DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: CD8U

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY A	GENCY		Facility ID: 00940
1. MEDICARE/MEDICAID PROVIDER NO.(L1) 245310 2. STATE VENDOR OR MEDICAID NO. (L2) 810313500).	3. NAME AND AL (L3) BENEDICT (L4) 1101 BLACI (L5) NEW BRIG	INE HEALTH K OAK DRIV	CENTER	INNSBRUCK	55112	4. TYPE OF A 1. Initial 3. Termination 5. Validation	2. Recertification 1. CHOW 2. Complaint
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Vis 8. Full Survey	it 9. Other After Complaint
6. DATE OF SURVEY 6/17/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR E	ENDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	105 (L18) 105 (L17)	Compliance1. As B. Not in Comp		am	2. Techi	nical Personnel our RN y RN (Rural SN	7. Medic	of Services Limit al Director t Room Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 105 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY N 1861 (e) (1) or		(L15)	
16. STATE SURVEY AGENCY REMAR	KS (IF APPLICA		ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE Gloria Derfus, Unit Su	pervisor	Date : 0	07/29/2016	(L19)	18. STATE SUR		Program Represe	Date: entative 07/29/2016 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	OFFICE OR	SINGLE S	TATE AGENC	Y
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Parti 2. Facility is not Eligible			MPLIANCE WITH HTS ACT:	H CIVIL	2. O		cial Solvency (HCF ₂ 1 Interest Disclosure :	
	3. LTC AGREEN		4. LTC AGREEN		26. TERMINAT	TION ACTION:	DAY	(L30)
OF PARTICIPATION 02/26/1986 (L24)	BEGINNING (L41)	JUALE	ENDING DA	IE .	VOLUNTARY 01-Merger, Closu 02-Dissatisfactio 03-Risk of Involu	n W/ Reimburse	05-Fa	DLUNTARY nil to Meet Health/Safety nil to Meet Agreement
25. LTC EXTENSION DATE: 2 (L27)	A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		04-Other Reason	•	OTH	rovider Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/	/CARRIER NO.		30. REMARKS			
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE				
	(L32)			(L33)	DETERMINA	ATION APPR	ROVAL	



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245310

July 29, 2016

Ms. Susan Ager, Administrator Benedictine Health Center Innsbruck 1101 Black Oak Drive New Brighton, MN 55112

Dear Ms. Ager:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 11, 2016 the above facility is certified for:

105 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 105 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 29, 2016

Ms. Susan Ager, Administrator Benedictine Health Center Innsbruck 1101 Black Oak Drive New Brighton, MN 55112

RE: Complaint Number H5310053, Project Number S5310026 and Complaint Number H5310055

Dear Ms. Ager:

On May 10, 2016, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective June 8, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by the Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on April 29, 2016, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on May 6, 2016. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 11, 2016, the Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 6, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 11, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 11, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of July 19, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 29, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 29, 2016, is to be rescinded. They will also notify the State

Benedictine Health Center Innsbruck July 20, 2016 Page 2

Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 29, 2016, is to be rescinded.

In our letter of May 24, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 29, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 11, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

• Per instance civil money penalty for the deficiency cited at F333 (S/S=G) will remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
245310 _{Y1}	B. Wing	Y2	6/17/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDICTINE HEALTH CENTER	INNSBRUCK	1101 BLACK OAK DRIVE		
		NEW BRIGHTON, MN 55112		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEI Y4			DATE Y5	ITEM Y4			DATE Y5	ITEM Y4			DATE Y5
ID Prefix Reg. # LSC	F0246 483.15(e)(1)		Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0280 483.20((2)	d)(3), 483.10(k)	Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)		Correction Completed 06/10/2016
ID Prefix Reg. # LSC	F0312 483.25(a)(3)		Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0314 483.25(c)	Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0315 483.25(d)		Correction Completed 06/10/2016
ID Prefix Reg. # LSC	F0323 483.25(h)		Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0329 483.25(l	1)	Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0371 483.35(i)		Correction Completed 06/10/2016
ID Prefix Reg. # LSC	F0431 483.60(b), (d), (e))	Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0441 483.65		Correction Completed 06/10/2016	ID Prefix Reg. # LSC	F0465 483.70(h)		Correction Completed 06/10/2016
ID Prefix Reg. # LSC			Correction Completed	ID Prefix Reg. # LSC			Correction	ID Prefix Reg. # LSC			Correction Completed
REVIEWE STATE AG		REVIEWE (INITIALS	ED BY) GD/mm	DATE 07/05/2	2016	SIGNATURE OF SI	JRVEYOR 18623	3		DATE 06/17	/2016
REVIEWE CMS RO FOLLOWU 5/6/2016	JP TO SURVEY CO	REVIEWE (INITIALS OMPLETED)			ANY UNCORRECTE ED DEFICIENCIES				DATE YES	s 🗆 no

Correction

Completed

05/04/2016

Correction

Completed

05/05/2016

Correction

Completed

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

LSC

LSC

NFPA 101

NFPA 101

K0144

K0038

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

LSC

LSC

NFPA 101

NFPA 101

K0062

K0034

		POST-C	ERT	FICATIO	N RE	VISIT F	REPO	RT		
	ER / SUPPLIER / C			_					DATE OF RE	VISIT
245310	ICATION NUMBER	A. Building 01 - _{Y1} B. Wing	- MAIN BU	JILDING 01				Y2	6/20/2016	Y3
NAME C	F FACILITY				STREET	ADDRESS, C	CITY, STATE	E, ZIP CODE		
BENED	ICTINE HEALTH	CENTER INNSBRUC	K		1101 BL	ACK OAK DRI	VE			
					NEW BF	righton, Mn	55112			
correcte provisio	ed and the date su	leficiencies previously uch corrective action v identification prefix c	was accon	nplished. Each	deficiency	should be fu	ılly identifi	ed using either t	he regulation	or LSC
ITE	EΜ	DATE	ITEN	Л		DATE	ITEM		D/	TE
Υ	4	Y5	Y4			Y5	Y4)	′ 5
ID Prefix	(Correction	ID Prefix	(Correction	ID Prefix		Cor	rection
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101		Completed	Reg. #	NFPA 101	Cor	npleted
LSC	K0018	05/16/2016	LSC	K0025		05/16/2016	LSC	K0033	05/0	4/2016

Correction

Completed

05/04/2016

Correction

Completed

05/16/2016

Correction

Completed

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

LSC

LSC

NFPA 101

K0052

Correction

Completed

05/04/2016

Correction

Completed

Correction

Completed

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building 02 - NEW BLDG			DATE OF REV	ISIT
	B. Wing	,	Y2	6/20/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE			
BENEDICTINE HEALTH CENT	ER INNSBRUCK	1101 BLACK OAK DRIVE			
		NEW BRIGHTON, MN 55112			

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	A 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0018	05/16/2016	LSC K002	25	05/16/2016	LSC	K0034		05/12/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	A 101	Completed	Reg. #	NFPA 101		Completed
LSC	K0038	05/04/2016	LSC K005	52	05/04/2016	LSC	K0061		05/16/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	A 101	Completed	Reg. #			Completed
LSC	K0062	05/05/2016	LSC K014	14	05/16/2016	LSC			
ID Prefix		Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
ID Prefix	_	Correction	ID Prefix		Correction	ID Prefix			Correction
Reg. #		Completed	Reg. #		Completed	Reg. #			Completed
LSC			LSC			LSC			
REVIEWS		REVIEWED BY (INITIALS) TL/mm	DATE 07/05/2016	SIGNATURE OF	SURVEYOR 37010)		DATE 06/20)/2016
REVIEW CMS RO		REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOW 5/4/2016		Y COMPLETED ON	CHECK FOUNCORRI	OR ANY UNCORREC	CTED DEFICIEN ES (CMS-2567)	ICIES. WAS SENT TO T	A SUMMARY OF HE FACILITY?		s 🗆 NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: CD8U

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY	AGENCY		Facil	ity ID: 00940)
MEDICARE/MEDICAID PROVIDE NO.(L1) 245310	R	3. NAME AND AI (L3) BENEDICT			INNSBRUCE	ζ.	4. TYPE O		2 (L8	tion.
2. STATE VENDOR OR MEDICAID N	NO.	(L4) 1101 BLACI	K OAK DRIV	E			1. Initial 3. Termina		l. Recertificat	uon
(L2) 810313500		(L5) NEW BRIG	HTON, MN		(L6)	55112	5. Validati 7. On-Site		6. Complaint 9. Other	
5. EFFECTIVE DATE CHANGE OF O	WNERSHIP	7. PROVIDER/SU			<u>02</u> (L7	<i>'</i>		rvey After Com		
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA			F	
	5/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF		FISCAL YEA	R ENDING D	OATE: (L	.35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID			09/			/
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE		09/	30		
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:						
From (a):		A. In Complia	ince With		And/Or Appr	oved Waivers Of	The Following R	equirements:		
To (b):			equirements		2. Tec	chnical Personnel	_ 6. Sc	ope of Service	s Limit	
		Compliance	e Based On:		3. 24	Hour RN	7. Me	edical Directo	r	
12.Total Facility Beds	105 (L18)	1. A	cceptable POC		4. 7-D	Day RN (Rural SN	(F) 8. Pat	tient Room Siz	e	
13.Total Certified Beds	105 (L17)	X B. Not in Con	onliance with Pro-	oram	5. Life	e Safety Code	9. Be	ds/Room		
13. Total Certified Beds	(and/or Applied V	-	* Code:	B*	(L12)			
14. LTC CERTIFIED BED BREAKDOV	VN				15. FACILITY					
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) o	or 1861 (j) (1):	(L	15)		
105					.,,,,	3, ()				
(L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):						
See Attached Remarks										
17. SURVEYOR SIGNATURE		Date :			18. STATE SU	RVEY AGENCY	APPROVAL		Date:	
Jacob Mabera, HFE	NE II	0	06/09/2016		Kamala Fiaka	Dawning Health	Drogram Door	a a a stativa	07/01/20)16
				(L19)		-Downing, Health			07/01/20	(L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	COFFICE O	R SINGLE S	TATE AGEN	NCY		
19. DETERMINATION OF ELIGIBILIT	ТҮ		IPLIANCE WITI ITS ACT:	H CIVIL		Statement of Finar Ownership/Contro	• '		7A 1512)	
1. Facility is Eligible to Pa	rticipate	RIGI	113 AC1.			Both of the Above		uie Suii (HCi	A-1313)	
2. Facility is not Eligible	7.24\)									
	(L21)			<u>.</u>						
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	ATION ACTION:		(L30)	1	
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY	_00	<u> </u>	NVOLUNTAR	<u> </u>	
02/26/1986					01-Merger, Clo			5-Fail to Meet	Health/Safety	/
(L24)	(L41)		(L25)		02-Dissatisfact	ion W/ Reimburse	ement 0	6-Fail to Meet	Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Invo	luntary Terminatio	n <u>O</u>	THER		
	A. Suspension	n of Admissions:			04-Other Reaso	n for Withdrawal	0	7-Provider Sta	tus Change	
(L27)			(L44)				0	0-Active		
(L27)	B. Rescind St	uspension Date:								
			(L45)							
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS	S				
		03001								
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539	37	. DETERMINATION	I OF APPROVAI	DATE						
I. TO RECEIF OF CHIS-1337		DI IDIAMIN'NI ION	. OI III RO MI		DEFERR	IAMION : SE	201111			
	(L32)			(L33)	-DFLEKWIN	JATION APPI	Z()\/Δ1			

PRINTED: 05/24/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245310	B. WING			05/0	06/2016
NAME OF F	PROVIDER OR SUPPLIEF	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CEN	TER INNSBRUCK			101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000		of correction (POC) will serve of compliance upon the	FC	000	point	31	3
		eptance. Your signature at the			F246 D The facility did not		
		page of the CMS-2567 form will tion of compliance.			ensure a call light was		
	be used as verilor	tuon of compliance.			within reach for 1 o 1		
		acceptable POC an on-site			resident (R47) who was at		
F 246 SS=D	revisit of your facil validate that substregulations has be your verification. 483.15(e)(1) REAOF NEEDS/PREFA resident has the services in the facaccommodations preferences, exce	ity may be conducted to cantial compliance with the een attained in accordance with	F 779 P	246	risk for falls. The call light policy was given		
	by: Based on observereview, the facility was within reach the was at risk for fall. Findings include: On 5/03/16, at 1:2 sitting upright in a positioning chair), from the edge of least review.	28 p.m. R18 was observed Broda chair (a tilt and recline The Broda chair was three feet R18's bed. The call light was	Moder	X .	He is able to make needs known. The patient has remained safe and has no history of a fall since admission to facility. Patient call report shows patient is consistently using a call light as needed. Staff did not observe the call light position when surveyor noted this.		
	lying across the b	ed. R18 was unable to reach					
LABORATOR	Y DIRECTOR'S OR PROV	IDER/ŞUPPLIER REPRESENTATIVE'S SIG	NATURE		, TITLE	1	(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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
	245310	B. WING			05/0	06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENT	ER INNSBRUCK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
R18 stated "I use mam supposed to rin At 1:31 p.m. nursing the call light. NA-E NA-E stated, "There room. I don't know call light." NA-E sai "Whenever I get [R the call light because enough to be heard unable to move Browas a fall risk, becathings and can fall make sure all my result in the call make sure all my result in the call make sure all my result in the call staff including there in the call light. He should have a call staff including there have their call lights.	tated could not move his chair. The call light to get the staff. I g it, not attempt to get up." g assistant (NA)-E answered gave the call light to R18. Tapy brought him back to the why they did not give him his d R18 used the call light: Tall up I make sure [R18] has see [R18] cannot call out loud d." NA-E verified R18 was ada chair. NA-E stated R18 ause R18 would reach for out of the bed. NA-E stated, "I residents have their call lights." This is in Minimum Data Set as severely cognitively ired assistance of two staff for ers, and toilet use. The care indicated R18 was at risk for staff to keep call light in reach a 5/3/16, at 1:40 p.m. licensed b can and does use the call b can are can and the can	Recept Benefor	246	How the facility will identify other residents having the potential to be affected by the same deficient practice. Facility policy states that the call light must be in reach at all times for each patient. Patient will be identified through admission assessment and annual assessment and quarterly review to identify ability to appropriately use call light and implement measures for patient who may not have the capacity to use call light. Call light audits are done monthly by environmental services staff. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Random call light audits are done both physically via daily and monthly room checks by environmental services,		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		E SURVEY PLETED
		245310	B. WING		05/	06/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 280 SS=D	PARTICIPATE PLA The resident has to incompetent or oth incapacitated under participate in plant changes in care at the comprehensive as interdisciplinary teaphysician, a regist for the resident, and disciplines as deteated and, to the extent the resident, the religious presentative.	he right, unless adjudged nerwise found to be er the laws of the State, to ning care and treatment or and treatment. care plan must be developed the completion of the esessment; prepared by an am, that includes the attending ered nurse with responsibility and other appropriate staff in ermined by the resident's needs, practicable, the participation of esident's family or the resident's re; and periodically reviewed eam of qualified persons after	F 280	through call light reports. Nurse and NAR training ir orientation and ongoing classes are used to reministrate. How the facility plans to monitor its performance make sure that solutions sustained. Random call liaudits will be done both physically and through callight reports monthly x 6 months and quarterly thereafter. Report will be reviewed in Safety Committee.	to are ght	
	by: Based on intervie facility failed to reinterventions to re 1 of 1 residents (Fother residents on failed to implement of 1 residents (R1 related to other refindings include: R21's admission h	ENT is not met as evidenced w and document review, the assess for and implement duce aggressive behaviors for (21) who had altercations with the unit. In addition, the facility at interventions to safe guard 14) who was at risk for injury sidents behaviors.		Include dates when corrective action will be completed. 06/10/203 F280 D The facility did not ensure behaviors were reassessed and intervention	t -	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		E SURVEY PLETED
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F 280	and "quite a few a bit of difficulty v R21's face sheet included dementi temporary care p behavior or mood R21's admission 12/2/15, indicated transfers, toileting ambulated with significated aggress residents. The call administer PRN used to treat anxithe behavior end intervene if need and redirect with A review of Benefit 1/25/15, through displayed aggress residents. On 12 "combative at time 12/4/15, indicated R21 he "gets verbit." A Progress R21 was wander residents rooms and was observed other residents. glasses off R14 interdisciplinary indicated staff w	behaviors disturbances and quite with delirium as well." A review of indicated diagnoses that a with behavioral disturbance. A lan, undated indicated no disconcerns. Mnimum Data Set (MDS) dated the required assistance for g, dressing and grooming, and taff supervision. A care plan indicated he was severely red and demonstrated socially ruptive behaviors that included ion toward staff and other are plan directed staff to (as needed) Ativan (a medication iety disorders), assess whether angered other residents and ed, maintain a calm approach,		280	implemented for 1 of 1 (R217) residents reviewed for accidents. How corrective action we be accomplished for tho residents found to have been affected by the deficient practice. Any patient involved in any so of aggressive behavior we result in both patients have an event documented in Matrix. The event will the trigger IDT to follow up a look at interventions for patients involved. How the facility will idea others residents having potential to be affected the same deficient practal residents are assessed upon admission, quarter annually and with a significant change to idea potential behavior that needs to be addressed a care planned.	ill se ort ill aving en and tify the by tice. d	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '		E CONSTRUCTION		E SURVEY PLETED
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	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		•
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 280	room, punched Rinto the wall unit for and fall. R14 susta and a scratch to hindication of intervredirect R21. R21 room and returned Progress Note dat tried to break dow food at other residents walker at table shaking his hwas discharged from A Benedictine Heat assessment of Beaggressive/combaindicated R21 gragrabbed the glass The evaluation of continue monitoring safe. plan of care Health Center at I Behavior And Modaggressive/combaindicated R21 had resident and punce evaluation of the aintervened and Rintervened and Rin	t 5:15 p.m., entered R14's 4 in the face and pushed him bring R14 to lose his balance ained a laceration to his wrist is forehead. There was no entions attempted by staff to was sent to the emergency diseveral hours later. A led 12/19/15, indicated R21 in a door and threw juice and lents. A subsequent Progress 1 attempted to throw another at him and moved from table to list. Staff called 9-1-1 and R21 from the facility. Alth Center at Innsbruck shavior And Mood Events for ative behavior dated 12/14/15 bed another resident and es off of that residents face. The incident indicated staff will and and ensuring residents are continues. A Benedictine innsbruck assessment of	F:	280	What measures will be p into place or systemic changes made to ensure that the deficient practic will not recur. This was a oversight and the current process works: Any residinvolved in any sort of aggressive behavior will result in both residents having an event docume in Matrix. The event will trigger IDT to follow up a look at interventions for residents involved. How the facility plans to monitor its performance make sure that solutions sustained. All events created will be reviewed IDT during the week Monthrough Friday. Include dates when corrective action will be completed. 06/10/20	e n t lent nted then to are by day	
		(RN)-A stated R21 admitted to					

PRINTED: 05/24/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 245310 B. WING 05/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 5 F 280 F 280 the facility in November 2015. She stated he had some confusion, sudden changes in behavior and displayed aggressive behaviors toward other residents, RN-A stated after R21 displayed negative behaviors on 12/8/15 his care plan was not updated, but stated staff attempted redirection when R21 was out of his room. During an interview on 5/5/16, at 9:48 a.m., the assistant director of nursing (ADON) stated after R21's altercation with another resident he was sent to the hospital. He stated the facility was trying to place him in the hospital but he was sent back from the emergency room. The ADON stated if a resident goes to the hospital for a few hours. "we don't do anything different." He stated behavior assessments are used for quarterly assessments but not following individual behavioral episodes. The ADON stated "if things come up and we become aware of it, we will care plan for that." R14's quarterly MDS dated 11/29/15, indicated he was severely cognitively impaired and required assistance with all activities of daily living. R14's

abuse.

care plan dated 2/24/15, identified him as a vulnerable adult related to cognitive impairment and directed staff to follow his plan of care to ensure safety and monitor for symptoms of

Although R14 was identified as the victim during an incident on 12/14/15, when R21 grabbed him and grabbed his glasses, and again on 12/19/15, when R21 punched him in the face, a review of R14's Benedictine health Center at Innsbruk Resident Progress Notes dated 12/11/15 through 12/24/15, did not reflect either incident, nor was a facility event form completed even thought R21's

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION IG	COMPLETED	
		245310	B. WING _		05/06/2016	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
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F 282 SS=D	notes indicated R scratch on 12/14/on 12/19/15. Furth victim of abuse or no care planned in direct staff to prote stated she would an incident form a During in interview ADON stated their for R14 following further stated, the missed it and the A policy for care preceived. 483.20(k)(3)(ii) S PERSONS/PER The services promust be provided accordance with care. This REQUIREM by: Based on observeriew, the facility of 3 residents (incontinence care the careplan for	14 sustained a laceration and a 15, and was punched in the face her, while R14 had been a 14 two separate dates, there was neterventions implemented to ect R14 from R21. When which was a staff to complete and document follow-up. When on 5/6/16, at 9:40 a.m., the re was no follow up completed the altercations with R21. He increases who were present interdisciplinary team missed it. Dianning was requested but none ERVICES BY QUALIFIED	F 2	F282 D The facility did not ensure the care plan was followed for 2 of 2 residen (R87, R25) How corrective action will be accomplished for those residents found to have been affective by the deficient practice. For borresidents, new assessment (Braden and tissue tolerand)	th ts nce) hat. tify ne oy ce. I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X			(X3) DATE SURVEY COMPLETED		
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her back on 5/5/16, (two hours and 22 r asked how often R2 practical nurse (LPI repositioned every tater when asked L1 positioned accordin At 9:43 a.m. LPN-B slightly on the left sigood." No check or incontinence was o At 11:34 a.m. on 5/5 on her right side in R25's pressure ulce assistant (NA)-A as brief had been wet R25 was observed which appeared de and one on her both have substance do pressure ulcer on the have substance do pressure ulcer on the both placed bandages of applied tape to hold stated the evening for R25's pressure R25 was lowered in a.m. with the ceiling NA-A and LPN-B at the top of R25's left needed two staff with NA-A stated R25 with hours and was che	ncontinence care: sly observed lying in bed on from 7:21 a.m. until 9:43 a.m. minutes). At 9:23 a.m. when 25 was repositioned licensed N)-B stated all residents get two hours. Fifteen minutes PN-C stated R25 was g to care plan and if needed. and LPN-C repositioned R25 ide. R25 stated, "That feels change of brief for		282	and service allotment. plans are changed to re any changes assessed. What measures will be into place or systemic changes made to ensu that the deficient prac will not recur. Random audits will be done on residents who identify requiring repositioning needs for repositioning Random audits will be on residents who ident requiring repositioning needs for repositioning weekly x 4. How the facility plans t monitor its performanc make sure that solution sustained. Residents w reviewed on admission, during quarterly and an care conferences and for significant change. Include dates when corrective action will be completed. 06/10/2	eflect e put re tice as or done ify as or ce to ns are rill be nual or	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 282	NA-A stated R25 d check and changed line was designed wetness. NA-A then her morning cares dining room in her. The resident was a she was assisted to watch the resident was finished eating table to watch the resident of care). R25 NA-B lowered R25 ceiling lift at 2:29 pher Broda chair for no offer by staff for and NA-B finished neck pillow on top R25's lower legs of about to leave the and NA-B if they we stated yes they wo which LPN-B and recard and without residence and without residence and without residence and said the pwas wet. NA-B state brief turns blue the changed. NA-B coline and had been placed a pillow on slightly to the left. I	vening before going to bed. id not sit on the toilet but was d, and when the brief's yellow to turn blue to indicate in proceeded to help R25 with before pushing R25 out to Broda chair to eat. continuously observed while of eat brunch and when she is R25 was moved to another moving playing for an hour after meals according to the sat a table until LPN-B and back into her bed with the lam. (R25 again had been up in two hours and 32 minutes with repositioning R25 in bed with a of a standard pillow and placed in a heel lifter, and as they were room, Surveyor asked LPN-B were going to toilet R25. LPN-B uld check and change R25 NA-B at 2:39 p.m. proceeded to brief and perform incontinence by brief on R25. (At that time hours and 42 minutes without for incontinence after the noon repostioning). LPN-B felt R25's bad they had taken off of R25 ted when yellow line on the entire was wet and needs to be infirmed R25's brief had a blue wet. LPN-B and NA-B then R25's right side turned R25 R25 stated she was B told R25 staff would be back	F2	282	RECEIVE JUN 03 2016 COMPLIANCE MONITORING LICENSE AND CERTIFIC	DIVISIO	7

AND PLAN (FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED	
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F 282	R25's careplan date to receive extensive bed mobility every to R25's careplan also to reliably notify star staff were to assist after meals, on night R25's careplan date indicated a pressurf bed and ROHO customicated and ROHO customicated and received and received and received and received and was toileted after meast of R25's NA assignments as the staff were needed to before and after meast of R25's incontinent of R25's inco	ge 9 ed 3/24/15, indicated R25 was assistance with two staff for wo hours and as needed. Indicated R25 was not able of of need to toilet, and two R25 upon rising, before and at rounds and as needed. In additionally reducing mattress on R25's which in R25's wheel chair receive the care and services for repositioniong and toileting. The properties according to the plan of reals according to the plan of reals according to the plan of reals according to the plan of reals, and as needed. In sheet also indicated two reals, and as needed because the of bowel and bladders. The reals according to the plan of reals, and as needed because the of bowel and bladders. The RN-B stated she had real work assignment sheets. The RN-B stated NAs knew are the real will be off loaded every two reals as repositioned every two because of R25's open areas as laid back down in bed after	F 282				

PRINTED: 05/24/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245310 B. WING 05/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK NEW BRIGHTON, MN 55112 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) F 282 Continued From page 10 F 282 brunch. NA-D stated R25 always lets staff reposition her and did not refuse. NA-D stated if R25 did not want to get up until later in the morning then she would be repositioned in bed. - At 1:53 p.m. NA-E stated the assignment sheet was how she knew what to do for R25. - At 1:59 p.m. NA-C stated she followed the assignment sheet for R25 and that she had not performed any cares for R25 today as nights had and NA-A had helped R25. R166 was continuously observed on 5/4/16, from 12:35 p.m. until 2:53 p.m. R166 was not seen approached by staff to offer toileting or repositioning. During interview with LPN-D on 5/4/16, at 12:35 p.m. LPN-D stated staff anticipated R166's needs as R166 might not be able to say she had to go to the toilet and it might be too late. NA-F standing nearby stated R166 had been dry when she helped R166 get up at 9:00 a.m. and R166 had voided then on the toilet. NA-F stated R166 had been wet after brunch when she toileted R166 at 11:45 a.m. NA-F stated R166 had voided on the toilet and was to be toileted every two hours. R166 went for two hours and 45 minutes without being toileted.

