DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CD8U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00940

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245310**

2. STATE VENDOR OR MEDICAID NO. (L2) **810313500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER INNSBRUCK**
(L4) **1101 BLACK OAK DRIVE**
(L5) **NEW BRIGHTON, MN** (L6) **55112**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/17/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Unit Supervisor 07/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/29/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **02/26/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

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

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245310 Y1	A. Building 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0246	Correction	ID Prefix F0280	Correction	ID Prefix F0282	Correction
Reg. # 483.15(e)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	06/10/2016	LSC	06/10/2016	LSC	06/10/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix F0315	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed
LSC	06/10/2016	LSC	06/10/2016	LSC	06/10/2016
ID Prefix F0323	Correction	ID Prefix F0329	Correction	ID Prefix F0371	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.35(i)	Completed
LSC	06/10/2016	LSC	06/10/2016	LSC	06/10/2016
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	06/10/2016	LSC	06/10/2016	LSC	06/10/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	GD/mm	07/05/2016	18623	06/17/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/6/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245310 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/20/2016 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).

ITEM 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. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	05/16/2016	LSC K0025	05/16/2016	LSC K0033	05/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0034	05/04/2016	LSC K0038	05/04/2016	LSC K0052	05/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	05/05/2016	LSC K0144	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	07/05/2016	37010	06/20/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/4/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245310 Y1	A. Building 02 - NEW BLDG B. Wing Y2	6/20/2016 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).

ITEM 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. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	05/16/2016	LSC K0025	05/16/2016	LSC K0034	05/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	05/04/2016	LSC K0052	05/04/2016	LSC K0061	05/16/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	05/05/2016	LSC K0144	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	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	TL/mm	07/05/2016	37010	06/20/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/4/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: CD8U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00940

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245310**

2. STATE VENDOR OR MEDICAID NO. (L2) **810313500**

3. NAME AND ADDRESS OF FACILITY
(L3) **BENEDICTINE HEALTH CENTER INNSBRUCK**
(L4) **1101 BLACK OAK DRIVE**
(L5) **NEW BRIGHTON, MN** (L6) **55112**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/06/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **105** (L18)

13.Total Certified Beds **105** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	105			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date : Jacob Mabera, HFE NE II 06/09/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 07/01/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION **02/26/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Received 6-3-16 BJ **F246 D The facility did not ensure a call light was within reach for 1 o 1 resident (R47) who was at risk for falls.** The call light policy was given twice per request to survey team.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach for 1 of 1 resident (R18) who was at risk for falls. Findings include: On 5/03/16, at 1:28 p.m. R18 was observed sitting upright in a Broda chair (a tilt and recline positioning chair). The Broda chair was three feet from the edge of R18's bed. The call light was lying across the bed. R18 was unable to reach	F 246	Accepted 6-7-16 **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The patient is on Hospice Care and is alert and orientated. 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.	

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

Administrator 6/2/16

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1 the call light. R18 stated could not move his chair. R18 stated "I use my call light to get the staff. I am supposed to ring it, not attempt to get up." At 1:31 p.m. nursing assistant (NA)-E answered the call light. NA-E gave the call light to R18. NA-E stated, "Therapy brought him back to the room. I don't know why they did not give him his call light." NA-E said R18 used the call light: "Whenever I get [R18] up I make sure [R18] has the call light because [R18] cannot call out loud enough to be heard." NA-E verified R18 was unable to move Broda chair. NA-E stated R18 was a fall risk, because R18 would reach for things and can fall out of the bed. NA-E stated, "I make sure all my residents have their call lights." R18's 4/19/16, admission Minimum Data Set (MDS) indicated R18 was severely cognitively impaired, and required assistance of two staff for bed mobility, transfers, and toilet use. The care plan dated 4/22/16, indicated R18 was at risk for falls and instructed staff to keep call light in reach at all times. During interview on 5/3/16, at 1:40 p.m. licensed practical nurse (LPN)-C stated, "I checked in with him this morning. He can and does use the call light. He should have had the call light in place." During interview on 5/3/16, at 1:53 p.m. assistant director of nursing (ADON) said, "All residents should have a call light within reach. I expect all staff including therapists to make sure residents have their call lights." Policy for call lights requested but not received.	F 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,	
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		

