due or as needed. [Social Worker] takes care of the care conferences. During interview with facility's director of social services (SS)-A on 1/15/25 at 2:23 p.m., SS-A stated she was responsible for scheduling and conducting the care conferences for all residents of the facility. SS-A stated R36 is due for one and, should be done every three months. In addition, SS-A stated [R36] is one to two months late. It should be done with every MDS cycle, but it was not done. SS-A unable to state why R36's October 2024 care conference was not done. During interview with family member (FM)-A on 1/16/25 at 7:25 a.m., FM-A stated she was R36's primary emergency contact. FM-A stated she was invited to R36's care conferences and was last invited, Last Summer [2024] and not since then. During interview with director of nursing (DON) on 1/16/25 at 10:40 a.m., DON stated expectation of care conferences to coincide with the MDS assessments. Facility policy titled Comprehensive Assessments and Care Planning dated 11/2017 state, Residents and resident representative will be involved in the comprehensive person-centered care planning. Facility policy titled Resident/Family Participation in Care Planning dated 11/28/2017 state, Care conference documentation includes that[sic] staff, resident and others that participate. And, Responsible for Implementation: Social Services, Nursing.

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	01/16/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44656 Based on observation, interview, and document review, the facility failed to ensure resident identifiable personal health information (PHI) was kept secured and out of public view. This had potential to affect all 73 residents of the second, third and fourth floors whose personal information was listed on exposed care sheets. Findings include: Document titled 3rd Floor Nursing Care Work Sheet downloaded 1/14/25, indicated, Carry this care worksheet with you during your shift; do not leave out for others to see (HIPAA/PHI) [Health Insurance Portability and Accountability Act - federal standards to protect PHI - Personal Health Information]. During observation on 1/15/25 at 8:37 a.m., on the third-floor transitional care unit (TCU), an alcove in the middle of the hallway across from room [ROOM NUMBER] contained two large plastic rolling containers with lids, a linen cart that was covered, and a tall office type chair. On top of the covered linen cart was an unattended, 3rd Floor Nursing Care Work Sheet containing twenty five resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status, and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking status, bedrail positioning, and tracheostomy and gastric tube presence. Two staff members walked past the unattended care sheet. During interview on 1/15/25 at 8:39 a.m., nursing assistant (NA)-A pointed to the third-floor unattended care sheet and stated, Care sheets should not be left unattended. During interview on 1/15/25 at 8:42 a.m., NA-B verified the third-floor unattended care sheet was his responsibility and stated, I forgot about it and left it there [pointing to the alcove]. There is private information on this sheet and should not be visible to anyone. During observation and interview on 1/15/25 at 9:39 a.m., on the fourth-floor of the facility, an unattended, 4th floor Nursing Care Work Sheet containing twenty five resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking status, bedrail positioning, and tracheostomy and gastric tube presence was left face up on an unattended medication cart located in the common area directly across from the nursing station. During interview with assistant director of nursing (ADON) at 9:43 a.m., the ADON verified the unattended fourth-floor care sheet contained, patient identifying information. The ADON stated, This could be visible to people who shouldn't see it. During interview with RN-B on 1/15/25 at 10:27 a.m., RN-B stated, unattended care sheets [sic] should not happen. [contains] Private information that others should not see. (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	01/16/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation on 1/16/25 at 8:48 a.m., on second-floor across from room [ROOM NUMBER], the alcove contained an unattended care sheet titled, 2nd Floor NAR WORKSHEET. The worksheet contained twenty three resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking status, bedrail positioning, and tracheostomy and gastric tube presence. During interview with trained medication aide (TMA)-A on 1/16/25 at 8:49 a.m., TMA-A pointed to the second-floor unattended care sheet and stated, [that] has patient information and [it is a] violation of HIPAA. During interview on 1/16/25 at 8:50 a.m., NA-D pointed to second-floor unattended care sheet and stated, should not be left open. Violation of HIPAA. [contains] patient information. [staff] should have this in their pocket and not out in the open. During interview with director of nursing (DON) on 1/16/25 at 11:15 a.m., DON stated, care sheets should always be out of sight. It is a privacy concern. 49339

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	01/16/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47495 Based on observation, interview and document review the facility failed to revise and update a comprehensive care plan for 1 of 1 resident (R23) who had a foley catheter, psychology provider anxiety interventions, and refusals of care not identified in the care plan. Findings include: R23's annual Minimal Data Set (MDS), dated [DATE], indicated R23 was admitted to the care facility on 12/18/19, had moderate cognitive impairment and was dependent on staff for toileting and bathing and required touching assistance with personal hygiene. R23's Hospital Discharge Summary, dated 12/31/24, indicated R23 was hospitalized on [DATE] and discharged back to the care facility on 12/31/24. A foley catheter was placed at the hospital on 12/28/24. R23's Orders indicated a nursing order, dated 1/11/25, for staff to monitor urine output every shift. R23's Active Orders, printed 1/16/25, lacked any other order related to R23's foley catheter. R23's Associated Clinic of Psychology (ACP) note, dated 12/13/24, indicated several interventions for R23's generalized anxiety disorder and major depressive disorder including milieu (a person's social environment) management/positive focus/socializing by tidy up R23's space and engaging in a blinds open program everyday to increase natural daylight exposure. R23's ACP note, dated 1/3/25, indicated several new and similar interventions for R23's generalized anxiety disorder and major depressive disorder including ensuring important items such as the TV remote and eyeglasses were left within reach for R23's sense of agency and control, continue to encourage staff to assist with cleaning up and organizing R23's room, use a non-judgmental, patient centered approach to encourage R23 to get up, out of bed with phrases such as I've heard you say you get so tired of being this bed. I'd be happy to get you up after lunch to get you get a soda and change it up for a while, and continue to engage in an open blinds program every day where curtains are opened in the morning and closed at night. R23's care plan, printed 1/16/24, indicated R23 was fully incontinent of bladder and for staff to check and change resident every 2-3 hours and prn [as needed]. Continue to offer commode, though I decline toileting. R23's care plan further indicated R23 had a foley catheter removed 3/29/21, and to encourage patient to void when urge is noted. The care plan lacked any updates on R23's current catheter use to ensure proper monitoring and catheter cares, and lacked any updates from R23's ACP notes to help R23 with a sense of control and to help reduce his anxiety and depression. R23's Care Work Sheet, printed 1/14/25, lacked any interventions for R23's foley catheter use and further lacked any ACP interventions for staff to use when approaching and providing cares for R23. During observation on 1/14/25 at 8:58 a.m., R23 was laying in bed with the blinds closed, a foley catheter bag hooked onto the side of his bed. (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	01/16/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 10:20 a.m., R23's nurse practitioner (NP) stated R23 had his foley catheter placed during his most recent hospitalization . The NP further stated urology, who placed the catheter, would usually remove it and she believed it would be temporary, stating she will have to make a plan for R23's catheter. During an interview on 1/15/25 at 10:35 a.m., registered nurse (RN)-C stated, as a nurse she would be expected to review the residents' care plans and orders prior to providing care to the residents to gain an understanding of what care, treatment, and medications to administer during her shift. RN-C confirmed the electronic medical record (EMR) lacked indication of and direction for R23's catheter. During an interview on 1/15/25 at 10:49 a.m., nursing assistant (NA)-B stated he worked with R23 about once a week, and this day was the first time he had noticed R23 had a catheter. NA-B stated the aides were expected to use the care work sheets to know what cares to provide a resident. During an interview on 1/16/25 at 9:33 a.m., clinical manager and RN-I stated it would be expected for the nurses and nursing assistants to use the residents care plans and care work sheets everyday while working with the residents. RN-I stated the nursing aides should report to the nurses if something was missing or different on the resident care sheets for updates. RN-I stated it was her and the MDS nurse's responsibility to update the care plans. The MDS nurse would generally review the resident's hospital discharge paperwork to review for any necessary care plan changes, confirming R23's foley catheter use should be care planned. RN-I stated ACP notes should be reviewed with social services and herself and discussed at IDT to ensure any new recommendations or updates are on the residents' care plans. RN-I stated keeping care plans up to date with the residents' current status is important to ensure nurses and nursing assistants are providing accurate care to the residents. During an interview on 1/16/24 at 10:55 a.m., the MDS nurse stated she reviewed the resident's hospital discharge summaries and generally updated them during an MDS cycle, though the nurse managers also reviewed them to try to catch changes in real time. The assistant director of nursing also confirmed that care plans should be updated in real time and that it was a work in progress to ensure care plans were updated and accurate.