At 12:35 p.m. on 5/4/16, R166 was seen sitting at the dining room table drinking some juice. NAs entered in and out of the dining room not approaching R166. At 1:15 p.m. activity staff asked nurse at the nurse's station if R166 had an appointment for the afternoon. When the nurse said no, activity staff asked R166 about attending activity and without asking about toileting pushed R166 down the hall, into the elevator and upstairs to the dining room. At 1:22 p.m. an activity staff

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 282	gloves on to help p.m. same staff a hands and gave F 2:06 p.m. R166 fin R166 put a new p bird seed into a for R166 take her glostaff, "It is time to drive. Staff assisting pushed R166 in welevator and down floor where R166 teeth hurt when e asked R166 about her teeth hurt when e asked R166 continued to At 2:49 p.m. NA-F toward the nursing asked when R166 and NA-F answerd 3:00 p.m. NA-F a coming on and if NA-F stated she surveyor notified toileted for over the look at R166's skyes she would an toileted after measure asked R166's skyes she would an toileted after measure asked R166's skyes she would an toileted after measure of the account of th	page 11 Is and assisted R166 to put with making bird seed. At 1:47 Issisted R166 to wipe off her R166 an ice cream sundae. At mished ice cream and staff help air of gloves on to help press orm. At 2:36 p.m. staff helped oves off. 2:39 p.m. R166 said to go home, but I do not want to ed R166 to clean her hands and over off		282			
		-D and NA-F stood R166 up at and removed R166's brief as					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/0	6/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
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F 282	R166 dribbled uring confirmed R166's I that the yellow line LPN-D stated R16 (It now had been the from when NA-F stated R16 (It now had been the from when NA-F stated R16 reddened, and kind skin nurse had loot treatment to R166' was toileted after reame back from as stated the NA shout to get R166. After toileting R166, went for exercise, she got back." R166's care pland was at a risk for prof dementia, was an eed to toilet, and needs. R166's car incontinent production of the production of the planting R166 in the planting R166's car incontinent production of the production of the planting R166's car incontinent production of the planti	e while standing. LPN-D prief was wet with urine and on the brief was now blue. So's brief was "moderately wet." aree hours and eight minutes aid she had last toileted R166). For observed R166's bottom to dedened on both buttocks and so's bottom was not open, just do of chronic for her and that the ked at it. LPN-D applied so bottom. LPN-D stated R166 meals, and that R166 usually ctivity at 2:00 p.m. LPN-D ald have went up to the activity of at 3:00 p.m. NA-F stated INA-F when she had to go to be asked about the time frame NA-F stated, "I knew she had but I was just going to wait until dated 11/20/15, indicated R166 ressure ulcers, had a diagnosis unable to reliably notify staff of staff was to anticipate R166's e plan indicated R166 wore and the term goal for R166 was for act and free of redness. The data R166 was to be repositioned two hours and as needed. The care and services as seed and repositioned every two	F	282			

PRINTED: 05/24/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 245310 05/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 282 Continued From page 13 F 282 The undated Nursing Assistant Assignment sheet for R166 indicated R166's mode of transportation was a wheelchair and R166 was to be transferred and toileted with one assistance of staff. The NA sheet did not indicate how often R166 was to be repositioned or toileted. During interview with acting director of nursing (ADON) on 5/4/16, at 3:13 p.m. ADON stated he expected staff to go and ask the resident to reposition or toilet, staff "should approach the resident." ADON stated if the resident's voiding

color at a certain point of wetness. Nail Care:

R87 was observed on 5/3/16, at 7:25 p.m. during general observations, resident teeth were observed covered with heavy food debris both hand fingernails were observed unclean and untrimmed with brown matter underneath.

pattern had a specific pattern it might make sense, if the voiding did not show a pattern that is why every two hours toileting was assigned. ADON stated the NAs assignment sheets should say something about toileting and repositioning and should reflect the care plan. ADON stated the briefs staff can tell when wet the line changes

On 5/4/16, at 9:48 a.m. when asked if resident got the help, she needed a family member stated "I come and see my mom in dirty clothes, and wondering if her teeth are getting cleaned."

On 5/4/16, at 1:43 p.m. and 5/5/16, at 7:30 a.m. to 9:20 a.m. and 11:35 a.m. resident was observed seated in wheelchair and both hand fingernails were noted to have approximately $\frac{1}{2}$ inch long with brown matter underneath them.

On 5/5/16, at 12:24 p.m. a nursing assistant

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		Í
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F 282	living room and indown for a nap. We to R87 for the shift however, she was unit. NA-M verified underneath. When for trimming the finot know and dire practical nurse (LI-At 12:29 p.m. regmanager stated reasked about nail or resident bathe was when looking throw Worksheet/Body been marked as twas no document resident refusing was surprised the regular nurse wor when resident bath verified in March abath/shower had not been docume -At 12:38 p.m. LP documented it wa -At 12:48 p.m. Recare plan was supplied to the plan was supplied to the plan was supplied to be a supplied to be a supplied to the plan was supplied to the plan was supplied to be a supplied to be a supplied to the plan was supplied to the plan was supplied to be a supplied to be a supplied to the plan was supplied to be a supplied to the plan was supp	rved wheel resident out of the dicated was going to lay her when asked if she was assigned to the NA-M stated she was, not a regular caregiver in the did the nails were long and dirty asked who was responsible agernails, NA-M stated she did cted surveyor to licensed PN)-A. istered nurse (RN)-A unit nurse esident was challenging when eare. RN-A and LPN-A verified is Monday 5/2/16, evening and uigh the Shower day Audit dated 5/2/16, nails had not rimmed. RN-A verified there ation in the progress notes of hail care. RN-A indicated she re was no documentation as a ked Monday evening shifts h/shower was scheduled. RN-A and April 2016, all days been completed nail care had inted as completed. N-A stated "If it's not	F 2	282			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245310	B. WING		05/06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE COMPLÉTION
F 282 F 312 SS=D	diagnoses of demer The CAA indicated assistance with man health and safety. R87's care plan da had an alteration in assist with her care lower extremity edweakness and decure [R87] will be clear Care plan indicated with grooming. R87's 14 day Minimal 2/11/16, indicated in physical assistance hygiene. In additional did not reject care On 5/6/16, at 9:41 nursing (ADON) st follow the plan of comproviding cares. A requested. 483.25(a)(3) ADL CONTENT RESULTANCE A resident who is a daily living receives.	we impairments and had entia and altered mental status. The resident may need aking decisions regarding atted 2/10/16, indicated resident a ADLs related to needing es due to dementia, chronic ema/wounds with pain, breased range of motion. Goal and an and well groomed." AB7 needed one staff assist mum Data Set (MDS) dated resident required extensive er of one staff with personal and the MDS indicated resident which included ADLs. p.m. the assistant director of cated all staff were supposed to care for residents when care plan policy was	F 28	F312 D The facility did	of 3 e for will ose
•	This REQUIREME by:	NT is not met as evidenced		been affective by the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		245310	B. WING	l		05	/06/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		110	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE
F312	Based on observareview, the facility services was provireviewed for urinar dependent on staff incontinence care. ensure nail care w (R87) reviewed for and who was dependent on the service services and who was dependent on the services of	ation, interview and document failed to ensure timely care and ded for 1 of 3 residents (R25) by incontinence who was for repositioning and In addition, the facility failed to as provided for 1 of 3 residents activities of daily living (ADLs) endent on staff for nail care.		312	deficient practice. This resident often refuses nail care from staff. Facility poli promotes patients independence and patient right to refuse while ensuri adequate documentation or resident choices. Nail care will be completed as reside allows. Documentation is completed for each time or refusal. How the facility will ident others residents having the potential to be affected be the same deficient practice. Residents needing nail car will be identified weekly of bath day. Any refusal will met with gentle encouragement and documented.	ng of ent f ify ne y ce.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05	5/06/2016	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 312	after meals, on n was not checked according to the The Nursing Progindicated R25's Eassessment scorimpairment. The had a skin tear of and had a recent left left. PN indicacaused by sheari indicated R25 was bearing and used Current physiciar overlay mattress 13 with risk factor of skin breakdow that the mattress and position Institutat resident was two hourly. Off lochair for a full min R25's significant (MDS) dated 3/1's staff assistance with the transportation of the transport	ight rounds and as needed. R25 and changed after meals olan of care. gress Note (PN) dated 6/4/15, Braden score skin risk ed 16 putting R25 at risk of skin PN dated 6/16/15, indicated R25 in the lower gluteal open area fracture on tibia and fibula on ated skin loss was most probably ing and friction. The PN also is incontinent, non weight if a w/c for mobility. In orders included: Apply air to bed due to Braden score of its resulting in an increased risk in, Special Instructions: Check was inflated dated 1/29/16, turn ructions: License staff to ensure in turned and repositioned every ad every two hours when in a nute dated 6/4/15. Change Minimum Data Set 19/16, indicated R25 needed two with bed mobility, transfer and ways incontinent of bowel and not reject cares. Change Care Area Assessment 19/16, indicated R25's cognition or paired, R25 was understood, ands, speech was clear and staff		312	What measures will be into place or systemic changes made to ensuthat the deficient pract will not recur. Nail catreatment order on the eMAR. Licensed staffed document on nail care eMAR. How the facility plans monitor its performant make sure that solutions sustained. Random at eMar documentation we completed monthly x somonths. Include dates when corrective action will be completed. 06/10/	tre ctice re is e will in the to ons are odits of will be ix		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING		the of the state o	05/0	06/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		11	REET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	and as needed bee bowel and bladder During interview w 5/5/16, at 9:53 a.m check R25 for inco Surveyor told RN-lobservations of overchecked and chan surveyor. RN-B stathey could not perfitmely for R25 they On 5/5/16, at 1:33 mostly what to do NA-D stated if a retoilet then the residence with the residence with the residence with heavy fingernails were of untrimmed with brown matter On 5/4/16, at 9:48 got the help, she reduced in wheelch were noted to have with brown matter On 5/5/16, at 7:30	ng, before and after meals, cause of R25's incontinence of the cause of R25's incontinence of R25's incontinenc	F	312			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245310	B. WING		O.F	5/06/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	IP CODE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 312	On 5/5/16, at 11:38 seated on her whe table. R87's finger brown matter under in the dining room licensed practical down the hallway i resident into room her room. LPN-A whose then wheeled mass never offere clean underneathAt 12:24 p.m. a new heel resident out indicated was goin When asked if she shift nursing assist however was not a NA-M verified the underneath. When for trimming the fir know and directed -At 12:29 p.m. reg manager stated reasked about nail or resident bathe was when looking throu Worksheet/Body Abeen marked as trivas no documentar resident refusing rivas surprised their regular nurse work when resident bath verified in March as the seatest and the seatest	brineath. 5 a.m. resident was observed elchair at the dining room nails were still long and had brineath the nails. R87 remained until 11:50 a.m. then observed nurse (LPN)-A wheel resident into her room. When LPN-A got resident indicated it was cold was observed wipe resident if resident to the living room for dithe trim the fingernails or aursing assistant was observed of the living room and got lay her down for a nap. It was assigned to R87 for the teant (NA)-M stated she was a regular caregiver in the unit. In alls were long and dirty asked who was responsible ingernails, NA stated she did not surveyor to LPN-A. Itstered nurse (RN)-A unit nurse sident was challenging when are. RN-A and LPN-A verified is Monday 5/2/16, evening and uph the Shower day undit dated 5/2/16, nails had not immed. RN-A verified there attoin in the progress notes of its was no documentation as a seed Monday evening shifts in/shower was scheduled. RN-A and April 2016, all days been completed nail care had	F3	12		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		
		245310	B. WING	i	- North Str.	05/	06/2016
	PROVIDER OR SUPPLIER			11	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112	ULD BE COMPLE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312	-At 12:38 p.m. LPI documented it was -At 12:48 p.m. RN nurses to docume worksheet or in the bath had been concare should be doacknowledged a resupposed to be for R87's diagnoses is behavioral disturb without complication obtained from the During review of temporary (CAAs) dated 2/4/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	N-A stated "If it's not so not done." -A stated she would expect the nt either in the weekly shower e progress notes if a resident impleted and/or refused and nail cumented if done or not. RN-A esident care plan was llowed. Included dementia without ance, type 2 diabetes mellitus ons and depressive episodes care plan dated 1/28/16. The Care Area Assessments (16, revealed the ADL CAA had)	F	312			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		245310	B. WING			05/0	06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK				STRE 1101 NEV	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 312	Continued From particles of the charge nursed to the charge nursed 483.25(c) TREATM PREVENT/HEAL From the facility who enters	p.m. the assistant director of ated he would expect the staff sident refusal and if there were would have to be care rther stated all staff was the plan of care for residents res. If Fingernails and Toenails 15, directed staff to provide port any problematic conditions e during care. MENT/SVCS TO PRESSURE SORES prehensive assessment of a y must ensure that a resident illity without pressure sores oressure sores unless the condition demonstrates that able; and a resident having beives necessary treatment and the healing, prevent infection and from developing. ENT is not met as evidenced ation, interview and document failed to ensure 1 of 3 residents ure ulcer received timely	F 3				DATE
	3 resident (R166)	the facility failed to ensure 1 of who was identified at being at licers received timely			completed. Resident remains incontinent and requires repositioning every 3 hours.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
	245310	B. WING		05	/06/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENT	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZI 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	P CODE	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
her back on 5/5/16 (two hours and 22 was interviewed, so repositioned every LPN-C stated R25 her care plan and stime, nursing assist repositioned R25 ewhen licensed pract LPN-C repositioned good." At 11:34 a.m. her right side in bet R25's pressure uld assisting. During the observed to have and on her bottom brown substance in pressure ulcer on the ulcer on R25's LPN-B was observed to have and on her bottom brown substance in pressure ulcer on the ulcer on R25's LPN-B was observed to have and on her bottom brown substance in pressure ulcer on the ulcer on R25's LPN-B was observed to have and and an her bottom brown substance in pressure ulcer on the ulcer on R25's LPN-B was observed to have an her bottom brown substance in pressure ulcer on the ulcer on R25's leg and hee chair (tilt and reclination, a small scalation, a	age 22 Justy observed lying in bed on a from 7:21 a.m. until 9:43 a.m. minutes). At 9:23 a.m. LPN-B tated all residents get two hours. At 9:38 a.m., was repositioned according to when needed. At that same stant (NA)-A stated he every two hours. At 9:43 a.m. otical nurse (LPN)-B and d R25, R25 stated, "That feels m. R25 was observed lying on ad with LPN-B finishing up the ers treatments with NA-A the observation, R25 was open sores on her left hip area. Both appeared to have a light in them. LPN-B stated the the left had honey gel in it, and bottom had packing in it. Wed to place bandages over ers and applied tape to secure N-B stated the evening shift eatments for pressure ulcers to al. During transfer to the Broda the positioning chair) at 11:57 was observed on the top of ring the transfers and A stated R25 was repositioned NA-A then proceeded to help hing cares before pushing R25 in her Broda chair to eat. The inuously observed while she at brunch and when she was 25 was moved to another table ng playing for an hour. R25 was		How the facility wother residents hapotential to be affithe same deficient Skin assessment, Etissue Tolerance aupon admission, quanually and with significant change plans are reviewed developed accord these assessment. What measures wointo place or systechanges made to	ill identify ving the fected by t practice. Braden and are done uarterly, a . Care d and ing to s. vill be put	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		ONSTRUCTION		ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER			1101	ET ADDRESS, CITY, STATE, ZIP COD BLACK OAK DRIVE BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 314	lowered R25 back at 2:29 p.m. (R25 for two hours and staff for reposition would be back in the minutes later, the loame into R25's rowisit R25 once a wand lotion. The houst had noticed R25's cushion that provid Broda chair was floack of cushion. The houst received the RC thought R25 needs talk to her case mand one from the fabefore. LPN-B states something was wrand that maintenated R25's careplan date to receive extensive bed mobility every R25's careplan also to reliably notify staff were to assist after meals, on nig R25's careplan date indicated a pressure date and ROHO control of the RC thought R25's mand that maintenate and ROHO control of the R25's mand the R25's man	into her bed with the ceiling lift had been up in her Broda chair 32 minutes with no offer by ing). LPN-B told R25 staff wo hours to reposition her. Five hospice home health aide com, and stated she came to reek, to give R25 a bed bath spice aide was asked if she ROHO cushion (a specialized des pressure relief) in her attened out from the mid to the hospice aide stated she had 0HO cushion flattened but ed a new cushion and would anager about it and added that acility had mentioned it to her ted previously it appeared rong with the ROHO cushion race filled it when necessary. Inted 3/24/15, indicated R25 was we assistance with two staff for two hours and as needed. So indicated R25 was not able aff of need to toilet, and two at R25 upon rising, before and ght rounds and as needed. The reducing mattress on R25's ushion in R25's wheel chair of repositioned according to the medical record revealed R25 e practitioner (NP) on 1/22/16, NP's visit note indicated the ad increased in size on the enter, and the pressure ulcer on	F	314	that the deficient pract will not recur. Use quacare conference schedulidentify residents at risk. How the facility plans to monitor its performance make sure that solution sustained. Random au will be done on resident who identify as requiring repositioning or needs for repositioning. Random audits will be done on patients who identify as requiring repositioning weekly x 4. Include dates when corrective action will be completed. 06/10/2	irterly ule to k. co ce to ns are dits ts eg for n	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		245310	B. WING	i		05/0	6/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK			1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	1 30,33,23,13		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	left leg was slowly	healing. NP's visit note	F	314			
	unstageable Pr unstageable Pr of left lower leg/an of unspecified hee seen by NP for act manage aspiration	re ulcer of sacral region, essure ulcer of left hip, essure ulcer of other site [back kle] stage 4 Pressure ulcer I, unstageable." On 2/19/16, ute visit to evaluate and I, wounds and S/P fracture of sit note indicated pressure ulcer					
	traumatic skin tear	reased in size with a new on R25's left leg. ent dated 2/29/16, indicated eased protein need for wound					
	healing. Nutrition a indicated, "No goa due to hospice sta	assessment dated 3/10/16, I weight for R25 at this time tus-provide food and fluids for n will be free of infection."					
	(MDS) dated 3/19, staff assistance who toilet use, was alw bladder, and did no indicated R25 had skin loss involving	hange Minimum Data Set /16, indicated R25 needed two ith bed mobility, transfer and rays incontinent of bowel and ot reject cares. The same MDS one Stage 3 (full thickness damage to or necrosis of					
St.	but not through, un presents clinically undermining of ad (full thickness skir necrosis of subcur	ue that may extend down to, nderlying fascia. The ulcer as a deep crater with or without jacent tissue) and one Stage 4 n loss involving damage to or taneous tissue that may extend					
	ulcer presents clir without undermini ulcer which was n readmission and t thickness loss in v	nrough, underlying fascia. The nically as a deep crater with or ng of adjacent tissue) pressure ot present upon admission or wo unstageable (full-tissue which the base of the ulcer is nor an eschar and, therefore.					

		AND HUMAN SERVICES				FORM A	05/24/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		245310	B. WING			05/0	6/2016
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE		
BENEDIC	TINE HEALTH CENT	TER INNSBRUCK		NE	EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pathe true depth of the	age 25 ne damage cannot be se are removed) pressure	F	314			
	ulcers, one of thes or readmission. Or	e not present upon admission					
	centimeters (cm) > the Stage 3 pression had been at a le	c 2.6 cm. The MDS revealed ure ulcer had not been present esser stage on prior					
	venous or arterial indicated R25 had	MDS indicated R25 had no ulcers present. The MDS a pressure reducing device for ducing device for bed,					
	turning/repositioni hydration interven Application of non the MDS, R25 had 11/24/15 to 12/7/1	ng program, nutrition or tion, pressure ulcer care and surgical dressings. According to d received physical therapy 5. The MDS indicated R25 e Braden (skin risk assessment)					
·	(CAA) dated 3/19 was severely impousually understan	change Care Area Assessment /16, indicated R25's cognition aired, R25 was understood, ds, speech was clear and staff needs. CAA indicated R25 had					
	open sores on leg weight and health indicated R25 wa bladder and recei toileting. CAA ind	gs, buttocks, had been losing a seemed to be declining. CAA is incontinent of bowel and wed two staff assistance with icated pressure ulcer stage 3 on g 2.2 cm x 2.3 x 0.7; Tunneling					
	1.4 cm from 6-1 c pressure ulcer, ul cm x 2.6 cm x 5.5 remain unchange cm partial thickne	b'clockon the left trochanter instageable, measuring about 2.5 cmOn the lower posterior leged and measured 8.2 cm x 2.6 ess skin lossLeft heel ulcer, asure about 3.4 cm x 4.0 cm.	5				
		ne routine NP monthly visit, NP's					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245310	B. WING			05/0	06/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		110	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112	ECTION (X5) HOULD BE COMPLETI	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETION
F 314	visit note indicated, condition including multiple wound, an comfort." The Nutritional Proindicated R25 had stage 3 since 2/9/1 3/10/16, a pressure	"Resident's declining hospice care, treatment of d plan of care to maintain gress Note dated 4/13/16, pressure ulcer on her coccyx, 6, increased in size since e ulcer on left trochanter,	F3	314			
	left heel, unstageal size since 3/10/16, posterior leg. R25 seen by physic notes indicated, "D expected because	2/19/16, a pressure ulcer on one since 1/18/16, increased in and two wound areas on lower cian on 4/26/16. the physician ecubitus ulcers - Healing not of end stage disease se]. Plan- Continue hospice					
	for R25 indicated F repositioned every did not receive the	ng Assistant Assignment Sheet R25 was to be turned and two hours and as needed. R25 care and services for e NA assignment and care					
	registered nurse (F stated when R25's ulcer was found no pressure ulcer on I 2015 was found wl RN-B stated reside themselves as R25 hours. RN-B stated were completed ev admission, readmi	n 5/5/16, at 9:53 a.m. with RN)-B (facility's wound nurse) cast was taken off a pressure ow healed. RN-B stated the R25's left heel from September hen R25 was repositioned. ents that could not reposition were repositioned every two dissue tolerance assessments very three months, upon ssion and if pressure ulcer verified the facility's tissue					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION		SURVEY PLETED:
		245310	B. WING		· · · · · · · · · · · · · · · · · · ·	05/0	06/2016
	PROVIDER OR SUPPLIEF			1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CONTRACTOR OF THE APPROPRIED	D BE	(X5) COMPLETION DATE
F 314	tolerance assessrindicated at two he had been reddened the procedure for assessment was to no skin redness. In no skin redness and R25's bottom RN-practical, and if I phours repositionin practical," RN-B s R25's left heel was (a slough or pieces from the surface of completed weekly pressure ulcers. Fulcer was found of and was now unstand undermining, pressure ulcer on found upon wound now unstageable left lower outer leg because the immediate for the surface of the s	page 27 Inent completed 8/31/15, purs R25's skin on her buttocks and blanchable. RN-B stated the tissue tolerance to try to get to the time frame of When asked why the facility did any sooner than two hours to dipossible skin breakdown on B stated, "I wanted to be but it any sooner [less than two g] they [staff] will tell me it is not tated the pressure ulcer on a now unstageable with eschare of dead tissue that is cast off of the skin). RN-B stated she wound assessments on R25's RN-B stated a Stage 2 pressure in R25's coccyx on 12/24/15, tageable with slough, tunneling RN-B stated the Stage 2 R25's left trochanter (IT) was drounds on 12/16/15, and was with slough. RN-B stated R25's gressure ulcer developed obblizer was rubbing on R25's about R25's pressure ulcers	F	314			
	developing RN-B feet about and the the pressure ulce RN-B stated "frict caused R25's pre "complex case." Freducing mattress now as the chair I for R25 to sit in. Fwhen the overlay intervention had be she expected stated	stated R25 moves her legs and efriction and shearing caused rs. When asked to re-clarify ion and shearing" is what ssure ulcers and that R25 was a RN-B stated R25 had a pressure and cushion in her Broda chair hospice provided was too hard RN-B was unable to give dates mattress and ROHO cushion been put in place. RN-B stated off to reposition and check R25 every two hours. Surveyor					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY PLETED
		245310	B. WING	i		05/	06/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	1 00/	30,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	observations of over been repositioned to from surveyor. RN-staff if they could not cares timely for R2. On 5/5/16, at 1:33 mostly what to do by NA-D stated if a restoilet then the resid hours with the resid hours with the resid hours. NA-D stated on her body she was brunch. NA-D stated on her body she was brunch. NA-D stated reposition her and on R25 does not want morning then she was consibility for the found flattened. RN ROHO cushion ever asked if the inflatable being monitored by NAs RN-B stated, "full responsibility." Were not checking a "Because I did not cushion flat somed." During an interview plant operations may start the start of the start of the cushion flat somed.	ing two separate continuous or two hours, R25 had not timely without the intervention B stated she had instructed out perform positioning and 5 they were to let RN-B know. In MA-D stated NAs knew by the assignment sheets. Sident does not want to use the ent will be off loaded every two dent standing up for a bit. The standing up for a bit. Th	F	314			
		on 5/5/16, at 3:41 p.m., the stated the therapy department					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245310	B. WING			05/0	6/2016
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	ROHO cushions a putting the informal monitoring. She sileducation on how the bottom of the check for inflation record and medicated and medicated and medicated 2003, Instruincluded 16 steps possible level of patisfaction for the cushion instruction Height Wiggle fine approximately ½ bottom. Caution: a cushion is most eletween all parts the person has be repeat the processindicated, "Pleased daily to ensure the and to assure the Undated policy Pleased and the steps of the cushion is most eletween the processindicated, "Pleased daily to ensure the and to assure the Undated policy Pleased and the cushion is most eletween all parts the person has be repeat the processindicated, "Pleased daily to ensure the and to assure the Undated policy Pleased and the cushion and skin followed for all reserved."	ow how much to inflate the and nursing is responsible for ation in the treatment record for atted nursing receives to measure the space between seat and the ischial tuberosity to. A review of R25's treatment ation record indicated there was or check for inflation of the astructions provided by therapy actions for Adjustment indicated for achieving the highest performance and personal are ROHO cushion. Step 16 of the ins indicated, "Check Cushion gers to make sure there is inch of air between person and Avoid [bottoming out]. The affective when there is air of the person and the chair. If the person and the chair. If the person and the chair is also be sure to check the cushion at you have not [bottomed out], cushion is properly adjusted." The same instructions also be sure to check the cushion at you have not [bottomed out], cushion is properly adjusted." The same instructions also be sure to check the cushion at you have not [bottomed out], cushion is properly adjusted." The same instructions also be sure to check the cushion at you have not [bottomed out], cushion is properly adjusted." The same instructions also be sure to check the cushion at you have not [bottomed out], cushion is properly adjusted." The same instructions also be sure to check the cushion at you have not [bottomed out], cushion is properly adjusted."		314			
		p to every 2 hours while in bed 2 hour when in a chair."					

