STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245266	A. BUILDING _____ B. WING _____	06/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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** Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R2) reviewed for activities of daily living was provided incontinence cares to stay clean and dry. Findings include: R2's annual Minimum Data Set ((MDS) dated [DATE], included cognitively intact, did not reject cares, and was totally dependent upon staff for transfers and toileting, and was always incontinent of bowel and bladder. R2's care plan, last revised 5/10/20, directed staff, Alteration in Urinary Function: due to paranoid [MEDICAL CONDITION], dementia with behavioral disturbances, generalized weakness and immobility. Staff were directed to, Check and change resident with repositioning and prn (as needed.) R2's physician orders, included a direction, dated 2/11/20, Turn and reposition every 2hrs (two hours) in bed place BLUE WEDGE BEHIND HIS BACK, up load in w/c (wheelchair) every 2 hours. R2's care plan, edited 1/30/20, directed staff, Reposition twice per shift and prn (as needed) On 6/5/20, at 9:30 a.m. R2 was observed sitting in his wheelchair in the dining room. R2 had a can of soda he was drinking. R2 remained seated there. At 11:10 a.m. a registered nurse, (RN)-A, was observed taking vitals on R2. R2 continued to sit in wheelchair in dining room in the same location. At 11:55 a.m. R2 groaned quietly and scrunched up his legs to his mid section, but did not remove his bottom from his wheelchair seat. at 12:01 p.m. a nursing assistant, (NA)-A handed R2 a hand cleaning wipe. At 12:02 p.m. RN-B took the wipe from R2. At 12:05 p.m. NA-B served R2 a plate of food and beverages. R2 ate and drank food, including milk independently until 12:30 p.m. R2 remained at the table with tray in front of him until it was removed by an unidentified staff at 12:36 p.m. At 12:39 p.m. NA-A removed R2's clothing protector and wheeled R2 to his room. At 12:40 p.m. NA-A and R2 joined NA-B in R2's room with a full mechanical lift. R2 was observed to have a large wet spot in the front of his pants as he sat in his wheelchair. NA-A and NA-B attached a sling surrounding R2 to a full mechanical lift and raised R2 up off his wheelchair. A large wet spot was observed on R2's bottom. A pungent odor of urine was noted. NA-A and NA-B placed R2 in his bed, removed his soiled disposable brief and pants, wiped his front private area and then bottom and put a clean disposable brief and pair of pants on R2. On 6/5/20, at 12:50 p.m. NA-A reported she was R2's primary aide for the day. She reported she provided morning cares when R2 awoke at about 9:00 a.m. and then changed his brief, pants and provided peri cares just prior to meeting. NA-A explained that was R2's routine. NA-A reported R2 was provided with repositioning and checked and changed between morning cares and lunch previously when R2 had a red area on his bottom, but that had been discontinued. NA-B reported she was not as familiar with R2's cares and deferred to NA-A for R2's care routine. NA-A verified it had been 3 hours and 40 minutes since R2 had been checked for incontinence and assisted with cares. On 6/5/20, at 12:55 p.m., RN-A reported R2 should be checked and changed every 2 hours, when he woke up, after breakfast and after lunch. RN-A reported she did vitals on R2 and did not note if he was wet. RN-A reported R2 drank a can of caffeine soda as well as water and milk, which may have contributed to his wetness. RN-A reported she believed R2 was assisted with morning cares at about 9:00 a.m. On 6/5/20, at 1:10 p.m. the director of nursing (DON) reported she believed R2 was to be checked and changed for incontinence when he got up in the morning, after breakfast and after lunch. DON was unclear what it meant to reposition twice per shift. DON reported R2 at times resisted more frequent cares and questioned if that was why he was not offered incontinence cares between 9:30 a.m. and 12:40 p.m. DON reported the caregivers on the unit today were not the ones routinely providing care for R2. DON reported the facility was experiencing challenges with consistent staffing related to the pandemic and recent unrest in the area.