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	01/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene and self-care was completed to promote a dignified appearance and reduce the risk of complication (i.e., scratches) for 3 of 4 residents (R23, R36, and R53) reviewed for activities of daily living (ADLs) and whom were dependent on staff for their care. Findings include: R53 R53's quarterly Minimum Data Set (MDS), dated [DATE], identified R53 had severe cognitive impairment, demonstrated no speech, and was unable or rarely able to be understood. Further, the MDS identified R53 was dependent on staff for nearly all self-care. R53's care plan, dated 11/22/24, identified R53 needed assistance with dressing and personal hygiene due to a history of stroke and hemiplegia (paralysis of one side). The care plan listed a goal which read, All my ADL needs will be anticipated and met by staff through the review date, and multiple interventions including assist of one with personal hygiene and, Staff to trim Resident's finger and toe nails as needed following weekly bath. The care plan lacked any identified nail length preferences. On 1/14/25 at 9:15 a.m., R53 was observed lying in bed while in his room. R53's eyes were closed and adjacent ventilator equipment was present at the bedside. R53 did not open his eyes or respond verbally with interaction. However, a few moments later, R53 picked up his left hand without being asked or commanded, and he shook it several times in the air with his eyes seeming to squint down or grimace with the motion. R53's hands were visible and had no braces or splints present. R53's fingers on both hands were clenched into his palms, however, multiple fingernails were visible and long in length with the nail being several millimeters (mm) long and, at times, pressing into the palm skin. Further, multiple nails had visible dark-colored substance underneath of them. Later on 1/14/25 at 11:38 a.m., R53's family member (FM)-B was interviewed. FM-B stated R53 getting bathed and personal hygiene care was another gray area of care and expressed R53, in general, wasn't being cleaned up well adding, Not as often as we'd like them to be [doing it]. FM-B stated R53 was often found unshaven and, at times, with long fingernails adding concern, He will just scratch himself. FM-B reiterated they wanted basic cares completed for R53 but often It's just not happening. The following day, on 1/15/25 at 8:45 a.m., R53 was again observed lying in bed with his eyes closed. R53 remained non-verbal with interaction and was connected to an external tube feeding pump. R53's fingernails remained long with several nails having dark-colored debris present under them as had been observed the day prior. R53's progress note, dated 12/23/24, identified R53 had a brace applied to his right hand. The note continued, Finger nails clipped. No discomfort . (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	01/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R53's subsequent Weekly Skin Check(s), dated 12/26/24 to 1/9/25, identified a total of three bed baths were completed on 12/26/24, 1/2/25, and, 1/9/25, respectively. These completed checks all listed a question to be answered by the staff which read, Was nail care completed?[,] which was answered, Not Necessary, on each of the completed evaluations. On 1/15/25 at 8:55 a.m., nursing assistant (NA)-E was interviewed. NA-E explained R53 was total care with everything and spent most of his time in bed due to being non-verbal and having a ventilator. NA-E stated nail care would be completed by the NA since R53 was not diabetic, and it should be completed as often as we need to. NA-E stated R53's nails and hands were, at times, hard to clean or trim as he would pull his hands away but reiterated staff have to make an effort. NA-E observed R53's nails at this time and expressed aloud, They could probably use a clipping, adding further, [They're] start digging into his skin. NA-E stated two people usually help to trim the nails due to R53's behavior but expressed it could be done. Further, NA-E stated any attempts or refusal of nail care wouldn't likely be documented by the NA as they just tell the nurse. R53's medical record was reviewed and lacked evidence nail care had been attempted or refused since 12/24/24, despite R53 having long, soiled nails present and needing total assistance with personal hygiene. When interviewed on 1/15/25 at 9:29 a.m., registered nurse (RN)-D stated R53 was total help with cares but would, at times, fight you a lot with some of them. RN-D stated two people usually were needed to get R53's nails clip and, at times, R53's family member would help them. RN-D stated they last helped R53 with nail care couple weeks ago but verified they should be clipped on bath day. RN-D stated nail care was charted using the Weekly Skin Check and any attempt or refusal should be charted in the record. On 1/15/25 at 12:49 p.m., registered nurse manager (RN)-E was interviewed. RN-E stated nail care should be address every time they have a shower [bath]. RN-E explained R53 could be a little difficult to get it completed on as, at times, the left arm goes everywhere but acknowledged the charting reflected such care was 'not necessary' adding they were unsure why it had been marked as such. RN-E stated R53's nails should have been clipped and kept clean adding they just updated his orders to include nail care and a nurse sign-off. RN-E stated they did this order update for everyone adding, If he's missed, who else is missed? RN-E stated it was important to ensure nail care was completed as his nails could penetrate the skin or he could scratch himself. RN-E verified the medical record lacked evidence nail care was attempted or provided since 12/24/24 adding aloud, no, no, no [none]. 44656 R36 R36's quarterly MDS, dated [DATE], identified R36 with significant cognitive impairment, did not reject care, dependent on staff for toileting, baths, upper and lower body dressing, personal hygiene, transfers, and bed mobility. In addition, R36 with diagnoses of Alzheimer's, dementia, hemiplegia (paralysis on one side of the body), stroke, and malnutrition. (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	01/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of document titled 3rd Floor Nursing Care Work Sheet scanned 1/14/25, identified all residents of third floor with column identifying 25 resident room numbers, names, and information on each resident such as assistance needed for dressing, grooming, oral cares, continence, toileting, bed mobility, transfer, ambulation safety devices, eating, bathing, infection control precautions status, and comments to include information on hearing, positioning needs, keeping bed in low position, fall risk, elopement risk, refusals of care, smoking status, bedrail positioning, and tracheostomy and gastric tube presence. This document identified: Facial hair and nail care (men and women) occur on bath days, Report off to your nurse; make sure you've brought any change in condition or concerns to the nurses attention, and Refusals of care/treatment or inability to complete identified cares for your residents must be reported to nurse. 