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F 280 SS=D	Continued From page 2 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared 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, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to re-assess for and implement interventions to reduce aggressive behaviors for 1 of 1 residents (R21) who had altercations with other residents on the unit. In addition, the facility failed to implement interventions to safe guard 1 of 1 residents (R14) who was at risk for injury related to other residents behaviors. Findings include: R21's admission history and physical dated 11/19/15, indicated He had advanced dementia	F 280	through call light reports. Nurse and NAR training in orientation and ongoing classes are used to remind staff. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Random call light audits will be done both physically and through call light reports monthly x 6 months and quarterly thereafter. Report will be reviewed in Safety Committee. **Include dates when corrective action will be completed.** 06/10/2016 **F280 D The facility did not ensure behaviors were re-assessed and interventions**	

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F 280	Continued From page 3 and "quite a few behaviors disturbances and quite a bit of difficulty with delirium as well." A review of R21's face sheet indicated diagnoses that included dementia with behavioral disturbance. A temporary care plan, undated indicated no behavior or mood concerns. R21's admission Mnimum Data Set (MDS) dated 12/2/15, indicated he required assistance for transfers, toileting, dressing and grooming, and ambulated with staff supervision. A care plan dated 12/14/15 indicated he was severely cognitively impaired and demonstrated socially inappropriate/disruptive behaviors that included physical aggression toward staff and other residents. The care plan directed staff to administer PRN (as needed) Ativan (a medication used to treat anxiety disorders), assess whether the behavior endangered other residents and intervene if needed, maintain a calm approach, and redirect 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 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 Progress Note dated 12/8/15, indicated R21 was wandering through the unit, into other residents rooms and taking their personal items and was observed a "couple of times"trying to hit other residents. On 12/14/15, R21 grabbed the glasses off R14 and grabbed R14. An interdisciplinary team (IDT) review of the behavior indicated staff would continue to monitor R21. A Progress Note dated 12/16/15, indicated R21 was	F 280	**implemented for 1 of 1 (R217) residents reviewed for accidents.** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Any patient involved in any sort of aggressive behavior will result in both patients having an event documented in Matrix. The event will then trigger IDT to follow up and look at interventions for patients involved. **How the facility will identify others residents having the potential to be affected by the same deficient practice.** All residents are assessed upon admission, quarterly, annually and with a significant change to identify potential behavior that needs to be addressed and care planned.	

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F 280	Continued From page 4 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 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 9-1-1 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. During an interview on 5/5/16, t 9:15 a.m., registered nurse (RN)-A stated R21 admitted to	F 280	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** This was an oversight and the current process works: Any resident involved in any sort of aggressive behavior will result in both residents having an event documented in Matrix. The event will then trigger IDT to follow up and look at interventions for residents involved. **How the facility plans to monitor its performance to make sure that solutions are sustained.** All events created will be reviewed by IDT during the week Monday through Friday. **Include dates when corrective action will be completed.** 06/10/2016	

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F 280	Continued From page 5	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 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 abuse.

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

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F 280	Continued From page 6 notes indicated R14 sustained a laceration and a scratch on 12/14/15, and was punched in the face on 12/19/15. Further, while R14 had been a victim of abuse on two separate dates, there was no care planned interventions implemented to direct staff to protect R14 from R21. During an interview on 5/6/16, at 8:43 a.m., RN-A stated she would have expected staff to complete an incident form and document follow-up. During in interview on 5/6/16, at 9:40 a.m., the ADON stated there was no follow up completed for R14 following the altercations with R21. He further stated, the nurses who were present missed it and the interdisciplinary team missed it. A policy for care planning was requested but none received.	F 280	**F282 D The facility did not ensure the care plan was followed for 2 of 2 residents (R87, R25)** **How corrective action will be accomplished for those residents found to have been affective by the deficient practice.** For both residents, new assessments (Braden and tissue tolerance) were completed and care plans changed to reflect that. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents are assessed with Braden and Tissue Tolerance to identify need for repositioning on admission, quarterly, annually and with significant change for appropriate care	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 2 of 3 residents (R25, R166) for repositioning and incontinence care, and the facility failed to follow the careplan for 1 of 3 residents (R87) who was dependent upon staff for activities of daily living (ADLs).	F 282		