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		245310	B. WING			05/0	06/2016
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
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F 315 F 315 SS=D	483.25(d) NO CAT RESTORE BLADE Based on the residents who enter indwelling catheter resident's clinical of catheterization was who is incontinent treatment and sent infections and to refunction as possib This REQUIREMED by: Based on observatives, the facility services with toiled residents (R166) residents (R	HETER, PREVENT UTI, DER dent's comprehensive acility must ensure that a is the facility without an is not catheterized unless the condition demonstrates that is necessary; and a resident of bladder receives appropriate vices to prevent urinary tract estore as much normal bladder	FS			nt s or	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245310	B. WING	ì		05/	/06/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
					potential to be affected	by	
F 315	Continued From page 31			315	the same deficient prac	tice.	
	R166 at 11:45 a.m.	NA-F stated R166 had voided			All residents are assesse	d on	
	on the toilet and was to be toileted every two hours.				admission, quarterly,		
	nours.	t 12:35 p.m. on 5/4/16, R166 was seen sitting at			annually and with signif	cant	
					change for appropriate	care	
	entered in and out	ole drinking some juice. NAs of the dining room and had not			and service allotment.		
	approached R166	or tolleting.			What measures will be	put	
		y staff asked nurse at the			into place or systemic		
	nurse's station if R166 had an appointment for the afternoon. When the nurse said no, activity				changes made to ensur	е	
		en the nurse said no, activity about attending activity and			that the deficient pract	ice	
		ut toileting pushed R166 down			will not recur. We will		
		evator and upstairs to the			continue to assess all		
		22 p.m. an activity staff sat assisted R166 to put gloves			residents on admission,		
		king bird seed. At 1:47 p.m.			quarterly, annually and		
	same staff assiste	d R166 to wipe off her hands			significant change for		
		ice cream sundae. At 2:06 lice cream and staff help R166			appropriate care and se	rvice	
	put a new pair of g	loves on to help press bird at 2:36 p.m. staff helped R166			allotment.		
	take her gloves off	. 2:39 p.m. R166 said to staff, me, but I do not want to drive.			How the facility plans t		
		6 to clean her hands and			monitor its performan		
		neelchair down the hall, into the			make sure that solutio		
		to the nurse's station on first reported to LPN-D that her			sustained. All resident	s are	
		iting the ice cream. LPN-D			assessed on admission	with	
		the pain and R166 reiterated			subsequent care confe	ences	
		n eating something cold. The ator (HUC) was sitting there			as needed to assess ne	eds	
	and asked R166 if	she wanted to see the dentist			and services.		
	•	led, "I was going to see the					
		S continued to sit up near the 2:49 p.m. NA-F came walking			Include dates when		
		the nursing station and stood.			corrective action will b		
		hen B166 was going to be			completed. 06/10/	2016	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i .		E CONSTRUCTION		E SURVEY PLETED
		245310	B. WING			05/0	06/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	toileted next and N going home at 3:00 time the next shift going to toilet R166 toilet R166. At 2:50 R166 had not beer and asked if she w surveyor. LPN-D si she expected R166 when she laid dow laid down today be stated R166 laid dorisk for pressure ull At 2:54 p.m. LPN-I the toilet and sink a R166 dribbled urin confirmed R166's that the yellow line LPN-D stated R166 (It had been three when NA-F said sh LPN-D and survey be non-smooth, all and LPN-D stated just reddened, kind skin nurse had loo treatment to R166' was toileted after roame back from ac stated the NA shou to get R166. After NA-F stated R166 had to go to the battime frame for toile knew she had wen going to wait until stated the NA should be shou	A-F answered that she was 0 p.m. NA-F was asked what coming on and if they were 3 and NA-F stated she would 0 p.m. surveyor notified LPN-D on toileted for over two hours ould look at R166 with stated yes she would and that 3 to be toileted after meals or on. LPN-D stated R166 had not cause of the activity. LPN-D own because she would be at cer. D and NA-F stood R166 up at and removed R166's brief as the while standing. LPN-D orief was wet with urine and on the brief was now blue. So brief was "moderately wet." thours and eight minutes from the had last toileted R166). For observed R166's bottom to reddened on both buttocks R166's bottom was not open, dof chronic for her and that the ked at it. LPN-D applied shottom. LPN-D stated R166 neals, and that R166 usually ctivity at 2:00 p.m. LPN-D uld have went up to the activity toileting R166 at 3:00 p.m. could not tell NA-F when she atthroom. When asked about the sting R166, NA-F stated, "It for exercise, but I was just		315			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		LE CONSTRUCTION	COMPLETED	
		245310	B. WING	i		05/0	6/2016
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	of dementia, was a need to toilet, and needs. R166's car incontinent productores, mobility, toi incontinence. Sho skin to remain interest two hours and as The Care Area As dated 11/25/15, in assistance with care and bladder incomproduct and receive every shift for previndicated R166 has and w/c cushion for breakdown. The Completed in February to anticipate R166 determine any voith the eday bowel a completed in February and was at ulcers. The MDS turning/reposition incontinent of bow a toileting program R166 needed externs ferring, locor	ressure ulcers, had a diagnosis unable to reliably notify staff of staff was to anticipate R166's eplan indicated R166 wore an et, needed assistance with leting and bowel and bladder at term goal for R166 was for act and free of redness. The d R166 was to be toileted every		315			
		3.					

	OF DEFICIENCIES F CORRECTION			(X3) DATE SURVEY COMPLETED			
		245310	B. WING	-10		05/0	06/2016
	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE I 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	Review of Nursing 4/26/16, PN indica open area on the of 4/27/16, progress poor skin integrity and redness on Poor R166 indicated morning. R166's progress and Clotrimazole of bottom three times May 2016 Treatmendicated R166 had Clotrimazole crear. The undated Nurs for R166 indicated was a w/c and R16 indicated with one as sheet did not indicated with one as sheet did not indicated staff to greposition or toilet resident." ADON spattern had a spensense, if the voiding why every two how ADON stated the say something ab and should reflect briefs staff can tel color at a certain progression and should reflect briefs staff can tel color at a certain progression or toil and should reflect briefs staff can tel color at a certain progression and should reflect briefs staff can tel color at a certain progression and should reflect briefs staff can tel color at a certain progression.	Progress Notes (PN) included: ted R166 had a red and small coccyx. note PN indicated R166 had and some areas of excoriation 166's bottom. O16 Physician Orders reviewed R166 received Lasix every physician orders also indicated rrier cream, antibiotic ointment cream (antifungal) to R166's and aday for redness. R166's ent Administration Record dereceived the barrier cream, and antibiotic ointment. Sing Assistant Assignment Sheet R166's mode of transportation 66 was to be transferred and essistance of staff. The NA eate how often R166 was to be leted. With acting director of nursing at a 3:13 p.m. ADON stated he go and ask the resident to a staff "should approach the stated if the resident's voiding cific pattern it might make and did not show a pattern that is surs toileting was assigned. NAs assignment sheets should out toileting and repositioning the care plan. ADON stated the I when wet the line changes		315			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CON		(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/	06/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1101 BI	ADDRESS, CITY, STATE, ZIP CODE LACK OAK DRIVE BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 315 F 323 SS=D	policy provided by the Living. 483.25(h) FREE OHAZARDS/SUPEFThe facility must end environment remains is possible; and	the facility for Acitivities of Daily FACCIDENT	F3		F323 D The facility did rensure adequate supervision for 1 of 1 resident (R217) reviewe accidents.		
	by: Based on interview facility failed to pro 1 of 1 residents (R behaviors directed Findings include: R21's admission h 11/19/15, indicated and "quite a few be a bit of difficulty wit R21's face sheet in included dementia temporary care play behavior or mood of R21's admission M 12/2/15, indicated transfers, toileting, ambulated with standated 12/14/15, indicated	NT is not met as evidenced v and document review, the vide adequate supervision for 21) who displayed negative at other residents on the unit. Istory and physical dated R21 had advanced demential ehaviors disturbances and quite the delirium as well." A review of adicated diagnoses that with behavioral disturbance. Aun, undated indicated no concerns. Inimum Data Set (MDS) dated the required assistance for dressing and grooming, and aff supervision. A care plan dicated the was severely d, had potential for pain related			How corrective action of be accomplished for the residents found to have been affective by the deficient practice. The residents had an altercat with another patient that not result in any injury to either resident. Subseque documentation following altercation did not show changes in resident's baseline. All resident to resident altercations will documented on for 72 her by nursing.	ion t did ent any	

	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING					(X3) DATE SURVEY COMPLETED	
		245310	B. WING		144	05	/06/2016
	PROVIDER OR SUPPLIE			11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	to a history of shot incontinent of bow demonstrated soot behaviors that incommon areas, at throughout the fastaff to administe medication used assess whether tresidents and into calm approach, at review of Bene Innsbruck Residents. On 11/restless, wanderiand pulling down naked and walke Progress Note da could not keep hinote further indicate kitchen" and 12/2/15, R21 was times." A Progres when staff attem mad and agitated 12/8/15, indicate the hallway, a su indicated R21 was into other resider personal items at times" trying to he R21 defecated or room. A noted da constantly taking	page 36 bulder and back pain, wel and bladder, and bladder, and bladder physical aggression other residents, undressing in and defecating on the floor cility. The care plan directed r PRN (as needed) Ativan (a to treat anxiety disorders), he behavior endangered other ervene if needed, maintain a and redirect with a therapy doll. dictine Health Center at ent Progress notes dated 12/23/15, indicated R21 sion directed toward other 27/15, R21 was noted as ng into other residents rooms, bedding. Resident stripped d into hallway six times. A ated 11/28/15, indicated R21 is clothes on the entire shift. The ated he "jumped over the rail in urinated in the garbage can. On a described as "combative at as Note dated 12/4/15, indicated pt to re-direct R21 he "gets very d and tries to hit." A note dated d R21 was found on the floor in bsequent note dated 12/8/15, as wandering through the unit, as observed a "couple of it other residents. On 12/9/15, a a chair in another resident's ated 12/13/15, indicated R21 was off his clothes, combative with ned a window and pushed the		323	How the facility will ident others residents having the potential to be affected by the same deficient practice. All residents will be identified by assessments quarterly, annually, upon admission and with significant change. Appropriate interventions will be documented if required. What measures will be printo place or systemic changes made to ensure that the deficient practice will not recur. All resident will be identified by assessments quarterly, annually, upon admission and with significant changes and with significant changes and with significant changes and with significant changes. Appropriate intervention will be documented if required. How the facility plans to monitor its performances.	ne Dy ce. S ut ee ats	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245310	B. WING			05	/06/2016	
	PROVIDER OR SUPPLIER		1101		TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 323	personal belonging went into the clear the floor, wrapped the cabinet. On 12 glasses off R14 ar interdisciplinary te indicated staff wow Progress Note dat walking the halls a room, punched R1 into the wall unit for and fall. R14 susta and a scratch to hindication of intervedirect R21. R21 room and returned Progress Note dat tried to break dow food at other residents walker at table shaking his was discharged from A Benedictine Heassessment of Beaggressive/combaindicated R21 gragrabbed the glass The evaluation of continue monitorisafe. Plan of care Health Center at Behavior And Mocombative behaving R21 had an alterepunched him in the same care the same combative behaving R21 had an alterepunched him in the same care the s	arted pushing other resident's gs out of the window. He also he linen room and defecated on it in a washcloth and put it in 1/14/15, R21 grabbed the he grabbed R14. An am (IDT) review of the behavior ald continue to monitor R21. A led 12/16/15, indicated R21 was at 5:15 p.m., entered R14's led in the face and pushed him orcing R14 to lose his balance ained a laceration to his wrist is forehead. There was no rentions attempted by staff to was sent to the emergency diseveral hours later. A led 12/19/15, indicated R21 in a door and threw juice and lents. A subsequent Progress 1 attempted to throw another at him and moved from table to fist. Staff called 9-1-1 and R21	F	323	make sure that solutions sustained. Random audit will be completed once patient altercation has be identified by nursing staff ensure that 72 hour documentation has occur lnclude dates when corrective action will be completed. 06/10/20	ts een f to rred.		

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
		245310	B. WING	i	- Andrew -	05/0	06/2016
	PROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From p	age 38	F:	323			
	interventions was returned to the fact and no new orders upon discharge from A review of R21's History dated 11/2 and order for Ativa hours as needed, administered once displayed signs of month of September plan identified potential in toileting, there was essed the need urinated and defeat and removed his contact of the fact of	Medication Administration 5/15 through 12/1/15, indicated in 0.5 milligrams (mg) every six however the Ativan was only on 12/17/15 even though R21 anxiety almost daily during the per. Further, while R21's care ential for pain and an alteration was no evidence the facility d for toileting when R21 cated in inappropriate areas clothing, nor was there evidence ed the need for pain medication					
	registered nurse (the facility in Nove some confusion, s displayed aggress residents. RN-As negative behavior not updated, but s when R21 was ou During an intervie assistant director R21's altercation sent to the hospita trying to place him back from the em stated if a residen	w on 5/5/16, at 9:15 a.m., RN)-A stated R21 admitted to ember 2015. She stated he had sudden changes in behavior and sive behaviors toward other tated after R21 displayed s on 12/8/15 his care plan was stated staff attempted redirection t of his room. w on 5/5/16, at 9:48 a.m., the of nursing (ADON) stated after with another resident he was al. He stated the facility was in the hospital but he was sent ergency room. The ADON it goes to the hospital for a few lo anything different." He stated					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05,	/06/2016
	PROVIDER OR SUPPLIER			1101 BLACK (ESS, CITY, STATE, ZIP CODE DAK DRIVE ITON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF CORRE IH CORRECTIVE ACTION SH 3-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 323	assessments but rebehavioral episode come up and we be plan for that." R14's quarterly MI was severely cognassistance with all care plan dated 2/vulnerable adult reand directed staffensure safety and abuse. Although R14 was an incident on 12/and grabbed his gwhen R21 puncher R14's Benedictiner Resident Progress 12/24/15, did not a facility event form notes indicated Rascratch on 12/14 face on 12/14/15, there was monitoring for injurbeen a victim of a there was no care protect R14 from During an interview and incident form a During interview of ADON stated their	ents are used for quarterly not following individual es. The ADON stated "if things secome aware of it, we will care DS dated 11/29/15, indicated he notively impaired and required activities of daily living. R14's 24/15 identified him as a elated to cognitive impairment to follow his plan of care to monitor for symptoms of identified as the victim during 14/15, when R21 grabbed him lasses, and again on 12/19/15, and him in the face, a review of a health Center at Innsbruck is Notes dated 12/11/15 through reflect either incident, nor was a completed even though R21's 14 sustained and laceration and 14/15, and was punched in the Following the incident on as no evidence of follow up or ares. Further, while R14 had buse on two separate dates, a planned interventions to		323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/0	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		STREET ADDRESS, CITY, 1101 BLACK OAK DRIV NEW BRIGHTON, MN	'E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTIO CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329 SS=D	further stated, the missed it and the imissed it and in program. The policitrack symptoms are documentation on interventions were the behavior Mana behaviors on the transport of the imissed in duplicate therapy); without adequate reduced in indications for its unadverse conseques should be reduced combinations of the Based on a compresident, the facility who have not used given these drugs therapy is necessary as diagnosed and record; and reside drugs receive grace behavioral interversidents.	d Benedictine health Center at or Management Process, dated ewed. The policy indicated the policy directed staff to Monitor and policy directed staff to Monitor and policy directed staff to Monitor and policy indicated the policy directed staff to Monitor and the program and track eatment sheet. EGIMEN IS FREE FROM DRUGS The program is any excessive dose (including or for excessive dose (including or for excessive duration; or monitoring; or without adequate se; or in the presence of noces which indicate the dose or discontinued; or any	F3	F329 D T ensure P recomme followed residents How corr be accorr residents been affe deficient measures place for based on	The facility did not tharmacy endations were I up on 2 of 5 of (R153, R85) rective action will explished for those of the practice. Correct is have been put in affected resident last pharmacy endation report.	l e ive	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING		05/0	06/2016	
	PROVIDER OR SUPPLIER CTINE HEALTH CEN			110	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	Continued From p	page 41	F;	329			
	by: Based on intervier facility failed to present antipsychotic media effectiveness for for unnecessary resolution for unnecessary resolution facility failed to acrecommendation reviewed for unnecessary reviewed for unnecessary resolutions include: R85's diagnoses multiple sclerosis anxiety disorder and Resident's face serview of R85's for Halog medication) 2 mill instructions to give daily. Review of R85's record/treatment (MAR/TAR) dated evidence of docuside effects and emedication.	ENT is not met as evidenced aw and document review, the ovide monitoring for dication side effects and 1 of 5 residents (R85) reviewed nedications. In addition the 1 upon consulting pharmacist's for 1 of 5 residents (R85) eccessary medications. Include but not limited to 1, adult personality disorder, and hypertension obtained from the dated 5/6/16. Physician Order Report dated evealed a physician order dated period (an antipsychotic digram (mg) per milliliter (ml) with 1 administration record 1 2/1/16 through 5/6/16, lacked mentation for monitoring the effectiveness of anti-psychotic			make sure that solutions are sustained. Random audits will be completed once patient altercation has been identified by nursing staff to ensure that 72 hour documentation has occurred Include dates when corrective action will be completed. 06/10/2016 F329 D The facility did not ensure Pharmacy recommendations were followed up on 2 of 5 residents (R153, R85) How corrective action will be accomplished for those residents found to have been affective by the deficient practice. Corrective measures have been put in place for affected residents based on last pharmacy recommendation report.	1.	
	II.	medical record revealed acist communication to nursing					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING	i		05/0	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	. ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPERTION (CROSS-REFERENCE)	D BE	(X5) COMPLETION DATE
F 329	Haloperidol. However lacked evidence the recommendations staff. During interview or practical nurse (LP locate anti-psychotanywhere in R85's During interview or registered nurse (Fwas no side effect anti-psychotic med record. During interview or assistant director of expected residents to be monitored for document in the rethat R85's medical effect monitoring for the expectation is consulting pharma ADON was asked recommendation for Haloperidol were in the was not sure if Facility's policy for monitoring and conwas requested but 483.35(i) FOOD P	16 and 4/1/16, with or side effect monitoring for yer R85's medical record at the consulting pharmacist's were acted upon by the facility in 5/5/16, at 12:10 p.m. licensed N)-G verified, was unable to ic side effect monitoring sheet medical record. 15/6/16, at 8:37 a.m. RN)-C, acknowledged there monitoring in place for ication in R85's medical in 5/6/16, at 11:27 a.m. the of nursing (ADON) stated he is on psychotropic medications in side effects and nurses are to esident's TAR. ADON verified record lacked evidence of side for Haloperidol. ADON stated that the facility to act upon the cist's recommendations. When if consulting pharmacist or side effect monitoring for not acted upon, ADON stated they were. antipsychotic medication insulting pharmacist reviews in one provided.		371	others residents having the potential to be affected by the same deficient practice. The pharmacy visits monthly and recommendations will be printed off and taken to each neighborhood. Printed off recommendations will be placed in MD/ NP folder and will be addressed by each provider. All external providers will be faxed to by our Health Unit Coordinators. The pharmacy provides a monthly update on recommendations that were addressed and pending recommendations. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The pharmacy provides a monthly update on recommendations that were addressed and pending recommendations that were addressed and pending recommendations that were addressed and pending recommendations.	/	

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		245310	B. WING			05,	/06/2016
	PROVIDER OR SUPPLIER			110	REET ADDRESS, CITY, STATE, ZIP CODE D1 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	considered satisfa authorities; and	rom sources approved or actory by Federal, State or local, distribute and serve food	F	371	How the facility plans to monitor its performance to make sure that solutions ar sustained. Findings of pharmacy review will be reviewed by quality council every 3 months.	e	
	by: Based on observereview, the facility procedures were possibility of food kitchen and in 3 of potential to 98 of fluids out of 3 of 4 kitchen Findings include Main kitchen On 5/3/16, at 11:4 initial kitchen tour (RD) and culinary the ovens of the 1 heavily soiled with Both the RD and clean and the coot the ovens recentled. The dishwasher white flaky poroud dishwasher chute	ation, interview, and document failed to ensure food sanitation followed to minimize the borne illness in the main of 4 kitchenettes. This had the 99 who were served food and/or kitchenettes and the main with the registered dietician of service cook both the inside of four burner stove were observed in black baked on substances. Cook verified the ovens were not obtained by was observed to have a light is lime build up inside the elair vent on the clean side. The bose/flaky with touch.			F371 E The facility did not ensure food sanitation procedures were followed the main kitchen and 1 of kitchenettes. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No resident was affected negatively. The oven in the kitchen was cleaned that day. The dishmachine ver	d in 4 I e	