3rd Floor Nursing Care Work Sheet scanned 1/14/25, identified R36 with a column titled, Bathing and identified, Aide trim nails. R36 care plan (CP) revised 9/16/24 identified, Resident is dependent on staff for grooming cares, which consists of bath/shower, shampoo, nail care shave and full skin assessment. Resident with diagnoses of CVA [cerebral vascular accident], dementia. During observation on 1/14/25 at 2:14 p.m., R36 was in bed with head of bed elevated and meal tray in front of her on rolling bedside table. R36 had both feet resting on pillow with heels positioned off mattress. The left foot middle toenail was half an inch long while rest of toenails on both feet were thick, jagged, and extending beyond the toe rubbing against the sheet and covers. All fingernails were half an inch to three quarters of an inch long, with dark matter noted, and their left hand was clenched in a fist with nails pressing into palm of hand. During interview with nursing assistant (NA)-A on 1/15/25 at 10:13 a.m., NA-A stated she was familiar with R36 and worked with her many times. NA-A stated, nail care is done the activities [department], they put fingernail polish and stuff like that. No, I do not do nail care on [R36]. NA-A stated, no nail for [R36] after showers by the [nursing] aides. NA-A stated, if nails are long on other residents, I would tell [nurse]. NA-A looked at R36's fingernails and toenails and stated, [R36's] fingernails are half inch to one inch long. NA-A verified dark matter under right thumbnail and, yes, toenails are long .half inch long. NA-A stated, [R36] don't want them trimmed. I haven't noticed or told anyone about them because she always refuses. I let nurses deal with that. During interview with NA-C and NA-D on 1/15/25 at 10:50 a.m., NA-C stated, nail care was done by nursing assistants, unless [resident] is diabetic. NA-D stated nail care involved clipping and file [nails]. During interview with infection control preventionist and nurse manager (ICPC) on 1/15/25 at 10:55 a.m., ICPC stated they expected nail trimming and maintaining nails to be done on shower day and prn mainly nurses and aides. ICPC stated she was aware of R36's refusals, but facility had nothing to address the R36's refusals for nail care. ICPC stated, [R36] has the right to refuse. (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	01/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with activities director (AD) on 1/15/25 at 12:04 p.m., AD stated she had worked at facility for three years and the activities department painted the nails, but did not file, clip, or trim them. R36's Weekly Skin checks documented by nurses for week of 1/9/25, 12/23/24, and 11/18/24, all indicated, Refused nail care. The record lacked documentation for the weeks of 1/13/25, 12/30/24, 12/16/24, 12/9/24, 12/2/24, and 11/25/24. During observation and interview with RN-C on 1/16/25 at 7:59 a.m., RN-C stated she was very familiar with R36 and stated, nail care[sic] cut them by nurses when needed on shower days. RN-C stated if very long we try to talk to the nurse after refusals and go to nurse manager and let the MD [provider] know. We are to document on weekly skin check in chart. RN-C stated, [R36] don't allow us to cut her nails. She needs a team of people to work together to go in and approach her and try to convince her to let us trim them. We should involve the family in the conversations. It takes a team to get her to allow us to cut her nails. RN-C stated she had not received report from aides regarding R36's nails and did not know of any communication or plan by facility to ensure nail care was being done for R36. RN-C looked at R36's fingernails and stated, they definitely need [sic] to be cut. Both feet [nails] are too long. During interview with family member (FM)-A on 1/16/25 at 7:30 a.m., FM-A stated she was R36's primary emergency contact. FM-A stated R36 required help with all hygiene, [R36] does nothing for herself. Also, [R36] scratches herself and cuts herself [with long nails]. But they [facility] got to keep them cut. Those nails on both [fingernails and toenails]. RM-A stated, it is ok if they [facility] knock her out if they have to to cut them off. I want them off. FM-A stated facility never contacted her to discuss nail care approaches. 47495 R23 R23's annual Minimal Data Set (MDS), dated [DATE], indicated R23 had moderate cognitive impairment and was dependent on staff for toileting and bathing and required touching assistance with personal hygiene. R23's Care Plan, revised 9/17/24, indicated R23 was dependent on staff for grooming cares, which consists of bath /shower, shampoo, nail care, shave, and full skin assessment. Resident with diagnosis of left side hemiplegia [inability to move] and CVA with an intervention to bathe R23 on Monday evenings. R23's care plan also included R23 was limited in ability to maintain grooming/personal hygiene R/T [related to] hemiplegia and hemiparesis following cerebral infarction to left side, generalized muscle weakness with an intervention to shave R23 on bath day with his electric shaver. R23's Nursing Care Work Sheet, dated 1/14/25, indicated, under the bathing category, the nursing assistants were to shave R23's facial hair. During interview and observation on 1/14/25 at 8:58 a.m., R23 was laying in bed, hair disheveled with approximately half inch long facial hair. R23 stated he preferred to be clean shaven but staff did not have time to assist him. On a shelf in R23's room was an electric shaver plug into an outlet. (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	01/16/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview and observation on 1/15/25 at 8:42 a.m., R23 was up in his wheelchair and had not been shaved. When asked again if he would like to be shaved, R23 shook his head yes. During an interview on 1/15/25 at 10:35 a.m., registered nurse (RN)-C stated she usually saw R23 clean shaven and that he had been readmitted to the facility on Friday, 1/10/25 after hospitalization with facial hair. RN-C was unsure why R23 had not been shaved with his bath day on Monday. During an interview on 1/15/25 at 10:49 a.m., nursing assistant (NA)-B stated the nursing assistants used the care work sheets to know how to care for each resident, including when their bath day is. NA-B further stated it was expected that all residents were offered to be shaved on bath days. During an interview on 1/16/25 at 9:33 a.m., nurse manager RN-I stated it was expected that the nursing assistants use the care work sheets every shift to know what cares to provide the resident. RN-I stated when a resident was readmitted after hospitalization it was expected they receive at least a bed bath, and residents should always be offered to be shaved during bathing. The Activities of Daily Living policy dated 2021, indicated care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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	01/16/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to ensure care-planned interventions for activities of interest were provided or offered for 1 of 2 residents (R53) reviewed for activities and whom was non-verbal and unable to be understood. Findings include: R53's quarterly Minimum Data Set (MDS), dated [DATE], identified R53 had severe cognitive impairment, demonstrated no speech, and was unable or rarely able to be understood. Further, the MDS identified R53 was dependent on staff for nearly all self-care. R53's most recent Activity Assessment, dated 11/25/24, identified R53 was a Christian and listed a section labeled, Specific Leisure Interests, which marked R53 as having a preference for card games, active sports, classical and jazz music, television and movie interests, and social visits adding, Res. will have 1:1 [one to one] visits. A section labeled, Programming Information, outlined R53 preferred 1:1 visits and was unable to participate with passive participation marked. Further, the evaluation concluded, Updated Care Plan on - 11/25/2024. R53's activities care plan, dated 11/25/24, identified a problem statement which read, Per family, res. enjoyment is listening to music, TV/movie shows and social visits with staff/family. The care plan outlined a goal which read, Per family, res. will listen to background classic, jazz, oldies, 50's & [NAME] music, TV/movie shows old time, science fiction and comedy and social visits with staff/family, along with multiple interventions including not listening to the news, staff setting up music on the radio or I-Pad, and tuning the TV to old time, science fiction or comedy shows. On 1/14/25 at 9:15 a.m., R53 was observed lying in bed while in his room. R53's eyes were closed and adjacent ventilator equipment was present at the bedside. R53 did not open his eyes or respond verbally with interaction. However, a few moments later, R53 picked up his left hand without being asked or commanded, and he shook it several times in the air with his eyes seeming to squint down or grimace with the motion. The room had a television mounted on the wall with a white-colored paper underneath which listed R53's favorite activities and television channels. The room also contained a CD player on the shelf. However, neither of these were activated or turned on and the room was silent. Later, on 1/14/25 at 11:29 a. m., R53's family member (FM)-B was interviewed and stated they were unsure if R53 would be able to enjoy activities or not adding he (R53) was kind of limited. FM-B stated R53 spent a majority, if not all, of his day in his room and expressed a few months ago someone had asked them about R53's activities