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F 282	Continued From page 7 Findings include: Repositioning and incontinence care: R25 was continuously observed lying in bed on her back on 5/5/16, from 7:21 a.m. until 9:43 a.m. (two hours and 22 minutes). At 9:23 a.m. when asked how often R25 was repositioned licensed practical nurse (LPN)-B stated all residents get repositioned every two hours. Fifteen minutes later when asked LPN-C stated R25 was positioned according to care plan and if needed. At 9:43 a.m. LPN-B and LPN-C repositioned R25 slightly on the left side. R25 stated, "That feels good." No check or change of brief for incontinence was observed. At 11:34 a.m. on 5/5/16, R25 was observed lying on her right side in bed with LPN-B finishing up R25's pressure ulcers treatments with nursing assistant (NA)-A assisting. LPN-B stated R25's brief had been wet and with bowel movement. R25 was observed to have two large open holes, which appeared deep, one on R25's left hip area and one on her bottom which both appeared to have substance down in them. LPN-B stated the pressure ulcer on the left had honey gel in it, and the ulcer on the bottom had packing in it. LPN-B placed bandages over both holes to cover and applied tape to hold on the bandages. LPN-B stated the evening shift completed the treatments for R25's pressure ulcers on her leg and heel. As R25 was lowered into her Broda chair at 11:57 a.m. with the ceiling lift and the assistance of NA-A and LPN-B a small scab was observed on the top of R25's left foot. NA-A stated R25 needed two staff with transfers and repositioning. NA-A stated R25 was repositioned every two hours and was checked for incontinence every two hours. NA-A stated R25 usually had a bowel	F 282	and service allotment. Care plans are changed to reflect any changes assessed. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Random audits will be done on residents who identify as requiring repositioning or needs for repositioning. . Random audits will be done on residents who identify as requiring repositioning or needs for repositioning weekly x 4. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Residents will be reviewed on admission, during quarterly and annual care conferences and for significant change. **Include dates when corrective action will be completed.** 06/10/2016	

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F 282	Continued From page 8 movement every evening before going to bed. NA-A stated R25 did not sit on the toilet but was check and changed, and when the brief's yellow line was designed to turn blue to indicate wetness. NA-A then proceeded to help R25 with her morning cares before pushing R25 out to dining room in her Broda chair to eat. The resident was continuously observed while she was assisted to eat brunch and when she was finished eating R25 was moved to another table to watch the moving playing for an hour (R25 was toileted after meals according to the plan of care). R25 sat a table until LPN-B and NA-B lowered R25 back into her bed with the ceiling lift at 2:29 p.m. (R25 again had been up in her Broda chair for two hours and 32 minutes with no offer by staff for repositioning). After LPN-B and NA-B finished positioning R25 in bed with a neck pillow on top of a standard pillow and placed R25's lower legs on a heel lifter, and as they were about to leave the room, Surveyor asked LPN-B and NA-B if they were going to toilet R25. LPN-B stated yes they would check and change R25 which LPN-B and NA-B at 2:39 p.m. proceeded to change R25's wet brief and perform incontinence cares and put a dry brief on R25. (At that time R25 had went two hours and 42 minutes without check and change for incontinence after the noon meal and without repostioning). LPN-B felt R25's brief and said the pad they had taken off of R25 was wet. NA-B stated when yellow line on the brief turns blue the brief was wet and needs to be changed. NA-B confirmed R25's brief had a blue line and had been wet. LPN-B and NA-B then placed a pillow on R25's right side turned R25 slightly to the left. R25 stated she was comfortable. LPN-B told R25 staff would be back in two hours to reposition her.	F 282		

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F 282	Continued From page 9 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 ROHO cushion in R25's wheel chair (w/c). R25 did not receive the care and services in a timely manner for repositioniong and toileting. R25 went for two hours and 55 minutes without being checked and changed. In addition, R25 was toileted after meals according to the plan of care. The undated Nursing Assistant (NA) 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 bladders. On 5/5/16, at 9:53 a.m. RN-B stated she had instructed staff if they could not perform positioning and cares timely for R25 they were to let RN-B know. On 5/5/16, at 1:33 p.m. NA-D stated NAs knew mostly what to do by the assignment sheets. NA-D stated if a resident does not want to use the toilet then the resident will be off loaded every two hours with the resident standing up for a bit. NA-D stated R25 was repositioned every two hours. NA-D stated because of R25's open areas on her body she was laid back down in bed after	F 282		

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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