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	245310	B. WING		05/0	06/2016	
PROVIDER OR SUPPLIER	TER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE	
On 5/3/16, at 5:06 and district manag flaky build was lime had a de-liming so stated she did not of her full time stafnot have any logs. The Villa Unit On 5/4/16, at 8:54 kitchenettes tour will district manager at -A ice scoop was comachine next to the DM and district may was not supposed and further stated where the scoop will when DM and distant observation may family member was glass to obtain ice use the scope at a sticky stain of juice verified. DM stated the area. On 5/6/16, at 7:50 done the job for midentified she was indicated other desired.	p.m. the dietary manager (DM) er verified the white porous e. When asked if the facility hedule for the dishwasher, DM have a schedule but had one f who cleaned it however did for cleaning the dishwasher. a.m. to 9:23 a.m. the vas completed with DM and the nd the following were observed: be refrigerator in the kitchenette. anager verified stated the scoop to be left inside the machine there was a scoop holder vas to be stored after each use. trict manager were informed of ade 5/3/16, at 4:25 p.m. when a is observed use a drinking both stated everyone was to all times. The summander were informed of a conserved with a large brown dried the erved with a large brown dried the DM and district manager dispersed by and district manager and housekeeping was to clean a.m. the DM indicated she had any years and with the issues well aware of them however partments were responsible for	F3	negatively. The oven in the kitchen was cleaned that day. The dishmachine ver was also cleaned that day. Villa (only 19 of 105 residents): ice machine scoop signed and labeled. Shelf scrubbed that day. Cleaning schedules have been updated and meetin with staff to educate them on new procedures have been completed. How the facility will ident others residents having the potential to be affected by the same deficient practice. Weekly checklist will be completed and reviewed manager. What measures will be provided in the same deficient practice changes made to ensure that the deficient practice will not recur. Manager will not recur. Manager will not recur.	gs ify ne vy ce. by		
-		F4	· •			
	Continued From particles of the full time staff not have any logs. The Villa Unit On 5/4/16, at 8:54 kitchenettes tour with district manager and have any logs. The Villa Unit On 5/4/16, at 8:54 kitchenettes tour with district manager and have any logs. The Villa Unit On 5/4/16, at 8:54 kitchenettes tour with district manager and have any logs. The Villa Unit On 5/4/16, at 8:54 kitchenettes tour with district manager and have any logs. The Villa Unit On 5/4/16, at 8:54 kitchenettes tour with district manager and have any logs. The Villa Unit On 5/4/16, at 8:54 kitchenettes tour with district manager and have any logs. The cacop was on the second where the scoop with the scoop with the scoop with the scoop and further stated where the scoop with the scoop and further stated where the scoop with the scoop and further stated where the scoop with the scoop and further stated where the scoop with the scoop and further stated where the scoop with the scoop and further stated where the scoop with the scoop and further stated where the scoop with the scoop and further stated where the scoop with the scoop	PROVIDER OR SUPPLIER CTINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 On 5/3/16, at 5:06 p.m. the dietary manager (DM) and district manager verified the white porous flaky build was lime. When asked if the facility had a de-liming schedule for the dishwasher, DM stated she did not have a schedule but had one of her full time staff who cleaned it however did not have any logs for cleaning the dishwasher. The Villa Unit On 5/4/16, at 8:54 a.m. to 9:23 a.m. the kitchenettes tour was completed with DM and the district manager and the following were observed: -A ice scoop was observed inside the small ice machine next to the refrigerator in the kitchenette. DM and district manager verified stated the scoop was not supposed to be left inside the machine and further stated there was a scoop holder where the scoop was to be stored after each use. When DM and district manager were informed of an observation made 5/3/16, at 4:25 p.m. when a family member was observed use a drinking glass to obtain ice both stated everyone was to use the scope at all times. -The cabinet shelves underneath the juice machine was observed with a large brown dried sticky stain of juice. DM and district manager verified. DM stated housekeeping was to clean the area. On 5/6/16, at 7:50 a.m. the DM indicated she had done the job for many years and with the issues identified she was well aware of them however indicated other departments were responsible for the cleaning which she had gotten tired of asking.	PROVIDER OR SUPPLIER CTINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 On 5/3/16, at 5:06 p.m. the dietary manager (DM) and district manager verified the white porous flaky build was lime. When asked if the facility had a de-liming schedule for the dishwasher, DM stated she did not have a schedule but had one of her full time staff who cleaned it however did not have any logs for cleaning the dishwasher. 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On 5/6/16, at 7:50 a.m. the DM indicated she had done the job for many years and with the issues identified she was well aware of them however indicated other departments were responsible for the cleaning which she had gotten tired of asking.	PROVIDER OR SUPPLIER CTINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 Con 5/3/16, at 5:06 p.m. the dietary manager (DM) and district manager verified the white porous flaky build was lime. When asked if the facility had a de-liming schedule for the dishwasher. The Villa Unit On 5/4/16, at 8:54 a.m. to 9:23 a.m. the kitchenettes tour was completed with DM and the district manager and the following were observed: -A ice scoop was observed inside the small ice machine next to the refrigerator in the kitchenette. DM and district manager verified stated the scoop was not supposed to be left inside the machine and further stated there was a scoop holder where the scoop was to be stored after each use. When DM and district manager were informed of an observation made 5/3/16, at 4:25 p.m. when a family member was observed with a large brown dried sticky stain of juice. DM and district manager verified. DM stated housekeeping was to clean the area. On 5/6/16, at 7:50 a.m. the DM indicated she had done the job for many years and with the issues identified she was well aware of them however indicated other departments were responsible for the cleaning which she had gotten tired of asking.	245310 245310 3 WING THEORIDER OR SUPPLIER TINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAY BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TO 5/3/16, at 5:06 p.m. the dietary manager (DM) and district manager verified the white porous flaky build was lime. 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DM and district manager verified 2 she had done the job for many years and with the issues identified she was well aware of them however indicated other departments were responsible for the cleaning which she hed gotten tired of asking.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/06/2016	
	PROVIDER OR SUPPLIER	ER INNSBRUCK		11	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112	•	
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F 431 SS=E	The facility must er a licensed pharmacof records of receip controlled drugs in accurate reconciliar records are in order controlled drugs is reconciled. Drugs and biologic labeled in accordar professional principappropriate access instructions, and the applicable. In accordance with facility must store a locked compartme controls, and perminave access to the The facility must propermanently affixed controlled drugs list Comprehensive Drugs and controlled drugs list Comprehensive Drugs ackage drug districted drugs districted access to the package drug districted drugs list of the package drug drugs list of the packag	and that an account of all maintained and periodically and include the cory and cautionary are expiration date when state and Federal laws, the all drugs and biologicals in the sunder proper temperature it only authorized personnel to keys. Tovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs single unit ibution systems in which the ninimal and a missing dose can	F 4	131	Include dates when corrective action will be completed. 6/10/2016 F431 E The facility did not ensure expired medications were promptly removed from use. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No resident was identified as being affected by the use of expired medication. Medication was immediately removed from circulation and all medication carts were examined for expired medications. All nurses involved in medication administration will check expiration dates as a part of their practice prior to giving medication.	,	
		tion, interview, and document					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245310	B. WING	i		05/	06/2016
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO , (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	expired Mantoux semedication refrige that they were not the facility failed to were removed from medication carts. Findings include: Villa Unit During medication at 1:08 p.m. a multiple solution for deternation tuberculosis) was refrigerator. The vibeen opened or dispersion of the vialent that the medication at 1:53 p.m. three the medication reduced as opened printed on the vialent dated as opened printed on the vialent dates the Aplison stated, "It did not opened. The vialent dates were as the vialent dates the vialent dates the vialent dates the vialent dates. The vialent dates the vialent dates. The vialent dates the vialent dates. The vialent dates the vialent dates the vialent dates. The vialent dates the vialent dates the vialent dates.	failed to ensure undated or solution was removed from rators for 3 of 4 units to ensure used on residents. In addition, of ensure expired medications on the medication cart for 1 of 3 of 4 units to ensure used on residents. In addition, of ensure expired medications on the medication cart for 1 of 3 of 4 units and the medication of 5 of		431	How the facility will identify others residents having the potential to be affected by the same deficient practice. All nurses involved in medication administration will check expiration dates a part of their practice prior to giving medication. What measures will be purinto place or systemic changes made to ensure that the deficient practice will not recur. Pharmacy nurse consultant complete quarterly pharmaceutical audit and checks all fridge and medication carts throughout the facility. Ni nurse will check medication carts and fridge on their neighborhood weekly on Fridays and remove any expired medications.	es as r t es as	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			 05/0	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		11	REET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 431	2:37 p.m. an undat the medication refr printed on the vial v (RN)-C verified that dated when opened for 30 days after opened. Yes we have Afluria influenza variedication refriger opened on it. The evial was 6/5/16. RN dated when opened year after it has be During a medication 8:18 a.m. LPN-G to (mg) bottle from the that Senna 8.6mg on the bottle. LPN-bottle labelled Sen expired and had almedication cart ware medication and an labelled calcium whom the cart with an verified the bottle labelled some of tablets in it. During interview of director of nursing good for 30 days a expect the nurses it. I helped give all we dated all vials vi	room observation on 5/4/16, at ed vial of Aplisol was found in igerator. The expiration date was 1/21/18. Registered nurse it the Aplisol had not been d. RN-C said, "Aplisol is good bened. This should have been e used it." A multi-dose vial of occine was found in the ator. There was no date expiration date printed on the I-C verified the Afluria was not d and said, "It is good for a en opened, I guess." In observation on 5/5/16, at book out Senna 8.6 milligrams are medication cart and noted had an expiration date of 6/15 G verified the medication na 8.6mg was open, had bout half tablets left in it. The as checked for expired open medication bottle with vitamin D 600mg was noted expiration date of 4/16. LPN-G abelled calcium with vitamin D had expired and had about 3/4 an 5/4/16, at 3 p.m. the assistant (ADON) stated, "Aplisol is ofter it has been opened. I to date the vial when they open the Flu vaccines this fall. I think when we opened them. I am not a rare good for after opening. I		431	How the facility plans to monitor its performance make sure that solutions sustained. Pharmacy nu consultant completes a quarterly pharmaceutica audit and checks all fridg and medication carts throughout the facility. Nurse will check medicat carts and fridge on their neighborhood weekly an remove any expired medications. Pharmacy remove at quality counquarterly. Include dates when corrective action will be completed. 06/10/2	e to s are rse l les light ion urse pe	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	ER INNSBRUCK		11	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
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F 441 SS=C	expectation is all e removed from the Policy for medicativials was requested. Undated Flu Vacci McKesson Medica facility instructed smulti-dose vial and be discarded after. Par Pharmaceutic revised 7/2015 inst than 30 days shou oxidation and deg potency." The package inse 7/27/10, directed smulti-dose vial, shwithdrawing each immediately. Betwith degrees Fahrenhet the stopper has be discarded within 2483.65 INFECTION SPREAD, LINENS Infection Control is safe, sanitary and to help prevent the of disease and in (a) Infection Control (a) Infection	Sa.m. ADON stated the expired medications to be residents' supply. on storage and dating of Aplisol and but not provided. ne Storage Instructions from all Surgical provided by the staff, "Once entered, and any residual contents should 28 days." all Aplisol package insert structed staff "Vials in use more all doe discarded due to possible radation which may affect aff "When using the lake the vial thoroughly before dose, and administer the dose ween uses, store the vial at 36 leit (F) to 46 degrees F). Once leen pierced, the vial must be 28 days. " ON CONTROL, PREVENT Sestablish and maintain an Program designed to provide a discomfortable environment and the development and transmission fection. Tol Program	F	441	F441 D The facility did rensure adequate disinfection of blood gloom monitors for 2 of 2 resion (R275, R7) residing on a residents on 2of 4 units thow corrective actions be accomplished for the	ucose dents 2 of 5 s. will	
	The facility must	establish an Infection Control			ne accompniance for the		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED		
		245310	B. WING		05	/06/2016
	PROVIDER OR SUPPLIER	FER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP (1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	 	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 441	in the facility; (2) Decides what personnel must hat ransport linens so infection. This REQUIREME by: Based on observations in the facility in the facility must be compared to the residen of the facility must be compared to the facility must be compared to the facility must be compared to the facility must be from direct contact will the facility must be facility must be formed to the facility must be facilit	ich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective infections. ead of Infection ction Control Program resident needs isolation to d of infection, the facility must t. est prohibit employees with a lease or infected skin lesions t with residents or their food, if rransmit the disease. est require staff to wash their direct resident contact for which idicated by accepted	F 4	residents found to he been affective by the deficient practice. E was provided per pokeep device wet with disinfectant product minute. How the facility will others residents have potential to be affect the same deficient proper policy proceed being followed. What measures will into place or system changes made to enthat the deficient pwill not recur. Randomorthly audits will conducted to ensur policy procedure is followed monthly x	ducation licy to for a full identify ving the cted by oractice. dits will sure dure is I be put nic nsure ractice lom be e proper being	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/0	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112	1	9,200
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	(LPN)-A was obser check for R275. LP the glucometer for disinfectant wipe, a R275 cleaned the f squeezed a drop of then told R275 his observed get back stationed across from disposed of the use glucometer for 10 swipe and put a dry small rectangular to supplies on the top Glucometer was not LPN-A then removed -At 8:16 a.m. LPN-always cleaned the a few seconds around where the stripe was acknowledged did full minute as indicated buring observation on 5/3/16, at 3:49 pcomplete a blood sobtaining a blood swiped the glucomedisinfectant wipe for glucometer back or sugar supplies on the LPN-F removed he hygiene and went to prepare medicated After 10 seconds the completely dry.	a.m. licensed practical nurse ved complete a blood sugar N-A applied gloves cleaned 15 seconds using a Oxivir Tb pplied a stripe, approached inger then punctured it and blood into the stripe. LPN-A reading was 174. LPN-A was to the medication cart om the dining room and ed supplies then wiped the seconds with the Oxivir Tb glucometer away inside a ote with all the blood sugar drawer of the medication cart. Ot visibly wet for one minute. Ed gloves and washed hands. A stated before and each use glucometer with the wipes for and the screen and the area	F	41	How the facility plans to monitor its performance to make sure that solutions are sustained. Audits will be reviewed at Quality Council quarterly. Include dates when corrective action will be completed. 06/10/2016		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/0	06/2016	
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 441	cleaned with the O five minutes and it residents. When as was disinfected wit wipes between res aware for how long cleaned with Oxivir verified did not ens remained wet with minute. During interview or assistant director of expectation is for s and ensure that the remained wet with minute. Oxivir Tb Wipes *\Fungicidal. Tubero container directed Cleaner/Disinfecta areas. Pull towelet and wipe hard, nor surfaces. All must minute" The overview use dated 12/5/08, direct heavily soiled area disposable wipe to environmental sur wet for one-minute and HCV. Use a fi and a ten-minute of surfaces dry, rinservices.	f each shift the glucometer is xivir Tb disinfectant wipes for is cleaned in between sked how long the glucometer h the Oxivir Tb disinfectant idents, LPN-F stated was not the glucometer should be to disinfectant wipes. LPN-F sure that the glucometer oxivir Tb disinfectant for one of 5/6/16, at 11:20 a.m. the of nursing (ADON) stated the staff to follow the facility policy enducometer machine oxivir Tb disinfectant for one oxivir Tb disinfectant for o	F4	441				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		245310	B. WING		1	05/0	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		110	REET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	glucometer with Ox five seconds and we that the machine redisinfectant for one dry before one min wipe with another (ensure wetness for 483.70(h) SAFE/FUNCTION/E ENVIRON The facility must prosanitary, and comformer residents, staff and This REQUIREMED by: Based on observative facility failed 149 and 151 were in the bathrooms of free of stains, and rooms 104, 151, 1 clean and in good Findings include: During interview of member (F)-A staff conducted with the	ted staff to clean/wipe the kivir Tb disinfectant wipes for watch the glucometer to ensure emains wet with the Oxivir Tb eminute. If glucometer starts to ute the policy directed staff to Oxivir Tb disinfectant wipe to one full minute. AL/SANITARY/COMFORTABL rovide a safe, functional, ortable environment for different the public. NT is not met as evidenced ation, interview and document different to ensure the floors in rooms free of cracks, that the ceilings of rooms 165, 201, 206 were that the doors and walls of 65, 166, 232, and 238 were		465	F465 E The facility did not ensure a safe and sanitary living environment. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected negatively. A flooring company was contacted to replace flooring in room 149, awaiting quot We are replacing the cracketiles in 151 and refinishing the surface. Doors are researched (special size an solid core) being ordered. We will then have to special order the replacements.	e. ed d	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(×:	3) DATE SURVEY COMPLETED
		245310	B. WING	1		05/06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CEN	•		STREET ADDRESS, CITY, STATE, ZIP CO 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	DDE	00/00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	
F 465	Room 104A On 5/4/16, at 8:42 was observed to h On 5/6/16, at 11:1 gouges were pres guy who goes thro does repairs. DON had been present. Garden unit Room 149 On 5/3/16, at 2:30 room had multiple through out the ro the HOM stated th with the floor crac raising funds for ro there was not a bi cracked floor tiles Room 151 On 5/3/16, at 2:30 to have missing tr left of the bathrooi had multiple small through out the ro the HOM verified to replaced and that the floor. Room 165A On 5/3/16, at 1:50 was observed to h inch scrape acros The ceiling in the round ring approx the corner of the b a.m. the DOM ver	a.m. the wall behind recliner have several small gouges in it. 2 a.m. the DOM verified that ent and stated that they have a bugh the rooms monthly and of unaware how long the gouges p.m. room 149A the floor of the small cracks with black built up om. On 5/6/16, at 11:19 a.m. ney are aware of the problems king and were working on eplacement. HOM stated that d yet for the replacement of the	F 4	During the interim, to identified doors on the Terrace were covered Decoguard to prevent All bathrooms on the Were checked for batiles and tiles were reas needed. Small good were repaired in lister numbers by a chair readitional chair rail readitional chair readitional chair readitional chair readitional chair readitional chair rail readition	Garden ad with at injury. a Villa d ceiling eplaced uges ad room ail. material be rooms. identify ng the ted by ractice. were ade for eent. be put	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		E CONSTRUCTION /	(X3) DAT COM	E SURVEY IPLETED
		245310	B. WING			05/	/06/2016
	PROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 01 BLACK OAK DRIVE EW BRIGHTON, MN 55112	1 00/	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465	observed to have shape with rough splinters. On 5/6/1 DOM verified that Villa unit Room 201A On 5/3/16, at 2:14 bathroom was obsthe DOM verified bathroom. Room 206 On 5/3/16, at 6:47 bathroom was obstat 11: 40 am the Edamage in the bathroom 232B On 5/3/16, at 2:05 sides of the bathrothe paint scraped bare metal. On 5/6 needed to be pain surface. Room 238A On 5/3/16, at 5:25 sides of the bathrothe paint scraped bathroom.	'p.m. the bathroom door was a weak spot that was oval in edges and loose wood 16, at 11:28 a.m. The HOM and this needed to be repaired. p.m. the ceiling tile in the served to be stained. On 5/6/16, there was water damage in the served to be stained. On 5/6/16, OM verified there was water throom. p.m. the door frames on both com were observed to to have off the lower edges exposing 6/16, the DOM verified that it ited as it was an uncleanable on the pom were observed to to have off the lower edges exposing 6/16, the DOM verified that it ited as it was an uncleanable on the pom were observed to to have off the lower edges exposing 6/16, the DOM verified that it ited as it was an uncleanable of p.m. the door frames on both pom were observed to to have off the lower edges exposing	F	165	that the deficient practice will not recur. Floor chee and ceiling tiles were added to monthly room checks to maintenance completes. Policy is written on how to and where to submit a woorder. Education was provided to housekeeping staff in identifying and writing work orders. How the facility plans to monitor its performance make sure that solutions sustained. Monthly room checks are completed and monitored. Work orders when witten for room corrections. TELS (electrosystem) will help us keep track of the work done in each room and trend reparcompleted. Include dates when corrective action will be completed. 7/15/2016	cks ed hat The o ork to are will nic	6/10/16 DD
	bare metal. The fa	on the lower edges exposing an in the bathroom was very missing plaster on the wall by					

PRINTED: 05/24/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 245310 B. WING 05/06/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 465 Continued From page 55 F 465 the bathroom and there were scratches on the closet door. On 5/6/16, the DOM verified that the bathroom door frame needed to be painted as it was an uncleanable surface. The DOM reached up and tightened a screw on the fan stopping the vibration. The DOM verified that there were scratches on the closet door and missing plaster on the wall of the room. During interview on 5/6/16, at 11:52 a.m. the HOM stated staff could e-mail issues or but them in the maintenance repair log located on each station. If the issue was life safety they can call his cell phone. The DOH verified that housekeepers were also to record issues on the maintenance repair log. Undated Resident Room Cleaning/Bathroom Cleaning procedure instructed staff that the expected results were that "The resident rooms are clean, disinfected, odor free and safe." It also instructed staff to report any maintenance repairs

using reporting procedures.

requested, but not provided.

Reporting Environmental concerns policy

75310025

PRINTED: 05/24/2016 **FORM APPROVED** OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B. WING 245310 05/04/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 **INITIAL COMMENTS** K 000 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR APPROVED | hu_ d SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE By Tom Linhoff at 7:46 am, Jun 09, 2016 USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey. Benedictine Health Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC). Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF **CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:** 2016 HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 MIN DEPT. OF PUBLIC SAFET ST. PAUL, MN 55101-5145 STATE FIRE MARSHAL DIVISION Or by email to: Angela.Kappenman@state.mn.usand Marian.Whitney@state.mn.us TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE	SURVEY PLETED
		245310	B. WING			05/0	04/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	ко	00			
		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:	0				
	A description of to correct the deficition	what has been, or will be, done ency.					
	2. The actual, or pr	oposed, completion date.		1			
		r title of the person rection and monitoring to ence of the deficiency.					
	2-story building with was built at 3 differ was constructed in be of Type II (222) addition was constructed to be of 2005 the Transition	Center at Innsbruck is a no basement. The building ent times. The original building 1965 and was determined to construction. In 1991 an ructed to the north and was f Type I(222) construction. In all Care Unit (TCU) was added as determined to be of Type I.					
	buildings because construction. Buildi to March 1, 2003. Taccordance with LS	rveyed as two separate of different dates of ng one was constructed prior Therefore, it was surveyed in SC Chapter 19 and the TCU yed in accordance with LSC		il i			
	sprinkler system. T system that consist corridors and areas each resident room	e a complete automatic fire the facility has a fire alarm to of smoke detection in the sopen to the corridors and in that is monitored for fire ation, the facility has a capacity					

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I C -,	E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245310	B. WING			04/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK	1	STREET ADDRESS, CITY, STATE, ZIP CO 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	of 105 census at the A K-067 has been further detailed investhat The supply and	age 2 written in past surveys was 97 written in past surveys, upon estigation it has been found d return for the 1965 building a C-06-18, letter from May 26,	K 000	Ţ-		
K 018 SS=E	NOT MET as evide NFPA 101 LIFE SA Doors protecting or required enclosure hazardous areas s as those constructore wood, or capa 20 minutes. Cleara and floor covering in fully sprinklered required to resist the no impediment to topen devices that in pushed or pulled a provided with a medoor closed. Dutch permitted. Door framade of steel or of with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3	perridor openings in other than sof vertical openings, exits, or hall be substantial doors, such ed of 13/4 inch solid-bonded able of resisting fire for at least unce between bottom of door is not exceeding 1 inch. Doors smoke compartments are only ne passage of smoke. There is the closing of the doors. Hold release when the door is re permitted. Doors shall be eans suitable for keeping the doors meeting 19.3.6.3.6 are there materials in compliance er latches are prohibited by a all health care facilities.	K 018	Main Building K18 E Rooms did no positively latch A description of what been, or will be don correct the deficient All doors to hallway facility have been chand adjusted as need The actual or proposition date. 5/16/16 Person-responsible	at has e to cy. in the necked ded. sed	
	door closed. Dutch permitted. Door fra made of steel or of with 8.2.3.2.1. Roll CMS regulations in 19.3.6.3 This STANDARD Based on the obstacility had several meet the requirem Section 19.3.6.3, ti	doors meeting 19.3.6.3.6 are times shall be labeled and ther materials in compliance er latches are prohibited by		and adjusted as nee The actual or propo completion date. 5/16/16	ded. sed . Plant	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G 01 - MAIN BUILDING 01		SURVEY PLETED
		245310	B. WING_		05/0	04/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE.	(X5) COMPLETION DATE
K 018		umber of staff and visitors, if vere allowed to enter the exit	K 011	3		
	5/04/2016 observat following room door	petween 0900 and 1700 on ions revealed that the rs did not positively latch: 3, 164, Janitor Room 2, Rm	=			12°
K 025 SS=D	The deficient practic Director of Environm NFPA 101 LIFE SAIN Smoke barriers shall least a one half hou constructed in accordance with the 2000 NFPA 101, Se The deficient practic pra	ce was observed by the mental Services (EA). FETY CODE STANDARD all be constructed to provide at a fire resistance rating and ardance with 8.3. Smoke rmitted to terminate at an a shall be protected by by wired glass panels and 5.5 s not met as evidenced by sion and staff interview, the attain smoke barrier walls in a following requirements of action 19.3.7.3, and 8.3.4.1. See could affect 80 of the 105 determined amount of staff	K 02	K25 D Smoke barriers in penetrations A description of what is been, or will be done to correct the deficiency. Caulking completed on penetrations The actual or proposed completion date. 5/16/16 Person responsible. P Operations Manager	nas o all	
	On the facility tour b	petween 0900 and 1700 on ions revealed that smoke		91		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CO ING 01 -	ONSTRUCTION MAIN BUILDING 01		PLETED
		245310	B. WING			05/	04/2016
	PROVIDER OR SUPPLIEF			1101	ET ADDRESS, CITY, STATE, ZIP CODE BLACK OAK DRIVE BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(FACH DEFICIENCE)	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
K 025	barriers had penel locations: Above the ceiling East wing to Villa Garden terrace at Above the door a Above door B-39 Stairwell B-1 penearound the edges The penetrations both sides of the The deficient pra Director of Environment of Exit enclosures (with construction at least one hour continuous path against fire or sn building. 7.1.3.2, This STANDARE Based on obserfailed to provide protection requir Sections 19.3.1. could affect all 1 Findings include On facility tour b 05/04/2016, it was the street of the construction of the constructi	in the wall of stairwell C above the ceiling bove the nurses station to smoke compartment D etration into the corridor and to of the new sheetrock. will all need to be sealed on smoke barrier. ctice was observed by the onmental Services (EA). SAFETY CODE STANDARD such as stairways) are enclosed having a fire resistance rating of a rearranged to provide a concover from other parts of the 8.2.5.2, 8.2.5.4, 19.3.1.1 or is not met as evidenced by: vation and interview, the facility and maintain the vertical opening ed by NFPA 101 - 2000 edition, 1, 8.2.5. This deficient practice 0.5 residents.	K	033	K33 C Hole in sprinkler door A description of what heen, or will be done to correct the deficiency. The door handle was replaced with a handle fits and the opening is covered. The actual or proposed completion date. 5/16/16 Person responsible. Plant Operations Management of the door of the deficiency.	that	

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION - MAIN BUILDING 01	(X3) DATE	SURVEY PLETED
		245310	B. WING			05/0	04/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		110	REET ADDRESS, CITY, STATE, ZIP CODE 11 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 033	located directly abo	ove the door knob. were observed by the Director	K	033	97		
K 034 SS=E	NFPA 101 LIFE SA Stairways and smo exits are in accord 18.2.2.4, 19.2.2.3, This STANDARD Based on observate facility has failed to unobstructed exit son NFPA 101 Life Sat This deficient practice of the exit staidelay needed staff	AFETY CODE STANDARD Okeproof enclosures used as ance with 7.2. 18.2.2.3,	K	034	A description of what has been, or will be done to correct the deficiency. All items moved removed from stairwells in Main Building. The actual or proposed completion date. 5/12/16 Person responsible. Plant Operations Manager		
K 038 SS=F	On facility tour bet 05/04/2016, It was several carts, han equipment being stairwell. This defexit capacity and ta required egress This deficient pracof Environmental NFPA 101 LIFE S Exit access is arra accessible at all ti 7.1. 19.2.1 This STANDARD	ctice was verified by the Director	K	3800	K38 F 2nd floor exit sticking Repaired during tour. A description of what has been, or will be done to correct the deficiency. Door repaired The actual or proposed completion date. 5/4/16 Person responsible. Plant Operations Manager		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION B 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245310	B. WING		05/	04/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 038	protection required Sections 19.3.1.1, could affect all 105 Findings include:	d maintain the vertical opening by NFPA 101 - 2000 edition, 8.2.5 .This deficient practice	K 03	8		
	O5/04/2016, it was The second floor e open freely and cle during the remaind The Chapel exit do freely and clearly during the remaind These deficiecies of Environmental S	observed that: xit door to the outside did not early. This deficiency was fixed ler of the inspection. for to the outside did not open This deficiency was fixed ler of the inspection. were observed by the Director Services (EA).	Kar	K52 F Fire alarm pull state obstructed by plant near chapel, fire alarm on OV	r	
K 052 SS=F	A fire alarm system be, tested, and ma NFPA 70 National National Fire Alarm available. The systemaintenance and applicable required 9.6.1.4, 9.6.1.7, This STANDARD Based on observatiled to maintain taccordance with Nection 9.6 and C and NFPA 72 (1997-5.2.2 and, Table	AFETY CODE STANDARD In required for life safety shall intained in accordance with Electric Code and NFPA 72 in Code and records kept readily term shall have an approved testing program complying with ment of NFPA 70 and 72. Is not met as evidenced by: ation and interview, the facility the building fire alarm system in IFPA 101 (00) Chapter 9, hapter 19, Section 19.3.4.1, 19 edition) Sections 7-3.2 and 7-3.1. This deficient practice fect 105 of 105 residents.		obstructed. A description of what haven, or will be done to correct the deficiency. Chapel is in New Building Obstacles repositioned of Oak View to eliminate obstruction. The actual or proposed completion date. 5/16/16 Person responsible. Plan Operations Manager	ş. n	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			TE SURVEY MPLETED
		245310	B. WING_	Table 1	05	/04/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP COL 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 052 K 062 SS=D	FINDINGS INCLUI On 05/04/2016 bet performing the faci the fire alarm pull schapel and next the decorative trees and Another pull station hour nurses station and books for paties. This finding was considered automatic continuously maint condition and are in periodically. 19.79.7.5 This STANDARD Is Based on observation complete automatic being maintained in 25(99) Section 9.2. effect all patients. Findings include: On facility tour betwo 05/04/2016, observations were misplaced along the This was noted in sections.	ween 0900 and 1700, while lity tour it was observed that station located outside the ethe exit was obstructed by indiginals. In on the second floor in the 24 in was obstructed by binders ents reference. In only the second floor in the 24 in was obstructed by binders ents reference. In on the second floor in the 24 in was obstructed by binders ents reference. In on the second floor in the 24 in was obstructed by binders ents reference. In on the second floor in the 24 in was obstructed by binders ents reference. In on the second floor in the 24 in was obstructed by binders entitled in reliable operating in the special entities and tested in reliable operating in the special entities in the second entitle in the special entities in the special entitle in the special entities in the special en	K 06		has to re ./5/16. d	

BTATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
		245310	B. WING		05	/04/2016	
	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
K 144 SS=D	Generators inspect under load for 30 r in accordance with 3-4.4.1 and 8-4.2 (110) This STANDARD Based on review of acility failed to main accordance with 1999 edition and section 3-4.1.1.2. affect the safety of Findings include: On facility tour bett 05/04/2016, based documentation it will documentation for a. The minimum 5 when testing the g	o minute cool down period enerator. tice was verified by the Director	K 144	K144 D Maintain emerg generator. A description of what heen, or will be done to correct the deficiency. The generator is schedu 30 minutes under load weekly with a 5-minute down. Our documenta did not show evidence ominute cool down after run. We are now using suggested form to docu the cool-down time and other information for orgenerator tests. The actual or proposed completion date. 5/16/2016 Person responsible. Pl. Operations Manager	as led cool- tion of a 5 each the ment		

PRINTED: 05/24/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 02 - NEW BLDG B. WING 245310 05/04/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE APPROVED / DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST By Tom Linhoff at 8:29 am, Jun 09, 2016 PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Health Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** JUN - 9 2016 HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION MN DEPT. OF PUBLIC SAFETY 445 MINNESOTA STREET, SUITE 145 STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Angela.Kappenman@state.mn.usand Marian.Whitney@state.mn.us

ST. PAUL, MN 55101-5145

Or by email to:

(X6) DATE TITLE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION NG 02 - NEW BLDG		(X3) DATE SURVEY COMPLETED	
		245310	B. WING		05/	04/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINT DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
K 000	Continued From page 1		Κo	00		
e		RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION:				
ž(A description of to correct the deficition	what has been, or will be, done ency.	-			
	2. The actual, or pr	oposed, completion date.				
		r title of the person rection and monitoring to ence of the deficiency.				
	2-story building with was built at 3 differed was constructed in the be of Type II (222) addition was constructed to be of 2005 the Transition to the north that was V(111) construction	Center at Innsbruck is a no basement. The building ent times. The original building 1965 and was determined to construction. In 1991 and fucted to the north and was frype I(222) construction. In al Care Unit (TCU) was added as determined to be of Type. There is an attic in the new I that is of wood frame trussed full sprinklered.				
	buildings because of construction. Building to March 1, 2003. Taccordance with LS	rveyed as two separate of different dates of ng one was constructed prior Therefore, it was surveyed in SC Chapter 19 and the TCU yed in accordance with LSC				
	sprinkler system. To system that consist	e a complete automatic fire he facility has a fire alarm s of smoke detection in the copen to the corridors and in		×		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION 02 - NEW BLDG		E SURVEY IPLETED
		245310	B. WING	· · · · · · · · · · · · · · · · · · ·	05/	04/2016
	PROVIDER OR SUPPLIER	FER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP COD 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	ΡΕ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	department notification of 105 census at the A K-067 has been further detailed invitat The supply and	age 2 In that is monitored for fire ation, the facility has a capacity he time of this survey was 97. Written in past surveys, upon estigation it has been found direturn for the 1965 building AC-06-18, letter from May 26,	K 000	ω.		
K 018 SS=E	NOT MET as evide NFPA 101 LIFE SA Doors protecting or constructed to resis Clearance between	orridor openings shall be st the passage of smoke. In bottom of door and floor	K 018	K18 E Rooms did not positively latch A description of what ha	s	
9	impediment to the devices that releas pulled are permitte positive latching ha 18.3.6.3.6 are permitted. 18.3.6.3 This STANDARD is Based on the obse	eeding 1 inch. There is no closing of the doors. Hold open e when the door is pushed or d. Doors shall be provided with ardware. Dutch doors meeting nitted. Roller latches shall be is not met as evidenced by: ervation and staff interview, the corridor doors that did not		been, or will be done to correct the deficiency. All doors to hallway in the facility have been checked and adjusted as needed. The actual or proposed completion date. 5/16/16	e ed	
	meet the requirement Section 19.3.6.3, the or latch. This defice safety of approximate an undetermined n	ents of NFPA 101 LSC (00) ney did not fit tight in the frame sient practice could affect the ately 80 of 105 residents and umber of staff and visitors, if were allowed to enter the exit		Person responsible. Pla Operations Manager	nt	3