but could not recall the specifics of the conversation. The following day, on 1/15/25 at 8:45 a.m., R53 was again observed in bed while in his room. R53's eyes remain closed and, again, he demonstrated no obvious response to verbal communication. R53 had a visible tracheotomy and was attached to an external tube feeding pump. However, again, the room was silent with no TV or radio or music being played in the room. (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	01/16/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/15/25 at 8:55 a.m., nursing assistant (NA)-E stated they had worked with R53 multiple times and described him as needing total care with everything. NA-E stated R53 did, at times, get up to a wheelchair but it was not every day. NA-E stated they had rarely, if ever, seen activities personnel in the room with him or doing one-to-one activities adding, Not to my knowledge, I haven't seen any. NA-E stated staff, at most, seemed to maybe peek in but that was it. NA-E stated nobody had ever told them to play music or have the television on for R53 adding aloud, Nope. NA-E stated the nursing staff and activities staff don't interact very well unless the NAs are told to get certain people up to some activities adding, They [activities] don't really communicate with us very much. NA-E stated they had, at times, seen R53 with his television set turned on and expressed there was a listing of channels taped to the wall to their recall which R53 enjoyed. NA-E showed this listing to the surveyor and verified it was posted in the room along with an activity calendar for the building. However, NA-E verified R53 did not attend any of the listed or advertised activities adding aloud, No. NA-E stated it was due to R53 using a ventilator and being unable to take it with him. Further, NA-E stated R53's wife visited and would, at times, turn on the TV or radio for R53 but added, I haven't seen her lately. On 1/15/25 at 9:29 a.m., registered nurse (RN)-D was interviewed and verified they were assigned to R53's care that day. RN-D explained R53 was total help with cares and expressed the wife would, at times, come and play music for him using the CD player in his room. RN-D stated themselves and staff didn't turn it on as the wife comes everyday, then adding aloud, But I don't know about Winter [if she visits]. When questioned on what, if any, activities were provided or done with R53, RN-D stated aloud, You'd have to ask activities. When interviewed on 1/15/25 at 10:15 a.m., therapeutic recreation director (TRD) explained R53 was supposed to have the television turned on for him adding such was care-planned and should be on. TRD explained the floor staff should be doing that or playing music for him and those items were basically it for his activities outside of some one-to-ones. TRD verified R53 did not attend group-based activities but explained there were some scheduled for his floor which could be attended, such as music, but getting him to those would be basically up to the nurse. TRD stated they had told staff R53 could attend the music groups on the floor if they brought him adding, I have told them. TRD stated the activities staff did complete one-to-ones with R53 and tracked those on the flowsheet which they would provide. However, TRD reiterated all staff should be turning on the television for R53 adding there was no specific schedule or times for that but rather should have it on throughout the day. TRD stated it was important to ensure the television was on so R53 had some type of stimulation. Later on 1/15/25, at 10:42 a.m., TRD provided R53's one-to-one tracking form. R53's One on One Visits Form, dated 9/2024 to 1/2025, identified all recorded one-to-one visits completed with R53 during the period. This recorded a total of five (5) visits since 12/1/24, and included: 12/1/24 Staff updated residents calendar. 12/16/24 Staff played [NAME] in Ipad and had social visit. 12/19/24 Staff had social visit with resident and made sure resident was comfortable . made sure TV was tuned. (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	01/16/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/1/25 Staff updated resident calendar to January. 1/10/25 Staff played [NAME] on Ipad and organized residents room. TRD verified the provided one-to-one tracking and reiterated all staff members, including nurse, should be playing music or turning on R53's radio. A provided Wellness & Life Enrichment policy, dated 3/2024, identified a facility' policy to involve residents in an ongoing program of activities designed to appeal to their interests and enhance their psychosocial well-being.

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	01/16/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 44656 Based on observation, interview, and document review, the facility failed to ensure gastrostomy tube water flushes were provided per physician orders for 1 of 1 residents (R75) reviewed for tube feedings. Findings include: R75's quarterly Minimum Data Set (MDS) dated , 12/3/24 identified R75 was severely cognitively impaired, dependent on staff for all oral, toileting, personal hygiene, and mobility. In addition, R75 had diagnoses of a stroke (poor blood flow to a part of the brain causing cell death resulting in parts of the brain to function properly), diabetes, chronic obstructive pulmonary disease, respiratory failure, convulsions, gastrostomy (feeding tube inserted into the stomach), and a tracheostomy (surgical opening in the neck to allow a machine called a ventilator to help with breathing). R75's physician orders (PO) dated 11/2/24 stated, Tube Feeding: H2O (water) 150 milliliters[ml] per feeding tube q4hrs (every four hours). R75's care plan goal, dated 9/12/24 stated, Approach: Water flushes via GT [gastrostomy tube] per MD [physician]. During observation and interview on 1/14/25 at 8:58 a.m., registered nurse (RN)-A entered R75's room to administer medications through GT. R75 was lying in bed with the feeding tube not attached to her. RN-A set up area on rolling bedside table with liquid and crushed medications in three small medication cups, and two larger plastic drinking cups. RN-A obtained an unopened bottle of water from resident room stating it was for mixing R75's medications prior to administering them through the GT. RN-A opened the 500ml water bottle, sanitized her hands and applied gloves. She then used a large piston syringe, attached it to R75's GT port and pulled back on the syringe to assess for residual (amount of liquid drained from the stomach following administration of tube feeding). RN-A removed the piston syringe from R75's GT port and used the bottled water to dilute and mix the liquid and crushed medications. RN-A withdrew the medication into the syringe and re-attached the syringe to R75's GT port and administered the medications. RN-A repeated the process until all the medication cups were emptied leaving visible residue in each of the cups. RN-A poured water into each of the medication cups and administered the mixtures into R75's GT port. When this was completed, RN-A capped R75's GT port and moved on to changing R75's tracheostomy in-line suctioning apparatus. RN-A did not measure out water to flush R75's GT port completely to ensure the entire GT was clear of residual medications. During interview at 9:18 a.m., RN-A stated, I flushed with water in each of the med cups. RN-A agreed she did not measure out 150ml of water after administering R75's medications. During interview with RN/infection control preventionist (ICPC) on 1/16/25 at 10:18 a.m., ICPC stated expectation of nursing staff to flush [GT] with water after administering all of the medications. ICPC stated it was likely the medications administered to R75 by RN-A were not flushed adequately which could cause complications with GT flow. (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	01/16/2025

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with director of nursing (DON) on 1/16/25 at 11:06 a.m., DON stated, the water should be used to flush the tube after administration and not mixed in with the bottom of all the med cups. There could easily be residual thick medications in those cups, and it not considered clean water. That practice is likely to plug the GT. Facility policy for flushing gastrostomy tube prior to and following medication administration was requested and not received.