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R2) reviewed for pressure ulcers received timely repositioning. Findings include: R2's annual minimum data set (MDS) assessment, dated 4/23/20, included, cognitively intact, did not reject cares, was totally dependent upon staff for transfers and bed bed mobility, and was at risk for pressure ulcers. R2's care plan, last revised 5/10/20, directed staff, Alteration in Urinary Function: due to paranoid [MEDICAL CONDITION], dementia with behavioral disturbances, generalized weakness and immobility. Interventions included, Check and change resident with repositioning and prn (as needed.) R2's orders, included a direction, dated 2/11/20, Turn and reposition every 2hrs (two hours) in bed place BLUE WEDGE BEHIND HIS BACK, up load in w/c (wheelchair) every 2 hours. R2's care plan, last revised 05/10/2020, directed staff, Resident is at risk for pressure ulcers R/T (related to) generalized weakness, altered mobility, and care refusals d/t (due to) dementia with behavioral disturbance, paranoid [MEDICAL CONDITION], and [MEDICAL CONDITIONS]. R2's care plan, edited 1/30/20, directed staff, Reposition twice per shift and prn (as needed) On 6/5/20, at 9:30 a.m. R2 was observed sitting in his wheelchair in the dining room. R2 had a can of soda he was drinking. R2 remained seated there. At 11:10 a.m. a registered nurse, (RN)-A, was observed taking vitals on R2. R2 continued to sit in wheelchair in dining room in the same location. At 11:55 a.m. R2 groaned quietly and scrunched up his legs to his mid section, but did not remove his bottom from his wheelchair seat. at 12:01 p.m. a nursing assistant, (NA)-A handed R2 a hand cleaning wipe. At 12:02 p.m. RN-B took the wipe from R2. At 12:05 p.m. NA-B served R2 a plate of food and beverages. R2 ate and drank food, including milk independently until 12:30 p.m. R2 remained at the table with tray in front of him until it was removed by an unidentified staff at 12:36 p.m. At 12:39 p.m. NA-A removed R2's clothing protector and wheeled R2 to his room. At 12:40 p.m. NA-A and R2 joined NA-B in R2's room with a full mechanical lift. R2 was observed to have a large wet spot in the front of his pants as he sat in his wheelchair. NA-A and NA-B attached a sling surrounding R2 to a full mechanical lift and raised R2 up off his wheelchair. A large wet spot was observed on R2's bottom. A pungent odor of urine was noted. NA-A and NA-B placed R2 in his bed, removed his soiled disposable brief and pants, wiped his front private area and then bottom and put a clean disposable brief and pair of pants on R2. On 6/5/20, at 12:50 p.m. NA-A reported she was R2's primary aide for the day. She reported she provided morning cares when R2 awoke at about 9:00 a.m. and then repositioned R2 when she changed R's brief, pants and provided peri cares just prior to meeting. NA-A explained that was R2's routine. NA-A reported R2 was provided with repositioning and checked and changed between morning cares and lunch previously when R2 had a red area on his bottom, but that had been discontinued. NA-B reported she was not as familiar with R2's cares and deferred to NA-A for R2's care routine. NA-A confirmed R2 had not been repositioned for 3 hours and 40 minutes this morning. On 6/5/20, at 12:55 p.m., RN-A reported R2 should be repositioned every 2 hours, when he woke up, after breakfast and after lunch. RN-A reported she did vitals on R2 and did not note if he was wet. On 6/5/20, at 1:10 p.m. the director of nursing (DON) reported she believed R2 was to be checked and changed for incontinence when he got up in the morning, after breakfast and after lunch. DON reported R2 at times resisted more frequent cares and questioned if that was why he was not offered incontinence cares between 9:30 a.m. and 12:40 p.m. DON reported the order for upload in wheelchair should be for offloading (repositioning to remove pressure

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) from a bony area). DON reported the caregivers on the unit today were not the ones routinely providing care for R2. DON reported the facility was experiencing challenges with consistent staffing related to the pandemic and recent unrest in the area.