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION 02 - NEW BLDG		(X3) DATE SURVEY COMPLETED	
		245310	B. WING		05	/04/2016	
	PROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP O 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 018	5/04/2016 observations following room do	age 3 between 0900 and 1700 on ations revealed that the ors did not positively latch: 43, 164, Janitor Room 2, Rm	K 018		**		
K 025 SS≃F	Director of Environ NFPA 101 LIFE S. Smoke barriers shall be patrium wall. Windofire-rated glazing approved frames. This STANDARD Based on observing facility failed to maccordance with the 2000 NFPA 101, SThe deficient prace	tice was observed by the inmental Services (EA). AFETY CODE STANDARD all be constructed to provide at re resistance rating and cordance with 8.3. Smoke ermitted to terminate at an ows shall be protected by or by wired glass panels in 8.3, 18.3.7.3, 18.3.7.5 is not met as evidenced by: ation and staff interview, the aintain smoke barrier walls in the following requirements of Section 19.3.7.3, and 8.3.4.1. tice could affect 80 of the 105 indetermined amount of staff	K 025	K25 F Smoke barriers penetrations A description of what been, or will be done correct the deficience Caulking completed of penetrations The actual or propose completion date. 5/16/16 Person responsible. Operations Manager	t has e to y. on all ed		
	05/04/2016 obser barriers had pene locations: Above the ceiling East wing to Villa Garden terrace at	r between 0900 and 1700 on vations revealed that smoke trations at the following in the wall of stairwell C above the ceiling bove the nurses station smoke compartment D					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I , ,	IPLE CONSTRUCTION NG 02 - NEW BLDG		É SURVEY PLETED
		245310	B. WING_		05/	04/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	1 332	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE	(X5) COMPLETION DATE
K 025	Above door B-39 Stairwell B-1 penet	ge 4 ration into the corridor and f the new sheetrock.	K 02	25		
	both sides of the sr					
K 034 SS=E	Director of Environs	ce was observed by the mental Services (EA). FETY CODE STANDARD	K 03	K34 E Exit stairway blocked	k	
e e	exits are in accordant 18.2.2.4, 19.2.2.3, This STANDARD is Based on observating facility has falled to unobstructed exit standard facility has falled to unobstructed exit standard facility has falled to unobstructed exit standard facility has falled for the facility of the exit standard facility fa	s not met as evidenced by: ions and staff interview, the maintain a clear and cairway in accordance with ty Code (2000) section 7.2.2. ce could negatively affect the way used by staff that would assistance to residents and		A description of what has been, or will be done to correct the deficiency. There are not any stairwells in the new building. All items moved removed from stairwells in main building. The actual or proposed completion date. 5/12/16		
-	Findings include:	ů ,		Person responsible. Plant Operations Manager		
	05/04/2016, It was a several carts, handle equipment being statement. This deficit	reen 09:00 AM and 1700 on observed, that there were es, tools, and other ored in all levels of the exit ient practice is restricting the e capability for this stairwell as				
K 038	of Environmental Se	ce was verified by the Director ervices (EA). FETY CODE STANDARD	K 03	.e. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION BUILDING 02 - NEW BLDG			(X3) DATE SURVEY COMPLETED	
		245310	B. WING		· · · · · · · · · · · · · · · · · · ·	05/0	04/2016	
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		11	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE	
K 038 SS=F	accessible at all tim 18.2.1, 19.2.1 This STANDARD i Based on observat failed to provide an protection required Sections 19.3.1.1, could affect all 105 Findings include: On facility tour betv 05/04/2016, it was The second floor ex open freely and cle during the remaind. The Chapel exit do freely and clearly, during the remaind. These deficiecies w of Environmental S NFPA 101 LIFE SA A fire alarm system be, tested, and mai NFPA 70 National E National Fire Alarm available. The system aintenance and to applicable requirem 9.6.1.4, 9.6.1.7, This STANDARD i Based on observat	rranged that exits are readily nes in accordance with 7.1. Is not met as evidenced by: tion and interview, the facility d maintain the vertical opening by NFPA 101 - 2000 edition, 8.2.5. This deficient practice residents. In the opening of the outside did not arrow the outside did not arrow the inspection. In the outside did not open the outside did not open on the outside did not open of the inspection.	KO		K38 F 2nd floor exit sticking Fixed during tour. A description of what has been, or will be done to correct the deficiency. Door was rubbing that prevent latching. Fixed during tour. The actual or proposed completion date. 5/4/16 Person responsible. Plant Operations Manager K52 F Fire alarm pull static obstructed by plant near chapel, fire alarm on OV obstructed. A description of what has been, or will be done to correct the deficiency. Plant in chapel removed raway. Obstacles repositioned on Oak View eliminate obstruction. The actual or proposed completion date. 5/4/16 Person responsible. Plant Operations Manager	on ight to		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 02 - NEW BLDG	(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/0	4/2016
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
K 052	Continued From page 6 accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. This deficient practice could adversely affect 105 of 105 residents. FINDINGS INCLUDE: On 05/04/2016 between 0900 and 1700, while		К	052			
	performing the faci the fire alarm pull s chapel and next the decorative trees ar Another pull station hour nurses station and books for patie	lity tour it was observed that station located outside the e the exit was obstructed by and plants. In on the second floor in the 24 in was obstructed by binders ents reference.					
K 061 SS=D	Environmental Ser NFPA 101 LIFE SA Automatic sprinkle attachments are in integrity in accorda a signal that sound continuously attend remote facility whe impaired. 9.7.2.1, I This STANDARD Based on observa system is not instal least a local alarm closed, in accorda Chapter 9, Section and NFPA 13 (199	r system supervisory stalled and monitored for tince with NFPA 72, and provide its and is displayed at a ded location or approved in sprinkler operation is NFPA 72 is not met as evidenced by: ations, the automatic sprinkler will sound when the valves are nce with NFPA 101 (2000), in 9.7.2.1 and NFPA 72 (1999) 9) accordance with NFPA 13 he Installation of Sprinkler		061			

STATEMENT OF DEFICIENCIES (X1) PRO IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG 02 - NEW BLDG		(X3) DATE SURVEY COMPLETED	
		245310	B. WING		05/0	04/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPRIOR OF THE	JLD BE	(X5) COMPLETION DATE	
K 061 K 062 SS=D	failure of the fire sp the patients, visitor FINDINGS INCLUI On facility tour beto 05/04/2016, observed facility's fire sprinkle required spare head been installed in the This deficient pract of Environmental SINFPA 101 LIFE SA Automatic sprinkle	compliance could allow for the prinkler system and affect all is and staff of the facility. DE: ween 0900 to 1700 on vations revealed that the er was not equipped with the ads matching those that have e attic.	K 06	K61 D Sprinklers-Spare Heads A description of what have been, or will be done to correct the deficiency. The missing duplicate sprinkler heads for the asprinklers have been replaced. The actual or proposed completion date. 5/16/16 Person responsible. Ploperations Manager	as e		
	inspected and tests 4.6.12, NFPA 13, NThis STANDARD Based on observation complete automatibeing maintained in 25(99) Section 9.2 effect all patients. Findings include: On facility tour bets 05/04/2016, obsensprinkler head esciprinkler heads we misplaced along the This was noted in section.	ed periodically. 18.7.6, 19.7.6, IFPA 25, 9.7.5 is not met as evidenced by: tion and interview, the crime sprinkler system is not accordance with NFPA. This deficient practice could eveen 0900 and 1700 on vation revealed that the utcheon plates on numerous re missing or have been e branch of the sprinkler head.		A description of what I been, or will be done to correct the deficiency. The missing plate was installed on 5/5/16. Movere ordered to replace used plate. The actual or proposed completion date. 5/5/16 Person responsible. Proposed of the completions Manager	o ore e the		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IMBER: A. BUILDING 02 - NEW BLDG				(X3) DATE SURVEY COMPLETED	
		245310	B. WING			05/0	04/2016	
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	ER INNSBRUCK		1	STREET ADDRESS, CITY; STATE, ZIP CODE 101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
K 062 K 144 SS=D	Generators inspect under load for 30 m in accordance with 3-4.4.1 and 8-4.2 (N 110) This STANDARD is Based on review of facility failed to main in accordance with 1999 edition and N section 3-4.1.1.2. The affect the safety of a Findings include: On facility tour between 05/04/2016, based documentation it was documentation for: a. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the getatory with the safety of a section 3-4.1.1.2. The minimum 5 when testing the safety of a section 3-4.1.1.2. The safety of a section 3	ervices (EA). FETY CODE STANDARD red weekly and exercised annutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA so not met as evidenced by: for records and interview, the ntain the emergency generator the requirements of NFPA 110 NFPA 99 - 1999 edition, this deficient practice could all patients, staff and visitors. In the emergency generator the requirements of NFPA 110 NFPA 99 - 1999 edition, this deficient practice could all patients, staff and visitors. In the emergency generator the requirements of NFPA 110 NFPA 99 - 1999 edition, this deficient practice could all patients, staff and visitors. In the emergency generator the requirements of NFPA 110 NFPA	K 1	062	A description of what has been, or will be done to correct the deficiency. The generator is scheduled 30 minutes under load weekly with a 5-minute codown. Our documentatio did not show evidence of a minute cool down after earun. We are now using the suggested form to docume the cool-down time and other information for our generator tests. The actual or proposed completion date. 5/16/16 Person responsible. Plant Operations Manager	ol- n a 5 ch e ent		



Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 1074

May 24, 2016

Ms. Susan Ager, Administrator Benedictine Health Center Innsbruck 1101 Black Oak Drive New Brighton, MN 55112

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5310026

Dear Ms. Ager:

The above facility was surveyed on May 3, 2016 through May 6, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE

Benedictine Health Center Innsbruck May 24, 2016 Page 2 STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792

Fax: (651) 215-9697

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gloria at (651) 201-3792.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION-NUMBER: COMPLETED A. BUILDING: 00940 B. WING 05/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) 2 000 **Initial Comments** 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. **INITIAL COMMENTS:** On May 3, 4, 5 and 6, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

CD8U11

(X6) DATE

If continuation sheet 1 of 78

PRINTED: 05/24/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00940 05/06/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments

that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:

On May 3, 4, 5 and 6, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
		00940	B. WING		05/0	6/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 1	2 565			
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use		2 565			
		omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility f 2 of 3 residents (R2 incontinence care, the careplan for 1 of	ent is not met as evidenced on, interview and document ailed to follow the care plan for 25, R166) for repositioning and and the facility failed to follow of 3 residents (R87) who was aff for activities of daily living				
	Findings include:					
	her back on 5/5/16, (two hours and 22 rasked how often R2 practical nurse (LPI repositioned every later when asked L positioned accordin At 9:43 a.m. LPN-B	sly observed lying in bed on from 7:21 a.m. until 9:43 a.m. minutes). At 9:23 a.m. when 25 was repositioned licensed N)-B stated all residents get two hours. Fifteen minutes PN-C stated R25 was 19 to care plan and if needed. It and LPN-C repositioned R25 ide. R25 stated, "That feels change of brief for				
	on her right side in R25's pressure ulce	5/16, R25 was observed lying bed with LPN-B finishing up ers treatments with nursing sisting. LPN-B stated R25's				

Minnesota Department of Health

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING.			
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR INNSBRUCK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	brief had been wet R25 was observed which appeared de and one on her bot have substance do pressure ulcer on the bot placed bandages o applied tape to hold stated the evening for R25's pressure R25 was lowered in a.m. with the ceiling NA-A and LPN-B at the top of R25's left needed two staff win NA-A stated R25 whours and was che two hours. NA-A stated R25 whours and was che two hours. NA-A stated R25 dicheck and changed line was designed to wetness. NA-A ther her morning cares dining room in her late to watch the resident was finished eating table to watch the resident was to she was assisted to was finished eating table to watch the resident was considered R25 was toileted a plan of care). R25 so NA-B lowered R25 ceiling lift at 2:29 puter Broda chair for no offer by staff for and NA-B finished neck pillow on top of the state of the product of the	and with bowel movement. to have two large open holes, ep, one on R25's left hip area tom which both appeared to wn in them. LPN-B stated the he left had honey gel in it, and tom had packing in it. LPN-B ver both holes to cover and don the bandages. LPN-B shift completed the treatments ulcers on her leg and heel. As not her Broda chair at 11:57 glift and the assistance of small scab was observed on the foot. NA-A stated R25 ith transfers and repositioning. The as repositioned every two cked for incontinence every ated R25 usually had a bowel wening before going to bed. It do not sit on the toilet but was do not and when the brief's yellow of turn blue to indicate in proceeded to help R25 with before pushing R25 out to				

Minnesota Department of Health

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Minnesota Department of Health

STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	about to leave the rand NA-B if they we stated yes they wou which LPN-B and N change R25's wet be cares and put a dry R25 had went two received and change meal and without rebrief and said the pwas wet. NA-B state brief turns blue the changed. NA-B conline and had been we placed a pillow on F slightly to the left. Recomfortable. LPN-E in two hours to report on 5/5/16, at 1:33 pmostly what to do be NA-D stated if a restoilet then the reside hours with the reside hours with the reside hours. NA-D stated on her body she was brunch. NA-D stated on her body she was brunch. NA-D stated reposition her and on R25 did not want to morning then she were at 1:53 p.m. NA-E was how she knew as how she knew at 1:59 p.m. NA-C assignment sheet for performed any care and NA-A had helper R25's careplan date.	oom, Surveyor asked LPN-B are going to toilet R25. LPN-B ald check and change R25 IA-B at 2:39 p.m. proceeded to orief and perform incontinence brief on R25. (At that time nours and 42 minutes without for incontinence after the noon apostioning). LPN-B felt R25's ad they had taken off of R25 and they had taken off of R25 and when yellow line on the brief was wet and needs to be affirmed R25's brief had a blue wet. LPN-B and NA-B then R25's right side turned R25 at told R25 staff would be back osition her. D.m. NA-D stated NAs knew by the assignment sheets. Sident does not want to use the ent will be off loaded every two lent standing up for a bit. The assignment sheet are done of R25's open areas as laid back down in bed after done of R25 always lets staff alid not refuse. NA-D stated if the get up until later in the would be repositioned in bed. The stated she followed the or R25 and that she had not as for R25 today as nights had	2 565			

Minnesota Department of Health

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00940		B. WING		05/0	6/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
BENEDI	BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BLA NEW BR						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	bed mobility every to R25's careplan also to reliably notify state staff were to assist after meals, on night R25's careplan date indicated a pressure bed and ROHO customicated a pressure bed and ROHO customicated and ROHO customicated and ROHO customicated and ROHO customicated and repositioned every R25's NA assignments aff were needed to before and after means of R25's incontinento Con 5/5/16, at 9:53 a instructed staff if the positioning and carrelet RN-B know. R166 was continued to R166 was continued as R166 might not the toilet and it mignearby stated R166 helped R166 get up voided then on the been wet after brundless.	ge 4 wo hours and as needed. o indicated R25 was not able ff of need to toilet, and two R25 upon rising, before and nt rounds and as needed. ed 3/4/16, additionally e reducing mattress on R25's shion in R25's wheel chair eceive the care and services for repositioniong and toileting. ng Assistant (NA) assignment ated R25 was to be turned and two hours and as needed. ent sheet also indicated two o toilet R25 upon rising, eals, and as needed because ce of bowel and bladders. a.m. RN-B stated she had ey could not perform es timely for R25 they were to usly observed on 5/4/16, from 3 p.m. R166 was not seen f to offer toileting or th LPN-D on 5/4/16, at 12:35 staff anticipated R166's needs be able to say she had to go to ht be too late. NA-F standing o had been dry when she o at 9:00 a.m. and R166 had toilet. NA-F stated R166 had toilet. NA-F stated R166 at ated R166 had voided on the	2 565				

Minnesota Department of Health

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	EB INNERBIILE	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ige 5	2 565			
	being toileted. At 12:35 p.m. on 5/	hours and 45 minutes without 4/16, R166 was seen sitting at				
	the dining room table drinking some juice. NAs entered in and out of the dining room not approaching R166. At 1:15 p.m. activity staff asked nurse at the nurse's station if R166 had an appointment for the afternoon. When the nurse said no, activity staff asked R166 about attending activity and without asking about toileting pushed R166 down the hall, into the elevator and upstairs to the dining room. At 1:22 p.m. an activity staff					
	sat down by R166 and assisted R166 to put gloves on to help with making bird seed. At 1:47 p.m. same staff assisted R166 to wipe off her					
	hands and gave R166 an ice cream sundae. At 2:06 p.m. R166 finished ice cream and staff help R166 put a new pair of gloves on to help press bird seed into a form. At 2:36 p.m. staff helped					
	R166 take her gloves off. 2:39 p.m. R166 said to staff, "It is time to go home, but I do not want to drive. Staff assisted R166 to clean her hands and					
	elevator and down floor where R166 re	c down the hall, into the to the nurse's station on first eported to LPN-D that her ing the ice cream. LPN-D				
	asked R166 about her teeth hurt wher health unit coordina	the pain and R166 reiterated a eating something cold. The ator (HUC) sitting there asked				
	responded, "I was of R166 continued to	to see the dentist and R166 going to see the dentist now." sit up near the nurse's station. came walking up the hall				
	toward the nursing asked when R166	station and stood. NA-F was was going to be toileted next d that she was going home at				
	3:00 p.m. NA-F ask coming on and if th	ked what time the next shift ey were going to toilet R166. buld toilet R166. At 2:50 p.m.				

Minnesota Department of Health

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Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
00940			B. WING		05/0	6/2016	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•		
BENEDIC	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DR GHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 565	surveyor notified LF toileted for over two look at R166's skin yes she would and toileted after meals LPN-D stated R166 because of the actidown because she ulcer. At 2:54 p.m. LPN-D the toilet and sink a R166 dribbled urine confirmed R166's beta the yellow line LPN-D stated R166 (It now had been the from when NA-F sa LPN-D and surveyobe non-smooth, red LPN-D stated R166 reddened, and kind skin nurse had look treatment to R166's was toileted after make to get R166. After toileting R166 R166 could not tell the bathroom. Whe for toileting R166, Newnt for exercise, be she got back."	PN-D that R166 had not been be hours and asked if she would with surveyor. LPN-D stated that she expected R166 to be or when she lays down. Shad not laid down today vity. LPN-D stated R166 laid would be at risk for pressure and NA-F stood R166 up at and removed R166's brief as while standing. LPN-D brief was wet with urine and on the brief was now blue. The shift she had last toileted R166's bottom to be deen on both buttocks and the she had last toileted R166's bottom to be deen on both buttocks and the she had last toileted R166's bottom to be deen on both buttocks and the she had last toileted R166's bottom to be deen on both buttocks and the she had last toileted R166's bottom to be deen at it. LPN-D applied to bottom. LPN-D stated R166's bottom. LPN-D stated R166's bottom. LPN-D stated R166's leals, and that R166's usually tivity at 2:00 p.m. LPN-D lid have went up to the activity at 3:00 p.m. NA-F stated NA-F when she had to go to a saked about the time frame NA-F stated, "I knew she had out I was just going to wait until	2 565				
	was at a risk for pre of dementia, was u	ated 11/20/15, indicated R166 essure ulcers, had a diagnosis nable to reliably notify staff of staff was to anticipate R166's					

Minnesota Department of Health

STATE FORM 6899 CD8U11 If continuation sheet 7 of 78

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00940	B. WING		05/	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	needs. R166's care incontinent product cares, mobility, toile incontinence. Short skin to remain intaccare plan indicated and toileted every trace to toilete hours. The undated Nursin for R166 indicated was a wheelchair a and toileted with on sheet did not indicare positioned or toilet. During interview wrough (ADON) on 5/4/16, expected staff to go reposition or toilet, resident." ADON strace pattern had a specisense, if the voiding why every two hour ADON stated the N say something abound should reflect to	e plan indicated R166 wore an and needed assistance with setting and bowel and bladder at term goal for R166 was for and free of redness. The R166 was to be repositioned wo hours and as needed. We the care and services as and and repositioned every two and assistant Assignment sheet R166's mode of transportation and R166 was to be transferred be assistance of staff. The NA attention that the how often R166 was to be steed. We the care and services as and and repositioned every two and R166 was to be transferred be assistance of staff. The NA attention that the tention of the staff was to be steed. We the care and services as a set and reposition that a staff "should approach the attention of	2 565			
	general observation observed covered v hand fingernails we	on 5/3/16, at 7:25 p.m. during ns, resident teeth were with heavy food debris both ere observed unclean and wn matter underneath.				

Minnesota Department of Health

STATE FORM 6899 CD8U11 If continuation sheet 8 of 78

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSRRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	On 5/4/16, at 9:48 a got the help, she ne "I come and see my wondering if her tee On 5/4/16, at 1:43 pto 9:20 a.m. and 11 observed seated in fingernails were not inch long with brow On 5/5/16, at 12:24 (NA)-M was observ living room and indidown for a nap. What to R87 for the shift however, she was runit. NA-M verified underneath. When for trimming the fing not know and direct practical nurse (LPI-At 12:29 p.m. regismanager stated resasked about nail caresident bathe was when looking throug Worksheet/Body Aubeen marked as trii was no documentatical see the second content and direct practical nurse (LPI-At 12:29 p.m. regismanager stated resasked about nail caresident bathe was when looking throug Worksheet/Body Aubeen marked as trii was no documentatical see the second content and the second con	a.m. when asked if resident eeded a family member stated mom in dirty clothes, and eth are getting cleaned." o.m. and 5/5/16, at 7:30 a.m. :35 a.m. resident was wheelchair and both hand ted to have approximately ½ n matter underneath them. p.m. a nursing assistant ed wheel resident out of the cated was going to lay her men asked if she was assigned the NA-M stated she was, not a regular caregiver in the the nails were long and dirty asked who was responsible gernails, NA-M stated she did ted surveyor to licensed N)-A. Stered nurse (RN)-A unit nurse sident was challenging when are. RN-A and LPN-A verified Monday 5/2/16, evening and gh the Shower day udit dated 5/2/16, nails had not mmed. RN-A verified there tion in the progress notes of	2 565			
	was surprised there regular nurse worke when resident bath, verified in March ar	-A stated "İf it's not				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	-At 12:48 p.m. RN-care plan was supported to the plan was supported to behavioral disturbation obtained from the contained from	A acknowledged a resident cosed to be followed. cluded dementia without nce, type 2 diabetes mellitus ns and depressive episodes care plan dated 1/28/16. e Care Area Assessments 6, revealed the ADL CAA had	2 565			

Minnesota Department of Health

STATE FORM 6899 CD8U11 If continuation sheet 10 of 78

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/06/2016	
_	PROVIDER OR SUPPLIER	STREET AD 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN		,	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 10	2 565			
		sing could in-service all staff to regards to specific resident . Also to monitor for				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty One				
2 570	MN Rule 4658.0409 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			
	Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B.					
	by: Based on interview facility failed to re-a interventions to red 1 of 1 residents (R2 other residents on t failed to implement	and document review, the assess for and implement uce aggressive behaviors for 21) who had altercations with the unit. In addition, the facility interventions to safe guard 1) who was at risk for injury idents behaviors.				
	Findings include:					
	R21's admission his	story and physical dated				

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		00940	B. WING		05/0	6/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BENEDIC	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DRI GHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
2 570	11/19/15 indicated I and "quite a few be a bit of difficulty with R21's face sheet in included demential temporary care plan behavior or mood of R21's admission m 12/2/15 indicated he transfers, toileting, ambulated with staff dated 12/14/15 indicognitively impaired inappropriate/disrup physical aggression residents. The care administer PRN (as used to treat anxiet the behavior endan intervene if needed and redirect with a staff of the properties of the service of th	He had advanced dementia haviors disturbances and quite in delirium as well." A review of dicated diagnoses that with behavioral disturbance. An, undated indicated no oncerns. Inimum data set (MDS) dated a required assistance for dressing and grooming, and if supervision. A care plan cated he was severely and demonstrated socially of two behaviors that included in toward staff and other plan directed staff to a needed) Ativan (a medication by disorders), assess whether gered other residents and maintain a calm approach,	2 570	DEFICIENCY)			
	12/4/15 indicated w R21 he "gets very r hit." A progress note was wandering thro residents rooms an and was observed a other residents. O	hen staff attempt to re-direct nad and agitated and tries to e dated 12/8/15 indicated R21 rugh the unit, into other d taking their personal items a "couple of times"trying to hit n 12/14/15 R21 grabbed the					
	indicated staff woul	m (IDT) review of the behavior d continue to monitor R21. A ed 12/16/15 indicated R21 was					

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Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK (X4) ID YAM YAM YAM YAM YAM YAM YAM YA	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 570 Continued From page 12 walking the halls at 5:15 p.m., entered R14's room, punched R14 in the face and pushed him into the wall unit forcing R14 to lose his balance and fall. R14 sustained a laceration to his wrist and a scratch to his forehead. There was no indication of interventions attempted by staff to redirect R21. R21 was sent to the emergency room and returned several hours later. A progress note indicated R21 attempted to throw another residents walker at him and moved from table to table shaking his fist. Staff called 911 and R21 was discharged from the facility. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for aggressive/combative behavior dated 12/14/15 indicated R21 grabbed another residents are safe. plan of care continues. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for Be					
SUMMARY STATEMENT OF DEFICIENCY SET TAG SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OF LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OWNELDTE DEFICIENCY OF THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY TO THE APPROPRIATE DEFICIENCY TAGE OF THE APPROPRIATE DEFICIENC	00940	B. WING		05/0	6/2016
(X4) ID PREFIX (EACH DEFICIENCE) SUMMARY STATEMENT OF DEFICIENCIES PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 570 Continued From page 12 walking the halls at 5:15 p.m., entered R14's room, punched R14 in the face and pushed him into the wall unit forcing R14 to lose his balance and fall. R14 sustained a laceration to his wrist and a scratch to his forehead. There was no indication of interventions attempted by staff to redirect R21. R21 was sent to the emergency room and returned several hours later. A progress noted dated 12/19/15 indicated R21 tried to break down a door and threw juice and food at other residents. A subsequent progress note indicated R21 attempted to throw another residents walker at him and moved from table to table shaking his fist. Staff called 911 and R21 was discharged from the facility. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for aggressive/combative behavior dated 12/14/15 indicated R21 grabbed another residents and grabbed the glasses off of that residents are safe. plan of care continues. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for Behavior An			*		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 570 Continued From page 12 walking the halls at 5:15 p.m., entered R14's room, punched R14 in the face and pushed him into the wall unit forcing R14 to lose his balance and fall. R14 sustained a laceration to his wrist and a scratch to his forehead. There was no indication of interventions attempted by staff to redirect R21. R21 was sent to the emergency room and returned several hours later. A progress note indicated R21 attempted to throw another residents walker at him and moved from table to table shaking his fist. Staff called 911 and R21 was discharged from the facility. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for aggressive/combative behavior dated 12/14/15 indicated R21 grabbed another residents are safe. plan of care continues. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for	RENEDICTINE HEALTH CENTER INNSBRUCK				
walking the halls at 5:15 p.m., entered R14's room, punched R14 in the face and pushed him into the wall unit forcing R14 to lose his balance and fall. R14 sustained a laceration to his wrist and a scratch to his forehead. There was no indication of interventions attempted by staff to redirect R21. R21 was sent to the emergency room and returned several hours later. A progress noted dated 12/19/15 indicated R21 tried to break down a door and threw juice and food at other residents. A subsequent progress note indicated R21 attempted to throw another residents walker at him and moved from table to table shaking his fist. Staff called 911 and R21 was discharged from the facility. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for aggressive/combative behavior dated 12/14/15 indicated R21 grabbed another resident and grabbed the glasses off of that residents face. The evaluation of the incident indicated staff will continue monitoring and ensuring residents are safe, plan of care continues. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for Behavior And Mood Events for	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
aggressive/combative behavior dated 12/16/15 indicated R21 had an altercation with another resident and punched him in the face. An evaluation of the altercation indicated staff intervened and R21 was sent to the emergency room. No other interventions were identified even though R21 had returned to the facility at the time of the evaluation and no new orders or instructions were received upon discharge from the hospital. During an interview on 5/5/16, t 9:15 a.m., registered nurse (RN)- A stated R21 admitted to	walking the halls at 5:15 p.m., entered R14's room, punched R14 in the face and pushed him into the wall unit forcing R14 to lose his balance and fall. R14 sustained a laceration to his wrist and a scratch to his forehead. There was no indication of interventions attempted by staff to redirect R21. R21 was sent to the emergency room and returned several hours later. A progress noted dated 12/19/15 indicated R21 tried to break down a door and threw juice and food at other residents. A subsequent progress note indicated R21 attempted to throw another residents walker at him and moved from table to table shaking his fist. Staff called 911 and R21 was discharged from the facility. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for aggressive/combative behavior dated 12/14/15 indicated R21 grabbed another resident and grabbed the glasses off of that residents face. The evaluation of the incident indicated staff will continue monitoring and ensuring residents are safe. plan of care continues. A Benedictine Health Center at Innsbruck assessment of Behavior And Mood Events for aggressive/combative behavior dated 12/16/15 indicated R21 had an altercation with another resident and punched him in the face. An evaluation of the altercation indicated staff intervened and R21 was sent to the emergency room. No other interventions were identified even though R21 had returned to the facility at the time of the evaluation and no new orders or instructions were received upon discharge from the hospital.	2 570			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	06/2016
	NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BL NEW BR					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	some confusion, sudisplayed aggressive residents. RN-A stanegative behaviors not updated, but stawhen R21 was out During an interview assistant director or R21's altercation we sent to the hospital trying to place him back from the emestated if a resident hours, "we don't do behavior assessments but no behavioral episode come up and we be plan for that." R14's quarterly MD was severely cognicassistance with all acare plan dated 2/2 vulnerable adult reland directed staff to ensure safety and rabuse. Although R14 was an incident on 12/1 and grabbed his glawhen R21 punched R14's Benedictine In Resident Progress 12/24/15 did not refacility event form on notes indicated R14	idden changes in behavior and ye behaviors toward other ited after R21 displayed on 12/8/15 his care plan was ated staff attempted redirection	2 570			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					B) DATE SURVEY COMPLETED	
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSRRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	on 12/19/15. Further victim of abuse on the noncare planned introduced staff to protect the noncare planned introduced staff to protect the noncare planned introduced staff to protect the noncare planned in	er, while R14 had been a two separate dates, there was erventions implemented to	2 570			
2 830	staff related to the trevisions. The qualicommittee could peensure compliance. TIME PERIOD FOR (21) days. MN Rule 4658.0520 Proper Nursing Car	imeliness of care plan ity assessment and assurance erform random audits to R CORRECTION: Twenty-one O Subp. 1 Adequate and	2 830			
	receive nursing care custodial care, and individual needs an	e and treatment, personal and supervision based on d preferences as identified in resident assessment and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY LETED	
00940			B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSRRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	plan of care as des 4658.0405. A nursi of bed as much as written order from the	scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			
	by: Based on interview facility failed to prov 1 of 1 residents (R2	and document review, the vide adequate supervision for 21) who displayed negative at other residents on the unit.				
	11/19/15, indicated and "quite a few be a bit of difficulty witl R21's face sheet in included dementia	story and physical dated R21 had advanced dementia haviors disturbances and quite a delirium as well." A review of dicated diagnoses that with behavioral disturbance. An, undated indicated no oncerns.				
	12/2/15, indicated harmsfers, toileting, ambulated with staff dated 12/14/15, indicognitively impaired to a history of shoul incontinent of bowed demonstrated social behaviors that inclutoward staff and other transfers.					