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	01/16/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to comprehensively assess and, if needed, develop interventions or implement appropriate pain monitoring to ensure comfort for 1 of 2 residents (R53) reviewed for pain management and whom was non-verbal and unable to communicate their needs. In addition, the facility failed to assess for and implement, if requested, non-pharmacological pain interventions for 1 of 2 residents (R70) reviewed for pain management. Findings include: R53 R53's quarterly Minimum Data Set (MDS), dated [DATE], identified R53 had severe cognitive impairment, demonstrated no speech, and was unable or rarely able to be understood. The MDS identified R53 was dependent on staff for nearly all self-care and outlined R53 consumed no scheduled medication or non-pharmacological interventions for pain management. However, the completed staff evaluation for pain on the MDS, located under Section J - Pain, identified staff had recorded, C. Facial expressions (grimaces, winces, .), during the review period. On 1/14/25 at 9:15 a.m., R53 was observed lying in bed while in his room. R53's eyes were closed and adjacent ventilator equipment was present at the bedside. R53 did not open his eyes or respond verbally with interaction. However, a few moments later, R53 picked up his left hand without being asked or commanded, and shook it several times in the air with his eyes seeming to squint down or grimace with the motion. Later, on 1/14/25 at 11:43 a.m., R53's family member (FM)-B was interviewed and stated R53 not being in pain was very important to me and a concern for them. FM-B stated R53 was hard to read given his lack of verbal communication and post-stroke deficits adding, It's not easy to read his face. FM-B stated they were unsure if R53 was absolutely free of pain but expressed, in the past, some physicians had communicated they didn't believe R53 to have pain, however, FM-B reiterated aloud, I don't want him to be suffering. R53's most recent Pain Interview, dated 11/26/24, identified R53 consumed no scheduled pain medication or non-pharmacological interventions for pain; however, had received a PRN (as-needed) medication within the past five days. The evaluation identified the pain interview with R53 should not be completed as he was rarely or never understood. As a result, a Staff Assessment For Pain was completed which, again, identified R53 demonstrated facial expressions of potential pain within the past five day period. The frequency was marked, Indicators of pain or possible pain observed 1 to 2 days, and the evaluation identified a non-pharmacological intervention listed as, Rest, and scheduled Tylenol recorded for symptom management. The completed evaluation lacked any detail on how R53's pain would be monitored to ensure comfort despite R53 being recorded as unable to be understood, nor evidence what, if any, assessment had been completed to determine if the identified symptom management techniques (i.e., rest, Tylenol) were adequate or not despite R53 having physical symptoms of possible pain. (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	01/16/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R53's pain management care plan, dated 9/5/24, identified R53 was at risk for pain due to a history of stroke with hemiparesis (paralysis on one side of the body) and . no ability to communicate to staff. Observation of non-verbal signs of pain is needed. The care plan listed a goal, [R53] will appear comfortable and rest well, without signs of pain or discomfort through the review date, along with multiple interventions including medications as ordered, assessing pain prior and post medication administration, completing pain assessments quarterly and as-needed, and rating his pain via a facial expression scale. All the listed interventions were created in 3/2023 and lacked documented revision or edit. When interviewed on 1/15/25 at 8:55 a.m., nursing assistant (NA)-E stated they had worked with R53 multiple times over the past months and described him as total care with everything. NA-E stated they had noticed, at times, R53 would raise his hand up in a ball while staff did cares and place it by his face adding, He put his hand up there. NA-E stated they had noticed R53 also, at times, seemed to squinch his eyes with facial washing, however, felt it was just random movement and not pain. NA-E stated R53 seemed not really in pain. R53's Medication Administration History, dated 1/2025, identified R53's medications and nursing treatments for the month period. This identified R53 was receiving baclofen (muscle relaxant) three times daily for spasms, and had an order for Tylenol 650 milligrams (mg) every six hours as needed for mild pain or temperature. The MAR identified Tylenol as being administered once on 1/11/25 at 5:52 p.m. for pain with results listed, SE [somewhat effective]. However, the MAR lacked what specific symptoms were observed which indicated pain and warranted medication, nor did the MAR have any ongoing pain monitoring to demonstrate what, if any, symptoms were being tracked or observed to ensure R53 remained comfortable despite floor staff seeing him make movements with cares which could be pain related (i.e., hand to face, squinted eyes) and now having Tylenol provided with only somewhat effective results. On 1/15/25 at 9:29 a.m., registered nurse (RN)-D was interviewed. RN-D verified they were assigned care for R53 and expressed he was total help with care. RN-D stated they felt R53 had no pain but voiced grimacing would be considered a sign of pain for him as he was non-verbal. RN-D reiterated, I've never seen [R53] in pain. RN-D stated they had observed R53 raise his clenched fists up before but felt he didn't appear uncomfortable with it adding, I've never associated that [movement] with pain. RN-D stated pain assessments would be done by the floor nurse in the moment when they determine whether or not to give pain medication, adding, a progress note would be completed. RN-D reviewed R53's MAR and verified PRN Tylenol was given on 1/11/25 and stated such administration must be new as they had never given him any before to their recall. RN-D reviewed R53's medical record and the corresponding progress note, dated 1/11/25, which merely recorded R53 as being uncomfortable and lacking what specific symptoms were displayed. RN-D then directed the surveyor to the unit manager for further discussion on pain monitoring and evaluation. R53's medical record was reviewed and lacked evidence R53 had been recently comprehensively assessed for his pain management needs despite having ongoing physical symptoms of pain (i.e., squinted eyes) and staff providing as-needed medication for pain. Further, the record lacked evidence of ongoing, comprehensive monitoring of pain (i.e., every shift, consistent manner) to ensure R53 was kept comfortable and ensure appropriate care-planning was completed for pain. (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	01/16/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/15/25 at 12:49 p.m., registered nurse manager (RN)-E was interviewed. RN-E reviewed R53's medical record and verified it lacked ongoing pain monitoring adding aloud, We should be monitoring it too. RN-E verified the completed Pain Interview (dated 11/26/24) identified physical symptoms were identified, however, lacked what, if any, interventions were done or placed despite them. RN-E stated they had not reviewed the evaluation prior as those were mainly done for the MDS. RN-E stated nobody had reported potential pain symptoms to them and, had they, then monitoring would have been placed in the order set. RN-E stated they recalled reading R53's note, dated 1/11/25, about being uncomfortable but didn't put two and two together with it being a pain issue. RN-E verified R53's demonstrated physical symptoms had not been comprehensively evaluated for what, if any, pain management was needed for them and expressed doing such would be important as we [staff] need to get to the bottom of what his pain is and help it. A provided Pain Management policy, dated 9/2023, identified the staff would evaluate residents for verbal and non-verbal symptoms of pain including the resident and responsible party in the development of pain management interventions. The policy directed, Reevaluate pain and document . [bullet] At regular intervals according to the needs of the resident . [bullet] With each new report of pain . [bullet] At appropriate intervals after pharmacological on [sic] non-pharmacological interventions. However, the policy lacked specific information on how a non-verbal resident would have their pain assessed or monitored. 