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F 282	Continued From page 11 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 pushed R166 in w/c down the hall, into the elevator and down to the nurse's station on first floor where R166 reported to LPN-D that her teeth hurt when eating the ice cream. LPN-D asked R166 about the pain and R166 reiterated her teeth hurt when eating something cold. The health unit coordinator (HUC) sitting there asked R166 if she wanted to see the dentist and R166 responded, "I was going to see the dentist now." R166 continued to sit up near the nurse's station. At 2:49 p.m. NA-F came walking up the hall toward the nursing station and stood. NA-F was asked when R166 was going to be toileted next and NA-F answered that she was going home at 3:00 p.m. NA-F asked what time the next shift coming on and if they were going to toilet R166. NA-F stated she would toilet R166. At 2:50 p.m. surveyor notified LPN-D that R166 had not been toileted for over two hours and asked if she would look at R166's skin with surveyor. LPN-D stated yes she would and that she expected R166 to be toileted after meals or when she lays down. LPN-D stated R166 had not laid down today because of the activity. LPN-D stated R166 laid down because she would be at risk for pressure ulcer. At 2:54 p.m. LPN-D and NA-F stood R166 up at the toilet and sink and removed R166's brief as	F 282		

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F 282	Continued From page 12 R166 dribbled urine while standing. LPN-D confirmed R166's brief was wet with urine and that the yellow line on the brief was now blue. LPN-D stated R166's brief was "moderately wet." (It now had been three hours and eight minutes from when NA-F said she had last toileted R166). LPN-D and surveyor observed R166's bottom to be non-smooth, reddened on both buttocks and LPN-D stated R166's bottom was not open, just reddened, and kind of chronic for her and that the skin nurse had looked at it. LPN-D applied treatment to R166's bottom. LPN-D stated R166 was toileted after meals, and that R166 usually came back from activity at 2:00 p.m. LPN-D stated the NA should have went up to the activity to get R166. After toileting R166 at 3:00 p.m. NA-F stated R166 could not tell NA-F when she had to go to the bathroom. When asked about the time frame for toileting R166, NA-F stated, "I knew she had went for exercise, but I was just going to wait until she got back." R166's care plan dated 11/20/15, indicated R166 was at a risk for pressure ulcers, had a diagnosis of dementia, was unable to reliably notify staff of need to toilet, and staff was to anticipate R166's needs. R166's care plan indicated R166 wore an incontinent product, needed assistance with cares, mobility, toileting and bowel and bladder incontinence. Short term goal for R166 was for skin to remain intact and free of redness. The care plan indicated R166 was to be repositioned and toileted every two hours and as needed. R166 did not receive the care and services as r166 was not toileted and repositioned every two hours.	F 282		

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	245310	A. BUILDING _____ B. WING _____	05/06/2016

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F 282	Continued From page 13 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 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 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. 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 ½ inch long with brown matter underneath them. On 5/5/16, at 12:24 p.m. a nursing assistant	F 282		

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F 282	Continued From page 14 (NA)-M was observed wheel resident out of the living room and indicated was going to lay her down for a nap. When asked if she was assigned to R87 for the shift the NA-M stated she was, however, she was not a regular caregiver in the unit. NA-M verified the nails were long and dirty underneath. When asked who was responsible for trimming the fingernails, NA-M stated she did not know and directed surveyor to licensed practical nurse (LPN)-A. -At 12:29 p.m. registered nurse (RN)-A unit nurse manager stated resident was challenging when asked about nail care. RN-A and LPN-A verified resident bathe was Monday 5/2/16, evening and when looking through the Shower day Worksheet/Body Audit dated 5/2/16, nails had not been marked as trimmed. RN-A verified there was no documentation in the progress notes of resident refusing nail care. RN-A indicated she was surprised there was no documentation as a regular nurse worked Monday evening shifts when resident bath/shower was scheduled. RN-A verified in March and April 2016, all days bath/shower had been completed nail care had not been documented as completed. -At 12:38 p.m. LPN-A stated "If it's not documented it was not done." -At 12:48 p.m. RN-A acknowledged a resident care plan was supposed to be followed. R87's diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus without complications and depressive episodes obtained from the care plan dated 1/28/16. During review of the Care Area Assessments (CAAs) dated 2/4/16, revealed the ADL CAA had not triggered, however, the cognitive loss/dementia CAA dated 2/4/16, indicated R87	F 282		