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		00940	B. WING		05/06/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	staff to administer I medication used to assess whether the residents and interv calm approach, and	ity. The care plan directed PRN (as needed) Ativan (a treat anxiety disorders), behavior endangered other vene if needed, maintain a directive with a therapy doll.				
	A review of Benedictine Health Center at Innsbruck Resident Progress notes dated 11/25/15 through 12/23/15, indicated R21 displayed aggression directed toward other residents. On 11/27/15, R21 was noted as restless, wandering into other residents rooms, and pulling down bedding. Resident stripped naked and walked into hallway six times. A Progress Note dated 11/28/15, indicated R21 could not keep his clothes on the entire shift. The note further indicated he "jumped over the rail in the kitchen" and urinated in the garbage can. On 12/2/15, R21 was described as "combative at times." A Progress Note dated 12/4/15, indicated when staff attempt to re-direct R21 he "gets very mad and agitated and tries to hit." A note dated					
	12/8/15, indicated F the hallway, a subs indicated R21 was into other residents personal items and	R21 was found on the floor in equent note dated 12/8/15, wandering through the unit, rooms and taking their was observed a "couple of				
	R21 defecated on a room. A noted date constantly taking of re-direction, opened	other residents. On 12/9/15, a chair in another resident 's d 12/13/15, indicated R21 was if his clothes, combative with d a window and pushed the				
	personal belonging went into the clean the floor, wrapped i the cabinet. On 12/ glasses off R14 and	ted pushing other resident's sout of the window. He also linen room and defecated on tin a washcloth and put it in 14/15, R21 grabbed the grabbed R14. An m (IDT) review of the behavior				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION (X3) DATE COM		SURVEY LETED	
		00940	B. WING		05/06/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RENEDI	CTINE HEALTH CENT	FR INNSBRUCK 1101 BLA	CK OAK DR	VE		
DENEDI	CIME HEALIH CENT	NEW BRIC	GHTON, MN	55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	indicated staff would Progress Note date walking the halls at room, punched R14 into the wall unit for and fall. R14 sustained a scratch to his indication of interveredirect R21. R21 wroom and returned Progress Note date tried to break down food at other residents walker at table shaking his fis was discharged from A Benedictine Heal assessment of Behaggressive/combat indicated R21 grab grabbed the glasse. The evaluation of the continue monitoring safe. Plan of care of Health Center at In Behavior And Mood combative behavior R21 had an altercat punched him in the altercation indicated was sent to the eminterventions was in returned to the faciliand no new orders upon discharge from the safe indicated from the safe indicated was sent to the eminterventions was in returned to the faciliand no new orders upon discharge from the safe indicated from the safe indicated was sent to the eminterventions was in the safe indicated was sent to the faciliand no new orders upon discharge from the safe indicated was sent to the faciliand no new orders upon discharge from the safe indicated was sent to the faciliand no new orders upon discharge from the safe indicated was sent to the faciliand no new orders upon discharge from the safe indicated was sent to the faciliand no new orders upon discharge from the safe indicated was sent to the faciliand no new orders upon discharge from the safe indicated was sent to the safe indicated was safe indicat	d continue to monitor R21. A ed 12/16/15, indicated R21 was 5:15 p.m., entered R14's 4 in the face and pushed him reing R14 to lose his balance ned a laceration to his wrist is forehead. There was no entions attempted by staff to was sent to the emergency several hours later. A ed 12/19/15, indicated R21 a door and threw juice and ents. A subsequent Progress attempted to throw another him and moved from table to st. Staff called 9-1-1 and R21 m the facility. The Center at Innsbruck eavior And Mood Events for ive behavior dated 12/14/15, bed another resident and soff of that residents face. The incident indicated staff will g and ensuring residents are continues. A Benedictine ensbruck assessment of a Events for aggressive/ and taled 12/16/15, indicated tion with another resident and face. An evaluation of the destaff intervened and R21 ergency room. No other dentified even though R21 had lity at the time of the evaluation or instructions were received	2 830			
	and no new orders upon discharge from	or instructions were received m the hospital.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00940	B. WING		05/06/20	016
BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BLAG		DRESS, CITY, S' CK OAK DRIV	VE		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE CO	(X5) OMPLETE DATE
hours as needed, he administered once of displayed signs of a month of September plan identified poter in toileting, there was assessed the need urinated and defect and removed his clothe facility assessed when R21 displayed. During an interview registered nurse (R the facility in Novem some confusion, su displayed aggressiv residents. RN-A stanegative behaviors not updated, but stawhen R21 was out of R21's altercation wis sent to the hospital. trying to place him i back from the emer stated if a resident shours, "we don't do behavior assessments but no behavioral episodes come up and we be plan for that."	a 0.5 milligrams (mg) every six owever the Ativan was only on 12/17/15 even though R21 anxiety almost daily during the er. Further, while R21's care ntial for pain and an alteration as no evidence the facility for toileting when R21 ated in inappropriate areas othing, nor was there evidence d the need for pain medication d behaviors on 5/5/16, at 9:15 a.m., N)-A stated R21 admitted to nber 2015. She stated he had dden changes in behavior and we behaviors toward other ted after R21 displayed on 12/8/15 his care plan was ated staff attempted redirection				

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		00940	B. WING 05/0		06/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	care plan dated 2/2 vulnerable adult rel and directed staff to ensure safety and r abuse. Although R14 was an incident on 12/1 and grabbed his gla when R21 punched R14's Benedictine I Resident Progress 12/24/15, did not re facility event form of notes indicated R14 a scratch on 12/14/ face on 12/19/15. F 12/19/15, there was monitoring for injure been a victim of ab there was no care p protect R14 from R During an interview stated she would ha an incident form an During interview on ADON stated there for R14 following th further stated, the r missed it and the in A facility policy titled Innsbruck, behavio 11/20/15, was revie effective managem assessment and in	4/15 identified him as a ated to cognitive impairment of follow his plan of care to monitor for symptoms of dentified as the victim during 4/15, when R21 grabbed him asses, and again on 12/19/15, I him in the face, a review of nealth Center at Innsbruck Notes dated 12/11/15 through flect either incident, nor was a ompleted even though R21's 4 sustained and laceration and 15, and was punched in the following the incident on so o evidence of follow up or es. Further, while R14 had use on two separate dates, planned interventions to	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	6/2016
BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BLA			ORESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	documentation on a interventions were the behavior Manage behaviors on the tree SUGGESTED MET. The director of nurse the assessment prochallenging behavior towards others. An ensure the proper a have been implementation behavior. The resurreported to the qual during the quarterly	an ongoing basis. If unsuccessful enroll resident in gement Program and track eatment sheet. THOD OF CORRECTION: sing could inservice staff on ocess for resident's who have ors and exhibit aggression audit could be developed to assessment and interventions ented after each aggressive alts of the audit could be lity assurance committee	2 830			
2 840	Proper Nursing Car Subp. 2. Criteria for proper care. The cadequate and proper B. Clean skin and odors. A bathing place resident's plan of cacondition requires the must be given a condition tresident every two hours, and following each episor [144A.04 Subd. 11 Notwithstanding Mineser Property 144 Notwiths	r determining adequate and criteria for determining	2 840			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BOILDING.	7. 55.E5.RG.			
		00940	B. WING		05/0	6/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BENEDI	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 840	checked according written in the reside attending physician interval longer than if competent, or a fappointed conserva agent of a resident in writing to waive p determining this int documented in the Clean linens or clot promptly each time Perineal care include the perineal area. to keep the bed dry comfort. Special as skin to prevent irritatypes of protectors completely covered contact with the resident areas to perine the perine of the perine	to a specific time interval ent's care plan. The resident's a must authorize in writing any two hours unless the resident, amily member or legally ator, guardian, or health care who is not competent, agrees physician involvement in erval, and this waiver is resident's care plan.] thing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's ttention must be given to the ation. Rubber, plastic, or other must be kept clean, be d, and not come in direct sident. Soiled linen and smoved immediately from revent odors. ent is not met as evidenced ion, interview and document ailed to ensure timely care and ng was provided for 1 of 3		DEFICIENCY			
	from 12:35 p.m. un	observation of R166 on 5/4/16, til 2:53 p.m. R166 was not by staff to offer toileting or					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR			
0(0.15	CLIMMA DV CTA		GHTON, MN		ON	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 22	2 840			
	(LPN)-D on 5/4/16, staff anticipated R1 be able to say she I might be too late. N standing nearby stashe helped R166 ge had voided then on had been wet after R166 at 11:45 a.m. on the toilet and wa hours.	th licensed practical nurse at 12:35 p.m. LPN-D stated 66's needs as R166 might not nad to go to the toilet and it lursing assistant (NA)-F ted R166 had been dry when et up at 9:00 a.m. and R166 the toilet. NA-F stated R166 brunch when she toileted NA-F stated R166 had voided is to be toileted every two				
	the dining room tab	4/16, R166 was seen sitting at le drinking some juice. NAs of the dining room and had not or toileting.				
	nurse's station if R1 the afternoon. Whe staff asked R166 alwithout asking about the hall, into the eledining room. At 1:23 down by R166 and on to help with mak same staff assisted and gave R166 and put a new pair of gluseed into a form. At take her gloves off. "It is time to go hom Staff assisted R166 pushed R166 in whelevator and down floor where R166 research without a station of the statio	r staff asked nurse at the 66 had an appointment for in the nurse said no, activity cout attending activity and at toileting pushed R166 down vator and upstairs to the 2 p.m. an activity staff sat assisted R166 to put gloves ing bird seed. At 1:47 p.m. R166 to wipe off her hands ace cream sundae. At 2:06 ice cream and staff help R166 oves on to help press bird 2:36 p.m. staff helped R166 2:39 p.m. R166 said to staff, he, but I do not want to drive. It to clean her hands and eelchair down the hall, into the to the nurse's station on first eported to LPN-D that her ing the ice cream. LPN-D				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00940	B. WING		05/0	06/2016
	PROVIDER OR SUPPLIER	FR INNSRRUCK 1101 BLA	DRESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	asked R166 about her teeth hurt when health unit coordina and asked R166 if and R166 responded dentist now." R166 nurse's station. At 2 up the hall toward t NA-F was asked witoileted next and Nagoing home at 3:00 time the next shift of going to toilet R166 toilet R166. At 2:50 R166 had not been and asked if she we surveyor. LPN-D st she expected R166 when she laid down laid down today be stated R166 laid dorisk for pressure uld At 2:54 p.m. LPN-D the toilet and sink a R166 dribbled urine confirmed R166's be that the yellow line LPN-D stated R166 (It had been three hwhen NA-F said sh LPN-D and surveyobe non-smooth, all and LPN-D stated Fijust reddened, kind skin nurse had look treatment to R166's was toileted after meame back from accompliance.	the pain and R166 reiterated eating something cold. The stor (HUC) was sitting there she wanted to see the dentist ed, "I was going to see the continued to sit up near the c:49 p.m. NA-F came walking the nursing station and stood. The nursing station and stood the nursing on and if they were and NA-F was asked what soming on and if they were and NA-F stated she would p.m. surveyor notified LPN-D toileted for over two hours build look at R166 with atted yes she would and that it to be toileted after meals or in LPN-D stated R166 had not cause of the activity. LPN-D with because she would be at	2 840			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00940	B. WING		05/0	06/2016
_	PROVIDER OR SUPPLIER	FR INNSRRUCK 1101 BLA	DRESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	NA-F stated R166 chad to go to the bat time frame for toilet knew she had went going to wait until s R166's careplan dawas at a risk for preof dementia, was uneed to toilet, and sneeds. R166's care incontinent product cares, mobility, toile incontinence. Short skin to remain intaccare plan indicated two hours and as not the Care Area Assidated 11/25/15, indicated 11/25/15, indicated 11/25/15, indicated 11/25/15, indicated 11/25/15, indicated 11/25/15, indicated R166 had and w/c cushion for breakdown. The CA to anticipate R166's determine any void three-day bowel and	bileting R166 at 3:00 p.m. could not tell NA-F when she hroom. When asked about the ing R166, NA-F stated, "I for exercise, but I was just he got back." Ited 11/20/15, indicated R166 essure ulcers, had a diagnosis hable to reliably notify staff of staff was to anticipate R166's plan indicated R166 wore an needed assistance with sting and bowel and bladder term goal for R166 was for at and free of redness. The R166 was to be toileted every eeded. Ressment (CAA) summary icated R166 needed es, mobility, toileting, bowel nence, wore an incontinent and treatment to her bottom ention. The 11/25/15, CAA also a pressure reducing mattress	2 840			
	indicated R166 had disease and R166's impaired. The MDS cares and was at ris	ata Set (MDS) dated 3/1/16, a diagnosis of Alzheimer's s cognition was severely indicated R166 did not reject sk for developing pressure so indicated R166 was on a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL		E SURVEY PLETED		
		00940	B. WING		05/	06/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DDRESS, CITY, S ACK OAK DRI IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 840	incontinent of bowe a toileting program. R166 needed extentransferring, locome extensive assistance. Review of Nursing I 4/26/16, PN indicate open area on the continuous and redness on R10. The current May 20 for R166 indicated I morning. R166's ph R166 received barrand Clotrimazole or bottom three times May 2016 Treatment indicated R166 had Clotrimazole cream. The undated Nursing for R166 indicated I was a w/c and R160 toileted with one as sheet did not indicated repositioned or toilet. During interview with (ADON) on 5/4/16, expected staff to go reposition or toilet, stresident." ADON stapattern had a specisense, if the voiding why every two hour	g program, was always I and bladder and was not on The MDS further indicated asive assistance with staff for otion on and off the unit, and the of two staff with toileting. Progress Notes (PN) included: ed R166 had a red and small occyx. ote PN indicated R166 had and some areas of excoriation 66's bottom. In 6 Physician Orders reviewed R166 received Lasix every eysician orders also indicated iter cream, antibiotic ointment eam (antifungal) to R166's a day for redness. R166's and Administration Record received the barrier cream, and antibiotic ointment. Ing Assistant Assignment Sheet R166's mode of transportation Is was to be transferred and sistance of staff. The NA te how often R166 was to be				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00940	B. WING		05/0	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 26	2 840			
	and should reflect to	ut toileting and repositioning he care plan. ADON stated the when wet the line changes bint of wetness.				
		eting was indicated in the he facility for Acitivities of Daily				
	The director of nurs develop and implento ensure that resid with toileting receive of nursing (DON) or as appropriate. The designee could more	HOD OF CORRECTION: sing (DON) or designee could nent policies and procedures ents who require assistance et timely services. The director r designee could educate staff et director of nursing (DON) or nitor or audit to ensure et and report the findings to the Committee.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty one				
2 860	MN Rule 4658.0520 Proper Nursing Car	Subp. 2 F. Adequate and e; Hands-Feet	2 860			
	proper care. The cadequate and proper care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure nail care was residents (R87) reviewed for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	EB INNERBIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	Continued From pa	age 27	2 860			
	activities of daily liv dependent on staff	ring (ADLs) and who was for nail care				
	Findings include:					
	observations, resid covered with heavy fingernails were ob	p.m. during general ent teeth were observed r food debris both hand served unclean and own matter underneath.				
	got the help, she no "I come and see m	a.m. when asked if resident eeded a family member stated y mom in dirty clothes, and eth are getting cleaned."				
	On 5/4/16, at 1:43 p.m. resident was observed seated in wheelchair and both hand fingernails were noted to have approximately ½ inch long with brown matter underneath them.					
		a.m. to 9:20 a.m. the Il untrimmed and noted with rneath.				
	seated on her whee table. R87's fingerr brown matter unde in the dining room licensed practical n down the hallway ir resident into room her room. LPN-A w nose then wheeled mass never offered clean underneathAt 12:24 p.m. a nu	is a.m. resident was observed elchair at the dining room hails were still long and had rneath the nails. R87 remained until 11:50 a.m. then observed hurse (LPN)-A wheel resident nto her room. When LPN-A got resident indicated it was cold ras observed wipe resident resident to the living room for d the trim the fingernails or ursing assistant was observed of the living room and				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING.			
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER INNSRRIICK	CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	When asked if she shift nursing assistate however was not a NA-M verified the nunderneath. When for trimming the finknow and directed -At 12:29 p.m. regis manager stated resasked about nail caresident bathe was when looking throu Worksheet/Body At been marked as triwas no documentaresident refusing nawas surprised there regular nurse work when resident bath verified in March ar bath/shower had be not been document -At 12:38 p.m. LPN documented it was -At 12:48 p.m. RN-nurses to document worksheet or in the bath had been comcare should be doc acknowledged a re supposed to be foll R87's diagnoses in behavioral disturbation without complication obtained from the control of th	was assigned to R87 for the ant (NA)-M stated she was regular caregiver in the unit. ails were long and dirty asked who was responsible gernails, NA stated she did not surveyor to LPN-A. Stered nurse (RN)-A unit nurse sident was challenging when are. RN-A and LPN-A verified Monday 5/2/16, evening and gh the Shower day udit dated 5/2/16, nails had not mmed. RN-A verified there tion in the progress notes of ail care. RN-A indicated she was no documentation as a ed Monday evening shifts /shower was scheduled. RN-A and April 2016, all days een completed nail care had ted as completedA stated "If it's not not done." A stated she would expect the t either in the weekly shower progress notes if a resident pleted and/or refused and nail umented if done or not. RN-A sident care plan was owed. cluded dementia without nce, type 2 diabetes mellitus ns and depressive episodes are plan dated 1/28/16.	2 860			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/06/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 860	Continued From pa	ige 29	2 860			
	had severe cognition diagnosis of demer The CAA indicated	A dated 2/4/16, indicated R87 re impairments, and had ntia and altered mental status. resident may need assistance ons regarding health and				
	had an alteration in assist with her care lower extremity ede weakness and dec "[R87] will be clean	ted 2/10/16, indicated resident ADLs related to needing es due to Dementia, chronic ema/wounds with pain, reased range of motion. Goal , neat and well groomed." I R87 needed one staff assist				
	2/11/16, indicated r physical assistance hygiene. In addition	num Data Set (MDS) dated esident required extensive of one staff with personal the MDS indicated resident which included ADL's.				
	nursing (ADON) state to document all restate a lot of incidences planned. ADON fur	o.m. the assistant director of ated he would expect the staff ident refusal and if there were would have to be care ther stated all staff was the plan of care for residents es.				
	policy dated 11/201	Fingernails and Toenails 5, directed staff to provide port any problematic conditions e during care.				
	The DON could ins as to their responsi residents with assis	THOD FOR CORRECTION: ure that staff are re-inserviced bility to provide dependent stance with nail care according e DON could conduct audits to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	00940 B. WING 05/0			6/2016		
	PROVIDER OR SUPPLIER	FR INNSRRIICK 1101 BLA	ORESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 860	ensure the care is to and take action as	peing provided as indicated	2 860			
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing service services unlessure sores un lessure sores un lessure sores un sores un lessure sores un les un la service sores un les un la se	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home pres does not develop eas the individual's clinical ates, and a physician they were unavoidable; and they were unavoidable; and they have pressure sores of treatment and services to event infection, and prevent reloping. ent is not met as evidenced on, interview and document ailed to ensure 1 of 3 residents are ulcer received timely	2 900			
	her back on 5/5/16,	sly observed lying in bed on from 7:21 a.m. until 9:43 a.m. minutes). At 9:23 a.m. LPN-B				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00940	B. WING		05/0	6/2016
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
RENEDICT	INE HEALTH CENT	ER INNSBRUCK 1101 BLA	CK OAK DRI	VE		
BLINEDICT	INC TICALITY CENT	NEW BRIC	GHTON, MN	55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900 C	Continued From page	ge 31	2 900			
week Lh time will gh Raoab pth Lb th sR caRR eRore we fit to a formation and the second secon	vas interviewed, state positioned every to PN-C stated R25 ver care plan and wome, nursing assisted positioned R25 evene licensed practions. PN-C repositioned ood." At 11:34 a.m. er right side in bed 825's pressure ulcessisting. During the bserved to have on the best on the licer on R25's beneded to have on the licer on R25's beneded treations. PN-B was observed to have on the licer on R25's beneded treating till and reclined and	ated all residents get wo hours. At 9:38 a.m., was repositioned according to then needed. At that same ant (NA)-A stated he very two hours. At 9:43 a.m. tical nurse (LPN)-B and R25, R25 stated, "That feels. R25 was observed lying on I with LPN-B finishing up ers treatments with NA-A erobservation, R25 was been sores on her left hip area Both appeared to have a light them. LPN-B stated the neeleft had honey gel in it, and bottom had packing in it. are stated the evening shift attments for pressure ulcers to During transfer to the Broda are positioning chair) at 11:57 was observed on the top of the transfer NA-A stated aff with transfers and stated R25 was repositioned A-A then proceeded to help and cares before pushing R25 in her Broda chair to eat. The uously observed while she brunch and when she was was moved to another table a playing for an hour. R25 was the bed by LPN-B and NA-B into her bed with the ceiling lift and been up in her Broda chair 2 minutes with no offer by and LPN-B told R25 staff	2 900			

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NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK SUMMARY STATEMENT OF DEFICIENCIES 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
SUMMARY STATEMENT OF DEFICIENCE NEW BRIGHTON, MN 55112			00940	B. WING		05/0	6/2016
XA ID SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCES REGULATORY OR LSC. IDENTIFYING INFORMATION) DEFICIENCE PREFIX TAG REGULATORY OR LSC. IDENTIFYING INFORMATION) DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DEFICIENCY DATE DEFICIENCY DATE DEFICIENCY DATE DEFICIENCY DATE DATE DEFICIENCY DATE DATE DEFICIENCY DATE DATE DEFICIENCY DATE	NAME OF	PROVIDER OR SUPPLIER		-			
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PRÉFIX TAG PRÉFIX	BENEDI	CTINE HEALTH CENT	FR INNSBRIICK				
minutes later, the hospice home health aide came into R25's room, and stated she came to visit R25 once a week, to give R25 a bed bath and lotion. The hospice aide was asked if she had noticed R25's ROHO cushion (a specialized cushion that provides pressure relief) in her Broda chair was flattened out from the mid to back of cushion. The hospice aide stated she had not noticed the ROHO cushion flattened but thought R25 needed a new cushion and would talk to her case manager about it and added that no one from the facility had mentioned it to her before. LPN-B stated previously it appeared something was wrong with the ROHO cushion and that maintenance filled it when necessary. R25's careplan dated 3/24/15, indicated R25 was to receive extensive assistance with two staff for bed mobility every two hours and as needed. R25's careplan also indicated R25 was not able to reliably notify staff of need to toilet, and two staff were to assist R25 upon rising, before and after meals, on night rounds and as needed. R25's careplan dated 3/4/16, additionally indicated a pressure reducing mattress on R25's	PREFIX	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
(w/c). R25 was not repositioned according to the plan of care. Review of R25's medical record revealed R25 was seen by nurse practitioner (NP) on 1/22/16, for monthly visit. NP's visit note indicated the pressure ulcers had increased in size on the coccyx and trochanter, and the pressure ulcer on left leg was slowly healing. NP's visit note indicated, "Pressure ulcer of sacral region, unstageable Pressure ulcer of other site [back of left lower leg/ankle] stage 4 Pressure ulcer of unspecified heel, unstageable." On 2/19/16,	2 900	minutes later, the h came into R25's roo visit R25 once a we and lotion. The hos had noticed R25's F cushion that provide Broda chair was flat back of cushion. The not noticed the ROI thought R25 needer talk to her case mano one from the fact before. LPN-B states something was wround that maintenant R25's careplan date to receive extensive bed mobility every to R25's careplan also to reliably notify states that the states of the receive extensive bed mobility every to R25's careplan date indicated a pressure bed and ROHO custom (w/c). R25 was not plan of care. Review of R25's mewas seen by nurse for monthly visit. Not pressure ulcers had coccyx and trochant left leg was slowly hindicated, "Pressure unstageable Preunstageable Preunstage	ospice home health aide om, and stated she came to sek, to give R25 a bed bath pice aide was asked if she ROHO cushion (a specialized ses pressure relief) in her ttened out from the mid to se hospice aide stated she had HO cushion flattened but d a new cushion and would nager about it and added that sility had mentioned it to her ed previously it appeared ng with the ROHO cushion ce filled it when necessary. Details a sessistance with two staff for wo hours and as needed. Indicated R25 was not able for need to toilet, and two R25 upon rising, before and at rounds and as needed. Details and as needed. Details and the shion in R25's wheel chair repositioned according to the sedical record revealed R25 practitioner (NP) on 1/22/16, and the pressure ulcer on the ter, and the pressure ulcer on the leading. NP's visit note indicated the details are ulcer of other site [back le] stage 4 Pressure ulcer				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
RENEDIA	CTINE HEALTH CENT	ED INNSBBLICK 1101 BLA	CK OAK DRI	VE		
BENEDI	CTINE HEALITI CENT	NEW BRI	GHTON, MN	55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 33	2 900			
	seen by NP for acumanage aspiration, left femur. NP's vision left leg had incretraumatic skin tear Nutrition assessme R25 required increatealing. Nutrition as indicated, "No goal due to hospice stati	te visit to evaluate and wounds and S/P fracture of t note indicated pressure ulcer eased in size with a new on R25's left leg. Int dated 2/29/16, indicated ased protein need for wound esessment dated 3/10/16, weight for R25 at this time us-provide food and fluids for				
	R25's significant ch (MDS) dated 3/19/1 staff assistance with toilet use, was alway bladder, and did no indicated R25 had on skin loss involving on subcutaneous tissue but not through, undermining of adjay (full thickness skin lanecrosis of subcutaneous tissue but not through, undermining of adjay (full thickness skin lanecrosis of subcutaneous the subcutaneous tissue but not through, undermining of adjay (full thickness skin lanecrosis of subcutaneous of subcutaneous down to, but not through undermining ulcer which was not readmission and two thickness loss in who covered by slough of the true depth of the estimated until these ulcers, one of these or readmission. On measurement was	ange Minimum Data Set 6, indicated R25 needed two hed mobility, transfer and ys incontinent of bowel and treject cares. The same MDS one Stage 3 (full thickness damage to or necrosis of e that may extend down to, derlying fascia. The ulcer is a deep crater with or without acent tissue) and one Stage 4 loss involving damage to or ineous tissue that may extend ough, underlying fascia. The cally as a deep crater with or gof adjacent tissue) pressure to present upon admission or or ounstageable (full-tissue nich the base of the ulcer is or an eschar and, therefore, e damage cannot be e are removed) pressure to pressure ulcer indicated in the MDS as 8.2 2.6 cm. The MDS revealed				