49339 R70 R70's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R70 had intact cognition with no hallucinations or delusions. Assessment indicated in section J-Health Conditions section J0100 pain medication section A: been on a schedule pain medication regimen marked yes, section B: received PRN (as needed) pain medication marked yes, section C: received non-medication interventions for pain marked no. Further the form indicated R70 frequently has pain which occasionally effects sleep and rated pain with a verbal descriptor scale of moderate pain. R70's face sheet, printed 1/16/25, included the following diagnoses: hip stress fracture (crack or break of the hip), fracture of the left lower leg, fracture of the right femur (crack or break of the right upper leg bone), upper abdominal pain, rheumatoid arthritis with rheumatoid factor of multiple sights (a chronic inflammatory disorder usually causing painful swelling of joint linings), muscle weakness and fibromyalgia (a long term condition that involves widespread body pain and tiredness). R70's care plan, printed 1/16/25, indicated R70 experienced pain related to broken hip/ankle as evidenced by reports of pain with the following approaches: -Administer my pain medications as ordered -Assess for psychological pain & document interventions used to address. -Assess the characteristics of my pain: location, severity based off pain scale appropriate to me, type, frequency. (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	01/16/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Consult with physician for pain management, notify physician of any changes in level or frequency of pain, any increase in use of PRN pain medications, and any noted side effects of pain medications. -Discuss with me the factors that precipitate pain and what may reduce it. -Discuss with me the importance of requesting PRN pain medications before pain becomes severe. -Educate me and my family about pain care and pain medications. -Offer alternative comfort measures: Acupressure, Acupuncture, Biofeedback, Brace, Cold, Comfort food, Decreased stimulation, Distraction, Guided imagery, Heat, Massage, Music, Prayer, Psychotherapy, Relaxation, Repositioning, Rest, Sleep, Television, TENS Unit, Whirlpool bath. -Reassess intervention with any changes in response to pain or pain medications and routinely per facility protocol. The care plan lacked evidence of what non-pharmacological interventions have been tried, what had been effective and not effective and what non-pharmacological interventions should be used. Furthermore, the care plan lacked identification of what pain scale would be appropriate/resident's preference to use. R70's January 2025 Medication Administration Record (MAR/TAR), printed 1/16/25, included the following orders and administrations: -acetaminophen [Tylenol] (pain reliever) tablet 500 milligrams (mg) tablet administer 1000 mg oral [by mouth] every 6 hours PRN [as needed] for pain. MAX DOSE 4000 MG daily. Started 12/13/24. The MAR indicated it was administered 21 times in the month of January. Of those administrations, 2/21 had a numeric pain scale and 5/21 had a location of pain listed. The remaining administrations, 19/21 administrations, did not have a pain scale listed and 16/21 administrations did not have a location of pain listed. -oxycodone (narcotic pain medication) 5 mg tablet administer daily as needed. Discontinued 1/2/25. The MAR indicated it had been administered 2 times in the month of January. Of those administered, 0/2 had a numeric pain scale and 0/2 had a location of pain listed. -oxycodone 5 mg tablet administer twice a day as needed. Started 1/3/25. The MAR indicated it was administered two times a day for the month of January starting on 1/3/25. Of those administrations, 4/26 had a numeric pain scale and 4/26 had a location of pain. The remaining administrations, 18/26 administrations, did not have a pain scale and 18/26 administrations did not have a location of pain listed. The MAR/TAR lacked orders or administrations of any non-pharmacological interventions offered, declined, or accepted prior to administration of pain medications. R70's progress notes, dated 1/1/25 to 1/15/25, were reviewed. The progress notes lacked evidence of pain scales being used prior to or after administration of pain medications. Furthermore, lacking evidence of any nonpharmacological interventions being offered, accepted, or declined. (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	01/16/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R70's Pain Interview completed 12/12/24 revealed the following: Pain Interview: questions are answered with radio-button answers: Pain: received scheduled pain med regimen at any time in the last 5 days: yes Received PRN pain medications OR was offered and declined in the last 5 days: yes Received non-medication intervention for pain: No Should Pain Assessment interview be conducted: yes Presence of pain: yes Pain frequency: frequently Pain effect on sleep: frequently Pain interference with therapy activities: does not apply. Pain interference with day-to-day activities: Not assessed/no information Verbal scale rating: severe On 1/16/25 at 11:00 a.m., R70 indicated the pain can get pretty intense. R70 indicated the facility had her try distraction once for pain reduction. R70 indicated they were open to trying other nonpharmacological interventions and added the facility had not talked to them about this before. R70 indicated their pain level was typically at a 6/7 and their goal was a 3/10. On 1/16/25 at 11:11 a.m., registered nurse (RN)-F stated when a resident reported pain then a pain assessment was completed which included: location, what is the pain, frequency, quality of the pain and have them rate the pain. RN-F indicated this would be documented in the progress notes or on the MAR. RN-F stated nonpharmacologic interventions are offered to residents such as repositing, distraction and music and stated this would be documented on the MAR. RN-F verified R70 did not have any nonpharmacological interventions on their MAR/TAR. On 1/16/25 at 11:39 a.m., RN-G stated that pain assessments for a resident reporting pain was documented in the progress notes which would include the pain level (either numeric scale or face scale), how long they have had the pain (chronic or new), location of pain and to check the site. RN-G stated a pain level was not always assessed for scheduled pain medications. RN-G indicated the pain level for new pain was assessed prior to giving PRN pain medications which would be documented on the MAR or possibly in the progress note. RN-G stated any non-pharmacological interventions would be documented in the progress notes. RN-G reviewed recent administrations of PRN acetaminophen and oxycodone and stated the pain scale was not completed as it is not new pain. (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	01/16/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 11:56 a.m., assistant director of nursing (ADON) indicated the location of documentation of nonpharmacological interventions prior to PRN medication use, along with pain scales with pain medication adminsitration, would depend on what floor the resident was on and the manager on the floor. During a follow up interview at 1:25 p.m., ADON verified a pain scale was not used (except for what was listed above) for the administration of acetaminophen and oxycodone. ADON verified the location of R70's pain was not documented (except for listed above) during the administration of PRN pain medication. ADON did indicate she had a follow up conversation with R70 about nonpharmacological interventions and preferred pain scale. On 1/16/25 at 12:50 p.m., director of nursing (DON) indicated the expectation would be nursing to do an assessment prior to administering PRN pain medication which would include assessing a pain level and location along with offering nonpharmacological interventions. A facility policy titled Pain Management reviewed 9/7/23 indicated the facility will evaluate the resident for verbal and nonverbal signs and symptoms of pain and reevaluate pain and document: at regular intervals according to the needs of the resident; with each new report of pain; at appropriate intervals after pharmacological and non-pharmacological interventions.

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	01/16/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51567 Based on observation, interview, and document review, the facility failed to attempt alternatives and ensure ongoing assessments for safety and appropriate use of side rails were completed for 1 of 1 resident (R18) who was observed to have side rails affixed to the bed. Findings include: R18's annual Minimum Data Set (MDS) dated [DATE], indicated R18 had moderately impaired cognition. R18's significant change MDS dated [DATE], indicated R18 had moderately impaired cognition. R18's quarterly MDS dated [DATE], indicated R18 had severely impaired cognition. R18's Restraint/Adaptive Equipment Use Observation was completed on 3/12/20 and 9/08/22. Both reports included assessments of R18 for side rail entrapment risk factors such as falls and medication use. The assessments indicated R18 had half side rails for bed mobility and assistance with transfers. R18's medical record was reviewed and lacked indication R18 was assessed for safety and appropriate use of side rails and alternatives were attempted since the assessment on 9/22. R18's Physical Therapy Discharge Summary dated 12/14/22, indicated R18 needed stand by assistance from staff for bed mobility. R18's Physical Therapy Discharge Summary dated 9/11/24, indicated R18 required maximum assistance with all bed mobility tasks on the baseline assessment completed on 8/21/24. At the time of discharge from physical therapy, on 9/11/24, R18 required assistance with bed mobility related to knee and hip pain. R18's care plan dated 12/16/24, indicated staff were to ensure R18's upper side rails were in the upright position and were to provide cues to use rails for bed mobility. During an observation on 1/14/25 at 12:45 p.m., R18 was observed sitting in a chair next to her bed. R18's bed was observed with half side rails in the fully upright position on both sides of the bed. During an interview on 1/15/25 at 12:20 p.m., LPN-A stated she thought all residents should have been assessed before bed rails were installed and have an order for bed rails. LPN-A stated she was unaware what further assessments or reassessments were required for bed rail use and referred further questions to the Director of Nursing (DON). On 1/16/25 at 10:47 a.m., LPN-A stated she had worked with R18 since her admission in 2018 and was her primary day shift nurse. LPN-A stated R18 had side rails on her bed that she could use while turning. LPN-A stated staff had to help R18 turn in bed as she had been declining over the last year and had been required more assistance. LPN-A stated R18 used to be able to use her walker with only stand by assistance but had not been able to recently. (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	01/16/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/15/25 at 1:05 p.m., the Director of Nursing (DON) stated bed rails should be assessed when they are installed but admitted that the facility did not have a process to ensure ongoing bed rail monitoring or reassessment of resident's risk related to side rail use. On 1/16/25 at 12:02 p.m., the DON stated she expected a resident to be assessed for the risk of entrapment and the safe use of bed rails anytime the resident had a change of condition but especially if it required a significant change such as the one R18 had in 6/24. The DON stated she would otherwise expect these resident specific entrapment risk assessments to be completed annually. The DON stated it was important that residents were reassessed for the continued need for bed rails as well as the potentially elevated risk of entrapment with resident changes of condition to minimize entrapment and potential resident injury. The DON confirmed the facility had reviewed the medical record and was unable to find an updated assessment of R18's potential risk and use of bed rails. The facility's Bed Safety and Bed Rails policy dated 8/22, indicated side rails and mattresses were checked for entrapment concerns annually. The facility policy did not indicate when or if ongoing resident assessments for safety and appropriate use of side rails were to be completed.

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	01/16/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33925 Based on observation, interview, and document review, the facility failed to complete comprehensive and ongoing behavioral monitoring (i.e., symptom or target behavior) for an administered antipsychotic medication to ensure efficacy of the medication for 1 of 5 residents (R62) reviewed for unnecessary medication use. Findings include: R62's quarterly Minimum Data Set, dated dated [DATE], identified R62 had severe cognitive impairment but demonstrated no delusional thinking, hallucinations, or other behaviors (i.e., physical, verbal, other) during the review period. Further, the MDS identified R62's consumed medications for the period which included both antipsychotic and antidepressant medication. On 1/14/25 at 9:05 a.m., R62 was observed while seated in a reclined high-back wheelchair in the commons area. R62 had multiple, red-colored scrapes on the left side of her face but was unable to verbally respond to questions when asked. R62 did not appear in distress at this time. Immediately following, at 9:09 a.m., registered nurse (RN)-D was interviewed. RN-D expressed R62's facial scrapes were due to a fall over the past few days. RN-D stated staff had heard a boom and found her on the floor adding, I'm assuming she tried to get up [from her wheelchair]. R62's Medication Administration Record (MAR), dated 1/2025, identified R62's current physician-ordered medications along with their corresponding administration or refusals. The MAR outlined an order for clonazepam (anti-anxiety medication) three times a day along with an order for Seroquel (antipsychotic medication) 50 milligrams (mg) once daily. The Seroquel had listed start date which read, 12/30/2024 - Open Ended, and listed a diagnosis for the medication as, Psychosis, MDD [major depression]. The MAR recorded the medication as being administered, as ordered, every day for the month period thus far. R62's corresponding Nursing Orders Flowsheet Administration History (i.e., TAR), dated 1/2025, identified an order which outlined, Resident on: Seroquel for Major depressive disorder [sic] with psychosis. Target behaviors [blank space], with a frequency recorded , Three times a day. This order listed a start date which read, 10/10/2023 - Open Ended, and was recorded by staff, as ordered, three times a day with a negative response (i.e., no, N/A). However, the documentation lacked evidence what symptoms or specific target behaviors were being tracked or monitored to ensure the medications' efficacy. R62's care plan, dated 12/2024, included R62 was identified as being at risk of adverse consequences due to antipsychotic medication use. A goal was listed which read, Resident will not exhibit signs of drug related side effects or adverse drug reaction, along with multiple interventions including, Monitor resident's behavior and response to medication, and, Resident on: Seroquel for Major depressive disorder [sic] with psychosis. Target behaviors [blank space]. The care plan lacked what specific symptoms or target behaviors (i.e., agitation, hallucinations, etc.) had been identified as R62's behavior warranting the medication, nor how such behaviors would be monitored. (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	01/16/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 1/16/25 at 8:15 a.m., nursing assistant (NA)-D stated they had worked with R62 multiple times and described R62 as needing total care adding, We do everything for her. NA-D explained R62 was mostly non-verbal but could, when seated in her wheelchair, still propel herself around the unit and, at times, even try to board the elevator by herself. NA-D stated they had noticed when R62's significant other leaves, then R62 does seem, at times, to become upset adding, It triggers a lot of mental [issues]. NA-D stated they had never seen or heard of R62 having other behavioral issues such as hitting out, verbal behaviors, or hallucinations adding, I haven't noticed none. NA-D stated it wasn't possible to determine what, if any, depression symptoms R62 had, either, as R62 was non-verbal adding, We can't tell. However, NA-D stated they had noticed R62 to have periods of crying before and reiterated it seemed more frequent when the significant other leaves or doesn't visit as planned. Further, NA-D stated the NA(s) didn't complete routine charting on behaviors but rather, if noticed, would do an incident report form and then it was routed to the nurse. R62's progress notes, dated 9/2024 to 1/2025, were reviewed. These notes identified only two recorded episodes of potential behavior including: On 12/9/24, R62 was recorded as crying and being distressed while attempting to pull out her feeding tube. The note concluded, The patient's condition will continue to be monitored closely. On 12/24/24, R62 