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00940 B. WING 05/06/2	6/2016
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
or had been at a lesser stage on prior assessment. The MDS indicated R25 had no venous or arterial ulcers present. The MDS indicated R25 had no venous or arterial ulcers present. The MDS indicated R25 had a pressure reducing device for chair, pressure ulcer care and Application of nonsurgical dressings. According to the MDS, R25 had received physical therapy 11/24/15 to 12/7/15. The MDS indicated R25 scored a 10 on the Braden (skin risk assessment) for risk for skin breakdown. R25's significant change Care Area Assessment (CAA) dated 3/19/16, indicated R25's cognition was severely impaired, R25's as understood, usually understands, speech was clear and staff anticipated R25's needs. CAA indicated R25 had open sores on legs, buttocks, had been losing weight and health seemed to be declining. CAA indicated R25 was incontinent of bowel and bladder and received two staff assistance with tolleting. CAA indicated R25 was incontinent of bowel and bladder and received two staff assistance with tolleting. CAA indicated Pressure ulcer stage 3 on coccyx measuring 2.2 cm x 2.3 x 0.7. Tunneling 1.4 cm from 6-1 o'clockon the left trochanter pressure ulcer, unstageable, measuring about 2.5 cm x 2.6 cm x 5.5 cmOn the lower posterior leg remain unchanged and measured 8.2 cm x 2.6 cm partial thickness skin lossLeft heel ulcer, unstageable measure about 3.4 cm x 4.0 cm. On 3/31/16, for the routine NP monthly visit, NP's visit note indicated, "Resident's declining condition including hospice care, treatment of multiple wound, and plan of care to maintain comfort." The Nutritional Progress Note dated 4/13/16, indicated R25 had pressure ulcer on her coccyx,	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/00	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DR			
	OUR MAR DV OTA		GHTON, MN		ON.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 35	2 900			
	unstageable since 2 left heel, unstageab	e ulcer on left trochanter, 2/19/16, a pressure ulcer on ble since 1/18/16, increased in and two wound areas on lower				
	notes indicated, "De expected because	cian on 4/26/16. the physician ecubitus ulcers - Healing not of end stage disease se]. Plan- Continue hospice				
	The undated Nursing Assistant Assignment Sheet for R25 indicated R25 was to be turned and repositioned every two hours and as needed. R25 did not receive the care and services for repostioning per the NA assignment and care plan.					
	registered nurse (R stated when R25's ulcer was found not pressure ulcer on F 2015 was found wh RN-B stated reside themselves as R25 hours. RN-B stated were completed evadmission, readmis were found. RN-B tolerance assessme indicated at two hou had been reddened the procedure for the assessment was to no skin redness. W not position R25 an avoid redness and	5/5/16, at 9:53 a.m. with N)-B (facility's wound nurse) cast was taken off a pressure w healed. RN-B stated the R25's left heel from September en R25 was repositioned. Into that could not reposition were repositioned every two tissue tolerance assessments ery three months, upon usion and if pressure ulcer verified the facility's tissue ent completed 8/31/15, urs R25's skin on her buttocks I and blanchable. RN-B stated he tissue tolerance try to get to the time frame of hen asked why the facility did y sooner than two hours to possible skin breakdown on stated, "I wanted to be				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, S	STATE, ZIP CODE		
BENEDICTINE HEALTH CENTER INNSBRUCK			CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ıge 36	2 900			
	practical, and if I pulsure repositioning practical." RN-B stated from the surface of completed weekly opressure ulcers. Risulcer was found on and was now unstated and undermining. It pressure ulcer on Found upon wound now unstageable will lower outer leg because the immobileg. When asked a developing RN-B stated friction caused R25's pressive ulcers. RN-B stated friction caused R25 to sit in. RN when the overlay mintervention had be she expected staff for incontinence evinformed RN-B dur observations of overbeen repositioned to from surveyor. RN-staff if they could no cares timely for R2.	at it any sooner [less than two all they [staff] will tell me it is not ated the pressure ulcer on now unstageable with eschar of dead tissue that is cast off it the skin). RN-B stated she wound assessments on R25's N-B stated a Stage 2 pressure R25's coccyx on 12/24/15, ageable with slough, tunneling RN-B stated the Stage 2 R25's left trochanter (IT) was rounds on 12/16/15, and was with slough. RN-B stated R25's pressure ulcer developed bilizer was rubbing on R25's bout R25's pressure ulcers tated R25 moves her legs and friction and shearing caused so when asked to re-clarify on and shearing" is what sure ulcers and that R25 was a N-B stated R25 had a pressure and cushion in her Broda chair pospice provided was too hard N-B was unable to give dates that respect and ROHO cushion then put in place. RN-B stated to reposition and check R25 they two hours. Surveyor ing two separate continuous for two hours, R25 had not attimely without the intervention of B stated she had instructed ot perform positioning and 5 they were to let RN-B know.				

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		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	ORESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	toilet then the reside hours with the reside NA-D stated R25 we hours. NA-D stated on her body she was brunch. NA-D state reposition her and of R25 does not want morning then she we can be responsibility for the found flattened. RN ROHO cushion ever asked if the inflatable being monitored by NAs RN-B stated, "full responsibility." Were not checking commonity and interview plant operations may what a ROHO cushion flat somedated buring an interview plant operations may what a ROHO cushions and putting the informat monitoring. She stated education on how to the bottom of the second and medicated control of the second control of the second and medicated control of the second control of the s	ent will be off loaded every two lent standing up for a bit. as repositioned every two because of R25's open areas is laid back down in bed after d R25 always lets staff does not refuse. NA-D stated if to get up until later in the vill be repositioned in bed. D.m. RN-B stated she took full a ROHO chair cushion being labeled by Menonday morning. When willity of the ROHO cushion was the nurses or checked by the no, only by myself and I take when asked why nursing staff or monitoring RN-B stated, want to come in and check the lay." on 5/5/16, at 3:37 a.m., the langer stated he did not know ion was and was not	2 900			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00940	B. WING		05/0	06/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	ROHO Cushion Instituted the possible level of persons the cushion instructions. Height Wiggle finger approximately ½ included 16 steps for the person has bottom. Caution: An acushion is most effect between all parts of the person has bottom and the per	structions provided by therapy tions for Adjustment indicated or achieving the highest rformance and personal ROHO cushion. Step 16 of the sindicated, "Check Cushion ers to make sure there is ch of air between person and void [bottoming out]. The ective when there is air if the person and the chair. If omed out, please add air and "The same instructions also be sure to check the cushion you have not [bottomed out], ushion is properly adjusted." ssure Ulcer and Non-Surgical attion provided by the facility ate and implement appropriate lan; and update as ons change 12. General are guidelines. Should be dents with potential and/or of skin integrity c. to every 2 hours while in bed hour when in a chair." observation of R166 on 5/4/16, til 2:53 p.m. (two hours and 18 eyor intervened) R166 was not by staff to offer toileting or d R166 request to go to the				
	p.m. LPN-D stated as R166 might not	staff anticipated R166's needs be able to say she had to go to ht be too late. NA-F standing				

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		00940	B. WING		05/	06/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 B	ADDRESS, CITY, S LACK OAK DRI RIGHTON, MN	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 900	nearby stated R166 helped R166 get up voided then on the been wet after brun 11:45 a.m. (two hou toiletings). NA-F statoilet and was to be At 12:35 p.m. on 5/the dining room tabentered in and out approaching R166. At 1:15 p.m. activity nurse's station if R1 the afternoon. Whe staff asked R166 al without asking about the hall, into the eledining room. At 1:2 down by R166 and on to help with mak same staff assisted and gave R166 an p.m. R166 finished put a new pair of gl seed into a form. At take her gloves off. "It is time to go hom Staff assisted R166 pushed R166 in whe elevator and down floor where R166 reteeth hurt when eat asked R166 about her teeth hurt when health unit coordina R166 if she wanted responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded, "I was get a significant to the proposed responded	6 had been dry when she of at 9:00 a.m. and R166 had toilet. NA-F stated R166 had not when she toileted R166 aurs and 45 minutes between ated R166 had voided on the toileted every two hours. 4/16, R166 was seen sitting alle drinking some juice. NAs of the dining room not	at at			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		00940	B. WING		05/0	6/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
BENEDIC	CTINE HEALTH CENT	ER INNSRRIICK	CK OAK DRI GHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 900	toward the nursing asked NA-F when I next and NA-F answhome at 3:00 p.m. what time the next toilet R166 and NAR166. At 2:50 p.m. had not been toilete if she would look at LPN-D stated yes expected R166 to be she lays down. LPN down today because R166 laid down becomessure ulcer. At 2:54 p.m. LPN-D the toilet and sink a R166 dribbled uring confirmed R166's bethat the yellow line LPN-D stated R166 (It had been 3 hour NA-F said she had and surveyor obsernon-smooth, all red LPN-D stated R166 reddened, kind of conurse had looked at to R166's bottom. Lafter meals, and the from activity at 2 p. should have went under the bathroom. Whe for toileting R166, Not the said she had and surveyor obsernon-smooth, all red LPN-D stated R166 reddened, kind of conurse had looked at the R166's bottom. Lafter meals, and the from activity at 2 p. should have went under the bathroom. Whe for toileting R166, Not the said she had and surveyor obsernon-smooth, all red LPN-D stated R166 reddened, kind of conurse had looked at the said she had looked at the s	ge 40 came walking up the hall station and stood. Surveyor R166 was going to be toileted wered that she was going Surveyor asked NA-F asked if shift coming on was going to F stated she would toilet surveyor notified LPN-D R166 and for over 2 hours and asked R166's skin with surveyor. The would and that she be toileted after meals or when N-D stated R166 had not laid the of the activity. LPN-D stated cause she would be at risk for and NA-F stood R166 up at and removed R166's brief as the while standing. LPN-D will be standing. LP	2 900				

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		00940	B. WING		05/0	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR INNSBRUCK 1101 BLA	ORESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	she got back." The following day of stated she made sucher resident before could keep them with repositioning/toileting the state of t	n 5/5/16, at 1:45 p.m. NA-D are she toileted or repositioned they went to an activity so she thin the two houring schedule. 3/1/16, indicated R166 had a mer's disease and R166's rely impaired. The MDS not reject cares and was at pressure ulcers. The MDS was on a g program, was always all and bladder and was not on The MDS further indicated asive assistance with staff for otion on and off the unit, and the of two staff with toileting. R166 dated 11/25/15, ded assistance with cares,	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00940	B. WING		05/	06/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DDRESS, CITY, S ACK OAK DRI IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	incontinent product cares, mobility, toile incontinence. Short skin to remain intac careplan indicated and toileted every to the undated Nursir for R166 indicated was a w/c and R16 toileted with one as sheet did not indicated morning. R166's ph R166 received barr and Clotrimazole crbottom three times May 2016 Treatment indicated R166 had Clotrimazole cream Review of Nursing 4/27/16, progress of poor skin integrity and redness on R1 4/26/16, PN indicated pen area on the control of t	needed assistance with eting and bowel and bladder term goal for R166 was for and free of redness. The R166 was to be repositioned wo hours and as needed. In Assistant Assignment Sheet R166's mode of transportation was to be transferred and sistance of staff. The NA te how often R166 was to be sted. In 6 Physician Orders reviewed R166 received Lasix every sysician orders also indicated iter cream, antibiotic ointment eam (antifungal) to R166's at Administration Record received the barrier cream, and antibiotic ointment. Progress Notes (PN) included: note PN indicated R166 had and some areas of excoriation and some areas of excoriation some areas of excoriation and R166's Braden skin risk of the positioned and ours. The PN indicated R166 ucing cushion in w/c and bed. and R166 needed extensive ities of daily living and staff				

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		00940	B. WING		05/0	6/2016	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		0, = 0 : 0	
BENEDI	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 900	risk for skin break of anticipate R166's nevery two hours in During interview wi (ADON) on 5/4/16, expected staff to go reposition or toilet, resident." ADON st pattern had a specsense, if the voiding why every two hour ADON stated the Nsay something abound should reflect the briefs staff can tell color at a certain pound and skin Color at a ce	down and staff would needs by repositioning R166 the w/c for one full minute. th acting director of nursing at 3:13 p.m. ADON stated he or and ask the resident to staff "should approach the stated if the resident's voiding iffic pattern it might make g did not show a pattern that is restoileting was assigned. JAs assignment sheets should nut toileting and repositioning the care plan. ADON stated the when wet the line changes oint of wetness. Lessure Ulcer and Non-Surgical ation provided by the facility ate and implement appropriate plan; and update as ions change 12. General are guidelines. Should be dents with potential and/or	2 900				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00940	B. WING		05/0	06/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	ED INNSBBIICK	CK OAK DR			
DENEDI		NEW BRI	GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	Subp. 4. Positionin positioned in good to of residents unable must be changed a including periods of been put to bed for has documented th hours during this tin the physician has of the physician has been interviewed at residents get reposed that same time, NA every two hours.	g. Residents must be body alignment. The position to change their own position to change their own position to least every two hours, time after the resident has the night, unless the physician at repositioning every two ne period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval. The period is unnecessary or redered a different interval.				
	side in bed with LPI	N-B finishing up R25's atments with nursing assistant				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
		00940	B. WING		05/0	6/2016
		OTDEET AD	DDEGG OFFICE			<u> </u>
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DR			
			GHTON, MN	55112		T
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
.,		,		DEFICIENCY)		
2 905	Continued From pa	ngo 45	2 905			
2 303	·		2 303			
		PN-B stated R25's brief had				
		ine and feces. During the				
		as observed to have open				
		p area and on her bottom.				
		ave a light brown substance in				
		d the pressure ulcer on the left				
		and the ulcer on R25's bottom				
		PN-B was observed to place				
		h pressure ulcers and applied				
		bandages. LPN-B stated the				
		completed treatments for				
		R25's leg and heel. During				
		da chair (tilt and recline				
		t 11:57 a.m., a small scab was p of R25's left foot. During the				
		ed R25 needed two staff with				
		sitioning. NA-A stated R25 was				
		two hours and was checked				
		ery two hours. NA-A then				
		R25 with her morning cares				
		5 out to dining room in her				
		The resident was continuously				
		was assisted to eat brunch				
		finished eating R25 was				
		able to watch the moving				
	playing for an hour.	. On 5/5/16, at 1:33 p.m. NA-D				
	stated NAs knew m	nostly what to do by the				
	assignment sheets	. NA-D stated if a resident				
		se the toilet then the resident				
		very two hours with the				
		p for a bit. NA-D stated R25				
		very two hours. NA-D stated				
		ppen areas on her body she is				
		ed after brunch. NA-D stated				
	•	aff reposition her and does not				
		d if R25 does not want to get				
		morning then she will be				
		I. At 1:53 p.m. NA-E stated the				
		s how she knew what to do for				
	H25. At 1:59 p.m. N	NA-C stated she followed the				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	performed any care and that the replace helped R25. R25 w by LPN-B and NA-bed with the ceiling been up in her Broominutes with no off LPN-B told R25 stato reposition her. Fe home health aide of stated she came to R25 a bed bath, lot beautiful. The hosp noticed R25's ROH cushion that provid Broda chair was flated back of cushion. The not noticed the RO thought R25 needed talk to her case mano one from the fact before. LPN-B states something was wrotand that maintenant R25's significant che (MDS) dated 3/19/staff assistance with toilet use, was alway bladder, and did not indicated R25 had skin loss involving a subcutaneous tissubut not through, un presents clinically a undermining of adjated (full thickness skin necrosis of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through, un presents clinically a undermining of subcutaneous tissubut not through the presents clinically a undermining of subcutaneous tissubut not through the presents clinically a undermining of subcutaneous tissubut not through the presents clinically a undermining of subcutaneous tissubut not through the presents clinically a undermining of subcutaneous tissubut not through the presents clinically a undermining of subcutaneous tissubut not through the presents clinically a undermining of subcutaneous tissubut not through the presents clinically a undermining of a undermining of subcutaneous tissubut not through the presents clinically a undermining of a undermining of a und	age 46 for R25 and that she had not see for R25 today as nights had sement for the call in NA-A had ras laid back down on the bed as lowered R25 back into her lift at 2:29 p.m. (R25 had da chair for two hours and 32 ser by staff for repositioning). If would be back in two hours ive minutes later, the hospice rame into R25's room, and visit R25 once a week, to give ion R25 and to help R25 feel sice aide was asked if she had IO cushion (a specialized se pressure relief) in her attened out from the mid to the hospice aide stated she had IO cushion flattened but an and added that cility had mentioned it to her sed previously it appeared ong with the ROHO cushion face filled it when necessary. In ange Minimum Data Set 16, indicated R25 needed two hod mobility, transfer and any incontinent of bowel and of reject cares. The same MDS one Stage 3 (full thickness damage to or necrosis of the that may extend down to, derlying fascia. The ulcer as a deep crater with or without accent tissue) and one Stage 4 loss involving damage to or aneous tissue that may extend rough, underlying fascia. The	2 905			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/0	<u> </u>
		1101 BI A	CK OAK DRI	•		
BENEDI	CTINE HEALTH CENT	ER INNSBRUCK NEW BRIG	GHTON, MN	55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 905	ulcer presents clinic without undermining ulcer which was no readmission and two thickness loss in whickness loss in whi	cally as a deep crater with or g of adjacent tissue) pressure t present upon admission or to unstageable (full-tissue nich the base of the ulcer is or an eschar and, therefore, e damage cannot be se are removed) pressure e not present upon admission e pressure ulcer indicated in the MDS as 8.2 2.6 cm. The MDS revealed re ulcer had not been present ser stage on prior MDS indicated R25 had no lcers present. The MDS a pressure reducing device for ucing device for bed, g program, nutrition or on, pressure ulcer care and urgical dressings. According to received physical therapy . The MDS indicated R25 Braden (skin risk assessment)	2 905			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH OBERICAL OF COMPLET OF COMPLET OF COMPLET OF COMPLET OF CROSS-REFERENCED TO THE APPROPRIATE OF CROSS-REFERENCED TO THE APPROPRIA		00940	B. WING		05/0	6/2016
NEW BRIGHTON, MN 55112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF PROVIDER OR SUPPLIER					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	BENEDICTINE HEALTH CENT	FR INNSRRIICK				
	PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETE DATE
remain unchanged and measured 8.2 cm x 2.6 cm partial thickness skin lossLeft heel ulcer, unstageable measure about 3.4 cm x 4.0 cm. R25's careplan dated 3/24/15, indicated R25 was to receive extensive assistance with two staff for bed mobility every two hours and as needed. R25's careplan also indicated R25 was not able to reliably notify staff of need to toilet, and two staff were to assist R25 upon rising, before and after meals, on night rounds and as needed. R25's careplan dated 3/4/16, additionally indicated a pressure reducing mattress on R25's bed and R0HO cushion in R25's wheel chair (w/c). The undated Nursing Assistant Assignment Sheet for R25 indicated R25 was to be turned and repositioned every two hours and as needed. R25's NA assignment sheet also indicated two staff were needed to toilet R25 upon rising, before and after meals, and as needed because of R25's incontinence of bowel and bladder. The Nursing Progress Note (PN) dated 6/4/15, indicated R25's Braden score skin risk assessment scored 16 putting R25 at risk of skin impairment. The PN dated 6/16/15, indicated R25's had a skin tear on the lower gluteal open area and had a recent fracture on tibia and fibula on left left. PN indicated skin loss was most probably caused by shearing and friction. The PN also indicated R25's as incontinent, non weight bearing and used a w/c for mobility. R25 was seen by physician on 8/20/15. Physician note indicated R25's splint was off and the wound was healing. Physician note also indicated R25 continued non weight bearing and the dot enting less well due to weight loss due to eating less well due to	remain unchanged cm partial thicknes unstageable measured to receive extensive bed mobility every receive to assist after meals, on night receive and attended and receive meals, on night received and ROHO current for R25's careplan data indicated a pressure bed and ROHO current for R25 indicated repositioned every repositioned every repositioned every received and after mean of R25's incontinent. The Nursing Progressing received received assessment scored impairment. The Pland a skin tear on the assessment received by shearing indicated received by shearing indicated received received as bearing and used a recent from the received receive	and measured 8.2 cm x 2.6 s skin lossLeft heel ulcer, ure about 3.4 cm x 4.0 cm. ed 3/24/15, indicated R25 was e assistance with two staff for two hours and as needed. It of need to toilet, and two R25 upon rising, before and hit rounds and as needed. It of need to toilet, and two R25 upon rising, before and hit rounds and as needed. It of need to toilet needed. It of needed needed needed. It of needed needed needed. It of needed needed needed needed. It of needed needed needed needed needed. It of needed need				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR INNSRRUCK 1101 BLA	ORESS, CITY, S CK OAK DRI GHTON, MN			
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2 905	progressive demend The 9/16/15, PN by R25 had a partial si with the wound base erythema (redness) indicated the skin lot the cast R25 had had nurse further indicated pressure ulcer developressure ulcer meands. 9 cm. R25 was seen by Covisit. Notes from the area on back of this there was a newly on back of left heel notes also indicated extremities and a significant with the second of the sec	tia. If the wound nurse indicated kin loss on posterior left thigh e covered with slough around. The PN also pass was most probably due to ad for broken tibia. The wound ted R25 had a Stage 2 glop on R25's left heel. The sured 4.9 cm (centimeters) x INP on 9/30/15, for monthly a NP visit indicated the open gh from splint was healing and developed intact blood blister (Stage 2 pressure ulcer). NPd numerous bruises on kin tear on R25's left wrist. R25 dated 10/15/15, indicated for protein for wound healing ageable pressure ulcer on left pressure ulcer on the left included were a high calorie, upplement, vitamin C fortified d a daily multi vitamin.	2 905			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	transferred with how R25 was seen by Chospital visit to evaleft femur fracture. admitted to hospital nursing home. PT a and treatment post The 12/3/15, NP viswas a newly development of the left heel blood to reabsorbed, was covered the left heel blood to reabsorbed, was covered for R25 was for skill Another Nutrition not dated 1/6/16, indicated 1/6/16	yer lift. ENP on 12/3/15, for post luate and manage fracture of NP notes indicated R25 was I on 11/19/15, after fall in the and OT (therapies) evaluation hospitalization. Bit notes also indicated there sped open area on coccyx less ultiple bruises on R25's 0.5 cm open area on inner left red with wound dressing and olister (intact) was being overed. Bed 12/7/15, indicated the goal on to heal and to remain intact. On the dated 1/5/16, received on the healing. A Nutrition note and healing. A Nutrition note and goal was for skin to heal was for skin to heal the tact was deep tissue injury openhed. The physician note area on coccyx had increased as now an open area on ysician note also indicated was okay, edema had cated R25 had decubitus rom immobilizer, Left byx and to continue with	2 905			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY	
		00940	B. WING		05/0	06/2016
	DER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DDRESS, CITY, S ACK OAK DRI IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
visi had trod slow ulca ulca other Pre R28 to 6 S/P pre with Nut incr pro indi due con R29 3/3 dec trea ma Nut R28 sind pre sind uns sind pos R29 4/2	I increased in sichanter, and the why healing. NP or of sacral region of left hip, unser site [back of I ssure ulcer of under the sacral region of left hip, unser site [back of I ssure ulcer of under the sacral region of left in a new traumater it in a sessent by Control of left in a new traumater it in a sessent protein for wound heated, "No goal of the the infort. Goal skin of left in fort. Goal skin of left in a sessent by Control of left in in a new traumater it in a sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in a new traumater in the sessent by Control of left in the sessent by Control	e indicated the pressure ulcers ze on the coccyx and pressure ulcer on left leg was visit note indicated, "Pressure on, unstageable Pressure ulcer of lower leg/ankle] stage 4 nspecified heel, unstageable." CNP on 2/19/16, for acute visit mage aspiration, wounds and femur. NP visit note indicated eft leg had increased in size ic skin tear on R25's left leg. Ents dated 2/29/16, indicated or increased demand for lealing. NA dated 3/10/16, weight for R25 at this time us-provide food and fluids for will be free of infection." CNP for monthly visit on the indicated, "resident's including hospice care, le wound, and plan of care to a seed in size since 3/10/16, a left trochanter, unstageable lessure ulcer on left heel, 1/18/16, increased in size two wound areas on lower lean for regulatory visit on notes indicated, "Decubitus texpected because of end				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1 03/0	0/2010
		1101 BI A	CK OAK DR			
BENEDI	CTINE HEALTH CENT	ER INNSBRUCK NEW BRIC	GHTON, MN	55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From page 52		2 905			
	stage disease [Alzheimer's Disease]. Plan- Continue hospice services."					
	The current Physici the facility 5/6/16, ir	an Orders for R25 provided by ncluded:				
	disturbed or satural Replace packing st complete wound ca every other day dat	are: PRN changes for ted dressings dated 4/15/16 rips every other day with are procedure; once a day, ed 3/23/16, document and catheter; Once a day				
	score of 13 with risl increased risk of sk Instructions: Check dated 1/29/16, turn License staff to ens and repositioned ex	mattress to bed due to Braden k factors resulting in an kin breakdown, Special that the mattress was inflated and position Instructions: sure that resident was turned very two hourly. Off load every a chair for a full minute dated				
	(who was also the v 9:53 a.m. stated wh pressure ulcer was healed. RN-B state left heel from Septe R25 was reposition could not reposition repositioned every for tissue tolerance months, upon admi pressure ulcer were help with the nurses tissue tolerance assindicated at two hou	th registered nurse (RN)-B wound nurse) on 5/5/16, at nen R25's cast was taken off a found and that it was now d the pressure ulcer on R25's ember 2015 was found when ed. RN-B stated residents that a themselves as R25 were two hours. RN-B assessments were completed every three ssion, readmission and if e found wound nurse would s. RN-B verified the facility's sessment completed 8/31/15, urs R25's skin on her buttocks and blanchable. RN-B stated				

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	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	LE CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMPL	_ETED
		00940	B. WING		05/0	6/2016
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
RENEDIC	CTINE HEALTH CENT	FR INNSRRIICK	ACK OAK DR			
		NEW B	RIGHTON, MN	55112		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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0.005	O : : ! : : : : I From no		2.005			
2 905	Continued From pa		2 905			
	the procedure for the					
	assessment was to try to get to the time frame of					
		hen asked why the facility did	i			
		ny sooner than two hours to				
		possible skin breakdown on				
		3 stated, "I wanted to be				
		ut it any sooner [less than two				
] they [staff] will tell me it is no	ot			
		ated the pressure ulcer on now unstageable with escha	_			
		of dead tissue that is cast off				
		f the skin). RN-B stated she				
		wound assessments on R25's	,			
		N-B stated a Stage 2 pressure				
		R25's coccyx on 12/24/15,	'			
		ageable with slough, tunneling				
		RN-B stated the Stage 2				
		R25's left trochanter (IT) was				
		rounds on 12/16/15, and was	;			
	now unstageable w	vith slough. RN-B stated R25's				
		pressure ulcer developed				
		bilizer was rubbing on R25's				
		ne nurses had been routinely				
		zer off to check R25's skin				
		nd the pressure ulcer. When				
		pressure ulcers developing				
		noves her legs and feet about				
		d shearing caused the pressur	е			
		d to re-clarify RN-B stated ng" is what caused R25's				
		d that R25 was a "complex				
		I R25 had a pressure reducing	,			
		ion in her Broda chair now as				
		provided was too hard for R25				
		unable to give dates when the				
		nd ROHO cushion interventio				
		ace. RN-B stated she expecte				
		and check R25 for incontinent				
		urveyor told RN-B staff during				
		servations of over two hours				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	R25 had not been of intervention from suinstructed staff if the positioning and carlet RN-B know. Late occupational therapinformed of the RO for R25. On 5/6/16, at 3:25 peen the scab of to covered it with white thought the strap of had caused it by behad instructed staff tight. RN-B stated Fistated the scab was the strap and that sorder for a pad to be foot to protect it. R2 and not draining. R responsibility for the found flattened. RN ROHO cushion ever asked if the inflatable being monitored by NAs RN-B stated, "full responsibility." Were not checking "Because I did not cushion flat somed. ROHO Cushion Instructions and the strap for the cushion instructions the global responsibility for the cushion instructions the global responsibility." Were not checking the cushion instructions the global responsible level of pesatisfaction for the cushion instructions the global responsibility.	checked and changed without urveyor. RN-B stated she had ey could not perform es timely for R25 they were to er in the afternoon by stated they had not been HO cushion being put in place o.m. RN-B stated she had pof R25's left foot and had e dressing. RN-B stated she f R25's heel protector's boots sing too tight. RN-B stated she to not put the boots on so R25's left foot is swollen and is caused from the tension of the had created a nursing e put on the top of R25's left eput on the top of R25's left exp. Stated it was just a scab N-B stated she took full er ROHO chair cushion being l-B stated she checked the ery Monday morning. When so will be roused from the top of R25's left ery Monday morning. When so when asked why nursing staff or monitoring RN-B stated, want to come in and check the	2 905			