was recorded as falling from her bed twice with both falls being unwitnessed. The note recorded, Res noted to be quite agitative [sic] for the most part of the shift. However, the note lacked what specific symptoms or observations were happening to detail 'agitative'. When interviewed on 1/16/25 at 10:04 a.m., registered nurse (RN)-D stated they were currently assigned care for R62 and had worked with R62 before. RN-D described her as aggressive but not hitting people, explaining R62 seemed aggressive when attempting to roll her wheelchair at times, but reiterated she had never physical hit anyone or had other behaviors to their recall. RN-D stated they were unsure if R62 had any delusional thinking or hallucinations as she's not talking, she might but we don't know. RN-D stated they were unsure what, if any, target behaviors were identified or tracked for R62 adding, I'm not sure. RN-D stated R62 had been falling a lot lately and attributed this to periods when R62 gets agitated. RN-D stated usually behaviors or symptoms were listed in the MAR or TAR and answered like a question but added they were unsure where in the medical record any recorded target behaviors or symptoms for the Seroquel use would be. RN-D stated, I'm not sure specifically for her. R62's most recent Extended Care Nursing Home Visit note, dated 12/10/24 and authored by the medical provider, identified R62 was seen at nursing' request for increased agitation during the day with some falls. The note outlined, [R62] is on Seroquel at night which has worked for her agitation when she was pulling on her trach she has been very upset and agitated after her significant other calls her or says that he is coming in [and] does not show up, most of these episodes as of cursed [sic] in the evening . However, R62's medical record was reviewed, including the recorded progress notes, and lacked evidence of ongoing, consistent monitoring of any identified target symptoms or behaviors despite being on a scheduled antipsychotic medication and staff reporting potential behaviors (i.e., upset, crying when significant other leaves) as being observed. (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	01/16/2025

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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/16/25 at 11:12 a.m., registered nurse unit manager (RN)-E was interviewed. RN-E verified they had reviewed R62's medical record and it lacked any specific target behaviors or symptoms for the Seroquel use adding, It wasn't in there. RN-E stated they had just updated the TAR to include the symptoms of wandering, anxiousness and refusing cares. RN-E verified behaviors, if happening, should be documented in the progress notes and tracked so they placed the new order for monitoring to be done every shift adding R62 was, at times, different on the nights versus the waking hours. RN-E stated it was important to ensure behaviors were tracked and monitored adding, We gotta make sure the medication is working, and, Make sure it's effective. A provided Psychotropic Medication Use policy, dated 9/2023, identified when a resident exhibited signs of distress which interfered with daily living, the nurse or interdisciplinary team (IDT) would identify target behaviors and non-pharmacological interventions for them. The policy outlined, Psychotropic medications are ordered by the medical provider to treat a specific condition as diagnosed and documented in the medical record. The policy directed, The IDT team monitors the resident condition and target behaviors for efficacy of the medications and any clinically significant adverse consequences, adding further, Documentation will reflect implementation of the above.

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	01/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 44656 Based on observation, interview and document review, the facility failed to implement appropriate infection control practices with proper glove use to prevent the spread of infection for 1 of 1 residents (R75) who was on enhanced barrier precautions (EBP) observed for tracheostomy care. Findings include: The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) dated 4/2/24, indicated MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. Enhanced Barrier Precautions (EBP) is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing that lead to indirect transfer of MDROs from resident to resident. The article indicated EBP should be implemented (when contact precautions did not apply) for residents who are high risk for acquiring infections with wounds or indwelling medical devices (central lines, urinary catheter, feeding tube, and ventilator dependent) regardless of MDRO colonization status. The CDC article titled Clinical Safety: Hand Hygiene for Healthcare Workers dated 2/27/24 indicated purpose of hand hygiene is to reduce, The potential spread of deadly germs to patients and reduce the risk of healthcare personnel colonization or infection caused by germs received from the patient. Per article, glove use in long term care facilities are to be changed, If moving from work on a soiled body site to a clean body site on the same patient. R75's quarterly Minimum Data Set (MDS) dated , 12/3/24 identified R75 was in a persistent vegetative state, and dependent on staff for oral care, toileting, personal hygiene, and mobility. In addition, R75 had diagnoses of a stroke (poor blood flow to a part of the brain causing cell death resulting in parts of the brain to function properly), diabetes, chronic obstructive pulmonary disease, respiratory failure, convulsions, gastrostomy (feeding tube inserted into the stomach), and a tracheostomy (surgical opening in the neck to allow a machine called a ventilator to help with breathing). R75's physician orders (PO) dated 11/3/24 identified, Tracheal Suction. Every shift. R75's care plan (CP) with start date of 3/21/24 identified, Change inline suction daily and Suction me as needed and record numbers[sic] times and total minutes. In addition, CP with a start date of 6/11/24, identified, Use Enhanced Barrier Precautions as indicated per facility policy. (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	01/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation of on 1/14/25 at 8:53 a.m., registered nurse (RN)-A entered R75's room to administer medications through the gastrostomy tube and to replace the in-line suction (a catheter inside a sterile plastic sleeve attached to the ventilator). RN-A sanitized hands, applied gloves, gown and mask (PPE) prior to contact with R75. RN-A administered the medications through the gastrostomy tube and opened the sterile package containing new in-line suction apparatus. RN-A did not change gloves following the medication administration task and moving to the pulmonary task. RN-A then removed the gauze surrounding the tracheostomy, placed it in the garbage, disconnected the in line suction apparatus attached to R75's tracheostomy and ventilator, and placed it in the garbage. RN-A inserted the sterile in-line suction apparatus and connected it to the portable suction machine at bedside and replaced the gauze surrounding the tracheostomy. RN-A then informed R75 that she was going to suction R75 through the new in-line suction apparatus and proceeded to suction R75's respiratory secretions twice before re-attaching the tracheostomy to the ventilator. RN-A then removed her gown, and gloves and sanitized her hands prior to exiting the room. During interview with RN-A on 1/14/25 at 9:18 a.m., RN-A stated, No I did not change gloves after I finished with [R75's] gastrostomy tube feeding and removed the old trach tubing and applying the new one. I should have for infection control. During interview with RN-C on 1/16/25 at 7:59 a.m., RN-C stated, we are to flush after medication administration in [the] GT [gastrostomy tube]. We must change gloves before going to the tracheostomy. You don't want to transfer infection from the GT to the trach[eostomy]. During interview with facility infection control preventionist (ICPC) on 1/16/25 at 10:14 a.m., ICPC stated, Change gloves after GT and trach care. [We] don't want to introduce anything that may have been in the GI tract. During interview with director of nursing (DON) on 1/16/25 at 10:40 a.m., DON stated, She [RN-A] should have changed her gloves between GT medication administration and the trach. I would agree that it is a concern for infection control. Facility policy titled Hand Hygiene reviewed 9/2023 stated, the purpose was identified as, Infection Prevention begins with the basic hand hygiene. By following proper hand hygiene practices, associated will reduce the spread of potentially deadly germs, as well as reduce the risk of healthcare provider colonization caused by germs acquired from the residents. In addition, the policy identified, Times to Perform Hand Hygiene are, but not limited to: Before and after direct resident contact, Before and after handling peripheral vascular catheters and other invasive devices, and Before and after changing a dressing.