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NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPANY STATEMENT OF DEFICE BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY FULL PREFIX	JRVEY ETED
BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	2016
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
bottom. Caution: Avoid [bottoming out]. The cushion is most effective when there is air between all parts of the person and the chair. If the person has bottomed out, please add air and repeat the process." The same instructions also indicated, "Please be sure to check the cushion daily to ensure that you have not [bottomed out], and to assure the cushion is properly adjusted." R166 During continuous observation of R166 on 5/4/16, from 12:35 p.m. until 2:53 p.m. (two hours and 18 minutes when surveyor intervened) R166 was not seen approached by staff to offer toileting or repositioning nor did R166 request to go to the bathroom. During interview with LPN-D on 5/4/16, at 12:35 p.m. LPN-D stated staff anticipated R166's needs as R166 might not be able to say she had to go to the toilet and it might be too late. NA-F standing nearby stated R166 had been dry when she helped R166 get up at 9:00 a.m. and R166 had voided then on the toilet. NA-F stated R166 had been wet after brunch when she toileted R166 at 11:45 a.m. (two hours and 45 minutes between toiletings). NA-F stated R166 had voided on the toilet and was to be toileted every two hours. At 12:35 p.m. on 5/4/16, R166 was seen sitting at the dining room table drinking some juice. NAs entered in and out of the dining room not approaching R166. At 1:15 p.m. activity staff asked nurse at the nurse's station if R166 had an appointment for the afternoon. When the nurse said no, activity staff asked R166 about attending activity and without asking about toileting pushed R166 down the hall, into the elevator and upstairs to the	

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STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/0	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 905	Continued From pa	ge 56	2 905			
	down by R166 and on to help with mak same staff assisted and gave R166 and p.m. R166 finished put a new pair of gluseed into a form. At take her gloves off. "It is time to go hom Staff assisted R166 pushed R166 in w/o elevator and down to floor where R166 reteeth hurt when eat asked R166 about ther teeth hurt when health unit coordina R166 if she wanted responded, "I was on R166 continued to shall a time the nursing asked NA-F when Finext and NA-F answhome at 3:00 p.m. Swhat time the next stoilet R166 and NA-R166. At 2:50 p.m. had not been toileted if she would look at LPN-D stated yes sexpected R166 to be she lays down. LPN down today becaus R166 laid down bed pressure ulcer.	assisted R166 to put gloves king bird seed. At 1:47 p.m. d R166 to wipe off her hands ice cream sundae. At 2:06 ice cream sundae. At 2:06 ice cream and staff help R166 oves on to help press bird t 2:36 p.m. staff helped R166 2:39 p.m. R166 said to staff, ne, but I do not want to drive. So to clean her hands and cown the hall, into the to the nurse's station on first eported to LPN-D that her ting the ice cream. LPN-D the pain and R166 reiterated in eating something cold. The ator (HUC) sitting there asked to see the dentist and R166 going to see the dentist now." sit up near the nurse's station. It came walking up the hall station and stood. Surveyor R166 was going to be toileted wered that she was going Surveyor asked NA-F asked if shift coming on was going to -F stated she would toilet surveyor notified LPN-D R166 at R166's skin with surveyor. She would and that she be toileted after meals or when N-D stated R166 had not laid ase of the activity. LPN-D stated cause she would be at risk for and NA-F stood R166 up at				

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the toilet and sink and removed R166's brief as

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		00940	B. WING		05/	06/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR INNSBRUCK 1101 BLA	DDRESS, CITY, S ACK OAK DRI IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AID DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 905	R166 dribbled urine confirmed R166's b that the yellow line LPN-D stated R166 (It had been 3 hour. NA-F said she had and surveyor obser non-smooth, all red LPN-D stated R166 reddened, kind of conurse had looked at to R166's bottom. Lafter meals, and that from activity at 2 p. 1 should have went us after toileting R166 R166 could not tell the bathroom. Whe for toileting R166, Nowent for exercise, bushe got back." The following day of stated she made sucher resident before could keep them with repositioning/toileting R166's MDS dated diagnosis of Alzheir cognition was sever indicated R166 did risk for developing also indicated R166 turning/repositioning incontinent of bower a toileting program. R166 needed extering R166 needed extering registering regis	e while standing. LPN-D wrief was wet with urine and on the brief was now blue. It's brief was "moderately wet." is and 8 minutes from when last toileted R166). LPN-D wed R166's bottom to be dened on both buttocks and it's bottom was not open, just hronic for her and that the skint it. LPN-D applied treatment PN-D stated R166 is toileted at R166 usually came back in. LPN-D stated the NA p to the activity to get R166. at 3:00 p.m. NA-F stated NA-F when she had to go to in asked about the time frame IA-F stated, "I knew she had out I was just going to wait until in 5/5/16, at 1:45 p.m. NA-D are she toileted or repositioned they went to an activity so she thin the two houring schedule. 3/1/16, indicated R166 had a mer's disease and R166's rely impaired. The MDS not reject cares and was at pressure ulcers. The MDS				

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		00940	B. WING		05/0	06/2016
	PROVIDER OR SUPPLIER	ER INNSRRUCK 1101 BLA	DRESS, CITY, S CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	extensive assistance. The CAA summary indicated R166 nee mobility, toileting, be incontinence, wore received treatment prevention. The 11/R166 had a pressu cushion for prevent CAA further indicate R166's needs. It was voiding pattern in the bowel and bladder at February 2016 due R166's careplan dawas at a risk for preof dementia, was unneed to toilet, and sneeds. R166's care incontinent product cares, mobility, toile incontinence. Short skin to remain intaccareplan indicated and toileted every to The undated Nursir for R166 indicated was a w/c and R160 toileted with one as sheet did not indicare repositioned or toiled. The current May 20 for R166 indicated morning. R166's phe R166 received barries.	R166 dated 11/25/15, ded assistance with cares, owel and bladder an incontinent product and to her bottom every shift for 25/15, CAA also indicated re reducing mattress and w/c ion of skin breakdown. The ed staff were to anticipate as unable to determine any re review of the three-day assessment completed in to incomplete data. Ited 11/20/15, indicated R166 essure ulcers, had a diagnosis hable to reliably notify staff of staff was to anticipate R166's plan indicated R166 wore and needed assistance with eting and bowel and bladder term goal for R166 was for and free of redness. The R166 was to be repositioned wo hours and as needed. Ing Assistant Assignment Sheet R166's mode of transportation as was to be transferred and sistance of staff. The NA te how often R166 was to be				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	May 2016 Treatment indicated R166 had Clotrimazole cream Review of Nursing 4/27/16, progress in poor skin integrity a and redness on R14/26/16, PN indicated open area on the consistency of the consistenc	a day for redness. R166's at Administration Record received the barrier cream, and antibiotic ointment. Progress Notes (PN) included: note PN indicated R166 had and some areas of excoriation 66's bottom. Red R166 had a red and small occyx. Red R166's Braden skin risk 6, was at risk for skin ould be repositioned and ours. The PN indicated R166 ucing cushion in w/c and bed. R166's needs. R166's needs. R166's Braden skin risk 6 which was suggestive of high down and staff would eeds by repositioning R166 the w/c for one full minute. The acting director of nursing at 3:13 p.m. ADON stated he of and ask the resident to staff "should approach the ated if the resident's voiding fic pattern it might make godid not show a pattern that is stoileting was assigned. As assignment sheets should ut toileting and repositioning he care plan. ADON stated the when wet the line changes	2 905			
	Undated policy Pres	ssure Ulcer and Non-Surgical				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00940	B. WING		05/0	6/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	-	
BENEDIC	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Wound Documenta indicated " 9. Initia measures in care p treatment/interventi Wound and skin Ca followed for all resid actual impairment of Turn/reposition up to and offload every 2 SUGGESTED MET The director of nurs development and in procedures for the for pressure ulcers, designee could the for adherence to the	ation provided by the facility ate and implement appropriate lan; and update as ons change 12. General are guidelines. Should be dents with potential and/or	2 905			
21015	MN Rule 4658.0610 Requirements- Sai Subp. 7. Sanitary procedures and conthe operation of the times. This MN Requirements by: Based on observation review, the facility for procedures were for possibility of food by kitchen and in 3 of said support the said support to the said support t	O Subp. 7 Dietary Staff nitary conditions. Sanitary nditions must be maintained in edietary department at all ent is not met as evidenced on, interview, and document ailed to ensure food sanitation llowed to minimize the orne illness in the main 4 kitchenettes. This had the 9 who were served food and/or	21015			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. BOILDING.			
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21015	Continued From pa	nge 61	21015			
	fluids out of 3 of 4 kitchen	citchenettes and the main				
	Findings include					
	initial kitchen tour v (RD) and culinary s the ovens of the for heavily soiled with I and cook verified th	a.m. to 12:06 p.m. during the with the registered dietician service cook both the inside of ur burner stove were observed plack baked on. Both the RD ne ovens were not clean and she had not used the ovens				
	white flaky porous I	as observed to have a light ime build up inside the air vent on the clean side. The se/flaky with touch.				
	and district manage flaky build was lime had a de-liming sch stated she did not h of her full time staff	o.m. the dietary manager (DM) er verified the white porous e. When asked if the facility nedule for the dishwasher, DM have a schedule but had one if who cleaned it however did or cleaning the dishwasher.				
	kitchenettes tour w	a.m. to 9:23 a.m. the as completed with DM and the d the following were observed:				
	machine next to the DM and district ma was not supposed and further stated t	bserved inside the small ice e refrigerator in the kitchenette. nager verified stated the scoop to be left inside the machine here was a scoop holder as to be stored after each use.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	1101 BI A	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	ER INNSBRUCK NEW BRI	GHTON, MN	55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21015	Continued From pa	ge 62	21015			
	an observation mad family member was	ict manager were informed of de 5/3/16, at 4:25 p.m. when a observed use a drinking both stated everyone was to times.				
	machine was obser sticky stain of juice.	es underneath the juice ved with a large brown dried DM and district manager housekeeping was to clean				
	done the job for ma identified she was v indicated other dep	a.m. the DM indicated she had any years and with the issues well aware of them however artments were responsible for she had gotten tired of asking.				
	The dietary director (DON), could developrocedures related kitchen and the kitchen kitchen. The Eprovide educations assessment and as	HOD OF CORRECTION: and/or the director of nursing op and implement policies and to the cleanliness of the henette areas outside of the OON or designee could to the staff. The quality surance committee could dits to ensure compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Control;	21375			
	home must establis	on control program. A nursing the and maintain an infection signed to provide a safe and nt.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21375	Continued From pa	age 63	21375			
	by: Based on observation document review, to procedures to previously blood glucos residents (R275, R	ent is not met as evidenced ion, staff interview and he facility failed to implement vent the spread of infection se monitoring for 2 of 2 7) observed who required itoring in 2 of 4 units.				
	Findings include:					
	(LPN)-A was obser check for R275. LP the glucometer for disinfectant wipe, a R275 cleaned the f squeezed a drop of then told R275 his observed get back stationed across frod disposed of the use glucometer for 10 swipe and put a dry small rectangular to supplies on the top Glucometer was not LPN-A then removed -At 8:16 a.m. LPN-always cleaned the a few seconds around where the stripe was acknowledged did full minute as indicated.	not wipe the glucometer for a ated in the container.				
	on 5/3/16, at 3:49 p complete a blood s	of glucose monitoring check o.m. LPN-F was observed to ugar check on R7. After ugar check on R7, LPN-F				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
00940 B. WING	05/06/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRING DEFICIENCY)	BE COMPLETE	
wiped the glucometer off with an Oxivir Tb disinfectant wipe for 23 seconds, then put the glucometer back on a caddy with all the blood sugar supplies on the top of the medication cart. LPN-F removed her gloves, performed hand hygiene and went to a medication cart proceeded to prepare medication to administer to a resident. After 10 seconds the glucometer was observed to be completely dry. During interview on 5/3/16, at 3:59 p.m. LPN-F stated at the end of each shift the glucometer is cleaned with the Oxivir Tb disinfectant wipes for five minutes and it is cleaned in between residents. When asked how long the glucometer was disinfected with the Oxivir Tb disinfectant wipes between residents, LPN-F stated was not aware for how long the glucometer should be cleaned with Oxivir Tb disinfectant wipes. LPN-F verified did not ensure that the glucometer remained wet with Oxivir Tb disinfectant for one minute. During interview on 5/6/16, at 11:20 a.m. the assistant director of nursing (ADON) stated the expectation is for staff to follow the facility policy and ensure that the glucometer machine remained wet with Oxivir Tb disinfectant for one minute. Oxivir Tb Wipes "Virucidal. Bactericidal. Fungicidal. Tuberculocidal directions on the container directed "For Use as a One- Step Cleaner/Disinfectant: Pre-clean heavily soiled areas. Pull towelette from dispenser (canister) and wipe hard, non-porous environmental surfaces. All must remain visibly wet for 1 minute" The overview use sheet from Johnsondiversy		

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		00940	B. WING		05/0	6/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21375	dated 12/5/08, direct heavily soiled areast disposable wipe to environmental surface wet for one-minute and HCV. Use a five and a ten-minute of surfaces dry, rinse. The facility policy tridated 2/8/10, direct glucometer with Oxfive seconds and with the machine redisinfectant for one dry before one minimal wipe with another Censure wetness for SUGGESTED MET The director of nursinfection control praind educate staff, designee, could condelivery of care to eservices are impler risk of infection. TIME PERIOD FOR	cted staff to "Pre-clean s. Apply solution by cloth or hard, non-porous aces. All surfaces must remain to kill bacteria, HIV-1, HBV re-minute contact time for Tb ontact time for fungi. Wipe or allow to air dry." Itled "Clean Glucose Meters" ted staff to clean/wipe the civir Tb disinfectant wipes for ratch the glucometer to ensure emains wet with the Oxivir Tb minute. If glucometer starts to ute the policy directed staff to Dxivir Tb disinfectant wipe to	21375			
21540	(21) days. MN Rule 4658.131 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			
	monitor each reside unnecessary drug u home's policies and	g. A nursing home must ent's drug regimen for usage, based on the nursing d procedures, and the eport any irregularity to the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	CK OAK DR			
DENEDI	OTINE HEALITI OLIVI	NEW BRIG	GHTON, MN	55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	resident's attending physician does not home's recommend adequate justification believes the resider adversely affected, matter to the medical director is the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physician the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the attending physician does not the order and if the change the order, the attending physician directly to the QAA. This MN Requirements by: Based on interview facility failed to provantipsychotic medic effectiveness for 1 for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for reviewed for unnecessary medicality failed to act recommendation for revie	physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist not's quality of life is being the pharmacist must refer the real director for review if the not the attending physician. If referring that the attending have adequate justification for attending physician does not he matter must be referred for y Assurance and Assessment required by part 4658.0070. If ician is the medical director, macist shall refer the matter and document review, the redications in addition the upon consulting pharmacist's or 1 of 5 residents (R85) reviewed redications. In addition the upon consulting pharmacist's or 1 of 5 residents (R85) cessary medications.	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
		00940	B. WING		05/0	06/2016
NAME OF PROVIDE		ER INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
	EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
medicinstructionstructions assisted anyw. Revierecorrection (MAF evide side of medicine constitution of the constitution of t	ew of R85's mod/treatment and A/TAR) dated 2 ince of docume effects and effects and effects and partial to the cation. Ew of R85's moditant pharman and 12/1/15, 1/4/nomendation for the cation of th	gram (mg) per milliliter (ml) with 0.5 ml sublingually at bedtime edication administration dministration record 2/1/16 through 5/6/16, lacked entation for monitoring the ectiveness of anti-psychotic edical record revealed cist communication to nursing 16 and 4/1/16, with or side effect monitoring for ver R85's medical record at the consulting pharmacist's were acted upon by the facility in 5/5/16, at 12:10 p.m. licensed N)-G verified, was unable to ic side effect monitoring sheet medical record. 15/6/16, at 8:37 a.m. (N)-C, acknowledged there monitoring in place for ication in R85's medical in 5/6/16, at 11:27 a.m. the finursing (ADON) stated he on psychotropic medications side effects and nurses are to sident's TAR. ADON verified record lacked evidence of side or Haloperidol. ADON stated that the facility to act upon the	21540			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00940	B. WING	····	05/0	6/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	Continued From pa	ge 68	21540			
	recommendation fo	f consulting pharmacist or side effect monitoring for ot acted upon, ADON stated they were.				
		antipsychotic medication sulting pharmacist reviews none provided.				
	The director of nurs regarding the imporside effects of medi records to assure the prescribed antipysor of side effects is initiassessed. This could be a support of the country of the co	THOD FOR CORRECTION: ses' could inservice staff rtance of assessing for the ications. She could audit nat when residents are shotic medications, monitoring tiated and adverse effects are all be reported and ty assurance committee				
	TIME PERIOD FOF (21) day	R CORRECTION: Twenty One				
21610	MN Rule 4658.1340 and Preparation Are	Subp. 1 Medicine Cabinet ea;Storage	21610			
	must store all drugs under proper tempe	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observati review, the facility for expired Mantoux so	ent is not met as evidenced on, interview, and document ailed to ensure undated or olution was removed from ators for 3 of 4 units to ensure				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00940	B. WING		05/0	6/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FR INNSBRIICK	ACK OAK DR IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	Continued From pa	age 69	21610			
	that they were not u	used on residents. In addition, ensure expired medications nather medication cart for 1 of 3				
	Findings include:					
	at 1:08 p.m. a mult solution for determ tuberculosis) was f refrigerator. The via been opened or dis nurse (LPN)-E veri "I thought they were	room observation on 5/04/16, i dose vial of Aplisol (testing ining possible exposure to ound in the medication al was not dated when it had spensed. Licensed practical fied it was not dated and said, e supposed to date it. They out of TCU [Transitional Care				
	at 1:53 p.m. three with the medication refridated as opened or printed on the vial with dated as opened or printed on the vial with dated as opened or printed on the vial with dates the Aplisol via stated, "It did not mopened. The vial dated the vial dated the vial dated the Aplisol via stated, and the vial dated the vi	room observation on 5/04/16, vials of Aplisol were found in igerator. The first vial was n 2/7/16. The expiration date was 3/17. The second vial was n 2/8/16. The expiration date was 3/17. The third vial was n 3/25/16. The expiration date was 4/17. LPN-B verified the als were opened. LPN-B natter when the vial was oes not have a different n the expiration date printed or				
	2:37 p.m. an undat the medication refr	nit room observation on 5/4/16, a ed vial of Aplisol was found in igerator. The expiration date was 1/21/18. Registered nurse				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	(RN)-C verified that dated when opened for 30 days after op dated. Yes we have Afluria influenza var medication refrigers opened on it. The evial was 6/5/16. RN dated when opened year after it has been buring a medication 8:18 a.m. LPN-G to (mg) bottle from the that Senna 8.6mg hon the bottle. LPN-bottle labelled Senr expired and had ab medication cart was medication and an labelled calcium with on the cart with an verified the bottle la 600mg was open, hof tablets in it. During interview on director of nursing (good for 30 days af expect the nurses to it. I helped give all to we dated all vials we ware how long they will have to find out on 5/6/16, at 11:16 expectation is all expended from the removed from th	at the Aplisol had not been d. RN-C said, "Aplisol is good bened. This should have been a used it." A multi-dose vial of cicine was found in the ator. There was no date expiration date printed on the -C verified the Afluria was not d and said, "It is good for a gen opened, I guess." In observation on 5/5/16, at sok out Senna 8.6 milligrams a medication cart and noted had an expiration date of 6/15 G verified the medication had 8.6 mg was open, had out half tablets left in it. The schecked for expired open medication bottle the vitamin D 600mg was noted expiration date of 4/16. LPN-G abelled calcium with vitamin D had expired and had about 3/4 5/4/16, at 3 p.m. the assistant (ADON) stated, "Aplisol is ter it has been opened. I o date the vial when they open he Flu vaccines this fall. I think then we opened them. I am not are good for after opening. I." a.m. ADON stated the spired medications to be				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED		
		00940	B. WING		05/0	6/2016
	PROVIDER OR SUPPLIER CTINE HEALTH CENT	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	vials was requested. Undated Flu Vaccin McKesson Medical facility instructed stranged after 2 Par Pharmaceutica revised 7/2015 instructed 7/2015 instructed 7/2015 instructed 7/2015 instructed 7/2015 instructed 7/2016 instructed 7/2016 instructed 7/2016, directed stranged insert 7/27/10, directed stranged inser	d but not provided. e Storage Instructions from Surgical provided by the aff, "Once entered, a any residual contents should 28 days." I Aplisol package insert ructed staff "Vials in use more d be discarded due to possible adation which may affect for Afluria from CSL dated aff "When using the ke the vial thoroughly before ose, and administer the dose en uses, store the vial at 36 to (F) to 46 degrees F). Once en pierced, the vial must be days. " CHOD OF CORRECTION: sing (DON) or designee could done or of nursing (DON) or cate all appropriate staff on ocedures. The director of esignee could develop	21610			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00940 B. WING 05/06		6/2016		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	FR INNSRRIICK	CK OAK DRI GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 72	21685			
21685	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the floors in rooms 149 and 151 were free of cracks, that the ceilings in the bathrooms of rooms 165, 201, 206 were free of stains, and that the doors and walls of rooms 104, 151, 165, 166, 232, and 238 were clean and in good repair.					
	Findings include:					
	During interview on 5/3/16, at 6:57 p.m. family member (FM)-A stated facility was not clean.					
	conducted with the	a.m. a tour of the facilty was director of maintenance ctor of housekeeping (DOH).				
	was observed to ha On 5/6/16, at 11:12 gouges were prese guy who goes throu	a.m. the wall behind recliner ave several small gouges in it. a.m. the DOM verified that nt and stated that they have a aigh the rooms monthly and unaware how long the gouges				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	06/2016
	PROVIDER OR SUPPLIER	FR INNSBRUCK 1101 BLA	DRESS, CITY, S CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	Garden unit Room 149 On 5/3/16, at 2:30 p room had multiple s through out the room the HOM stated the with the floor cracki raising funds for rep there was not a bid cracked floor tiles. Room 151 On 5/3/16, at 2:30 p to have missing trin left of the bathroom had multiple small of through out the room the HOM verified the	o.m. room 149A the floor of the small cracks with black built up m. On 5/6/16, at 11:19 a.m. by are aware of the problems ng and were working on blacement. HOM stated that yet for the replacement of the door. The floor of the room bracks with black built up m. On 5/6/16, at 11:22 a.m. at the trim needed to be ney were aware of cracks on	21685			
	was observed to had inch scrape across. The ceiling in the baround ring approximate corner of the baram. The DOM verification and verified the bathroom ceiling. Room 166A On 5/3/16, at 6:47 probserved to have a shape with rough explinters. On 5/6/16	o.m. the door to room 165A ave a two and a 30 inch x 0.5 the middle of the inside door. athroom was stained with a nately 12 inches in diameter in throom. On 5/6/16, at 11:23 ed that the door needed to be see water damage to the out. o.m. the bathroom door was weak spot that was oval in dges and loose wood at 11:28 a.m. The HOM and this needed to be repaired.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING		05/0	6/2016
	NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CENTER INNSBRUCK 1101 BLA NEW BRIG					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21685	Continued From pa	ge 74	21685			
	bathroom was obse	o.m. the ceiling tile in the erved to be stained. On 5/6/16, ere was water damage in the				
	On 5/3/16, at 6:47 p.m. the ceiling tile in the bathroom was observed to be stained. On 5/6/16, at 11: 40 am the DOM verified there was water damage in the bathroom.					
	sides of the bathroom the paint scraped of bare metal. On 5/6/	o.m. the door frames on both om were observed to to have ff the lower edges exposing 16, the DOM verified that it ed as it was an uncleanable				
	sides of the bathrood the paint scraped of bare metal. The farmoisy. There was method the bathroom and the closet door. On 5/6, bathroom door fram was an uncleanable up and tightened a vibration. The DOM scratches on the cloon the wall of the room the paint scrape.	o.m. the door frames on both om were observed to to have ff the lower edges exposing in the bathroom was very issing plaster on the wall by here were scratches on the 16, the DOM verified that the ne needed to be painted as it is surface. The DOM reached screw on the fan stopping the liverified that there were oset door and missing plaster from.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED	
		00940 B. WING 05/06		6/2016			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
BENEDIC	TINE HEALTH CENT	FR INNSRRIICK	CK OAK DR GHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21685	Continued From pa	ge 75	21685				
	in the maintenance station. If the issue his cell phone. The housekeepers were maintenance repair. Undated Resident F Cleaning procedure expected results we are clean, disinfected instructed staff to reusing reporting procedure.	e also to record issues on the log. Room Cleaning/Bathroom instructed staff that the ere that "The resident rooms ed, odor free and safe." It also eport any maintenance repairs cedures.					
	Reporting Environm requested, but not p	nental concerns policy provided.					
21810	MN St. Statute 144 Residents of HC Fa	.651 Subd. 6 Patients & ac.Bill of Rights	21810				
	residents shall have medical and persor needs. Appropriate care designed to er highest level of phy This right is limited	riate health care. Patients and e the right to appropriate hal care based on individual e care for residents means hable residents to achieve their sical and mental functioning. where the service is not blic or private resources.					
	by: Based on observati review, the facility for	ent is not met as evidenced on, interview, and document ailed to ensure the call light r 1 of 1 resident (R18) who					

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00940	B. WING	····	05/0	06/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
BENEDI	CTINE HEALTH CENT	FR INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 76	21810			
	sitting upright in a E positioning chair). The from the edge of Relying across the beat the call light. R18 stated "I use mam supposed to rin." At 1:31 p.m. nursing the call light. NA-E stated, "There room. I don't know call light." NA-E said "Whenever I get [Reference to the call light because enough to be heard unable to move Browas a fall risk, becathings and can fall of the call light."	p.m. R18 was observed Broda chair (a tilt and recline The Broda chair was three feet 18's bed. The call light was d. R18 was unable to reach tated could not move his chair. By call light to get the staff. If g it, not attempt to get up." If g assistant (NA)-E answered gave the call light to R18. Bused the call light. By brought him back to the why they did not give him his d R18 used the call light. By I make sure [R18] has see [R18] cannot call out loud 1." NA-E verified R18 was ada chair. NA-E stated R18 ause R18 would reach for out of the bed. NA-E stated, "I esidents have their call lights."				
	(MDS) indicated R1 impaired, and requi bed mobility, transfer plan dated 4/22/16,	ission Minimum Data Set 8 was severely cognitively red assistance of two staff for ers, and toilet use. The care indicated R18 was at risk for staff to keep call light in reach				
	practical nurse (LPI him this morning. H	5/3/16, at 1:40 p.m. licensed N)-C stated, "I checked in with the can and does use the call the had the call light in place."				
	director of nursing (should have a call l	5/3/16, at 1:53 p.m. assistant ADON) said, "All residents ight within reach. I expect all pists to make sure residents				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00940		B. WING		05/0	6/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT	ER INNSBRIICK	CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21810	Continued From pa	ge 77	21810			
	have their call lights	3."				
	Policy for call lights	requested but not received.				
	SUGGESTED MET director of nursing (educate staff regardenvironment. The looordinate with staff areas residents fredare within reach.	THOD OF CORRECTION: The (DON) or designee, could ding the importance of a safe DON or designee, could ff to conduct periodic audits of quent to ensure a call lights R CORRECTION: Twenty-one				

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