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F 282	Continued From page 15 had severe cognitive impairments and had diagnoses of dementia and altered mental status. The CAA indicated the resident may need assistance with making decisions regarding health and safety. R87's care plan dated 2/10/16, indicated resident had an alteration in ADLs related to needing assist with her cares due to dementia, chronic lower extremity edema/wounds with pain, weakness and decreased range of motion. Goal "[R87] will be clean, neat and well groomed." Care plan indicated R87 needed one staff assist with grooming. R87's 14 day Minimum Data Set (MDS) dated 2/11/16, indicated resident required extensive physical assistance of one staff with personal hygiene. In addition the MDS indicated resident did not reject care which included ADLs. On 5/6/16, at 9:41 p.m. the assistant director of nursing (ADON) stated all staff were supposed to follow the plan of care for residents when providing cares. A care plan policy was requested.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312	**F312 D The facility did not provide nail care for 1 of 3 residents (R87) who are dependent upon staff for grooming.** **How corrective action will be accomplished for those residents found to have been affective by the**	

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F 312	Continued From page 16 Based on observation, interview and document review, the facility failed to ensure timely care and services was provided for 1 of 3 residents (R25) reviewed for urinary incontinence who was dependent on staff for repositioning and incontinence care. In addition, the facility failed to ensure nail care was provided for 1 of 3 residents (R87) reviewed for activities of daily living (ADLs) and who was dependent on staff for nail care. Findings include: Incontinence care: R25 was continuously observed lying in bed on her back on 5/5/16, at 11:34 a.m. R25 was observed lying on her right side in bed with LPN-B finishing up R25's pressure ulcers treatments with nursing assistant (NA)-A assisting. LPN-B stated R25's brief had been soiled with urine and feces. NA-A stated R25 was checked for incontinence every two hours. NA-A then proceeded to help R25 with her morning cares before pushing R25 out to dining room in her Broda chair to eat. The resident was continuously observed while she was assisted to eat brunch and when she was finished eating R25 was moved to another table to watch the moving playing for an hour, R25 was laid back down on the bed by LPN-B and NA-B lowered R25 back into her bed with the ceiling lift at 2:29 p.m. R25 had gone two hours and 55 minutes without being checked and changed. 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	F 312	deficient practice. This resident often refuses nail care from staff. Facility policy promotes patients independence and patient right to refuse while ensuring adequate documentation of resident choices. Nail care will be completed as resident allows. Documentation is completed for each time of refusal. **How the facility will identify others residents having the potential to be affected by the same deficient practice.** Residents needing nail care will be identified weekly on bath day. Any refusal will be met with gentle encouragement and documented.	

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F 312	Continued From page 17 after meals, on night rounds and as needed. R25 was not checked and changed after meals according to the plan of care. 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 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 was incontinent, non weight bearing and used a w/c for mobility. Current physician orders included: Apply air overlay mattress to bed due to Braden score of 13 with risk factors resulting in an increased risk of skin breakdown, Special Instructions: Check that the mattress was inflated dated 1/29/16, turn and position Instructions: License staff to ensure that resident was turned and repositioned every two hourly. Off load every two hours when in a chair for a full minute dated 6/4/15. R25's significant change Minimum Data Set (MDS) dated 3/19/16, indicated R25 needed two staff assistance with bed mobility, transfer and toilet use, was always incontinent of bowel and bladder, and did not reject cares. R25's significant change Care Area Assessment (CAA) dated 3/19/16, indicated R25's cognition was severely impaired, R25 was understood, usually understands, speech was clear and staff anticipated R25's needs. The undated Nursing Assistant Assignment Sheet for R25 indicated R25 two staff were needed to	F 312	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Nail care is treatment order on the eMAR. Licensed staff will document on nail care in the eMAR. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Random audits of eMar documentation will be completed monthly x six months. **Include dates when corrective action will be completed.** 06/10/2016	

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F 312	Continued From page 18 toilet R25 upon rising, before and after meals, and as needed because of R25's incontinence of bowel and bladder. During interview with registered nurse (RN)-B on 5/5/16, at 9:53 a.m. stated she expected staff to check R25 for incontinence every two hours. Surveyor told RN-B staff during two continuous observations of over two hours R25 had not been checked and changed without intervention from surveyor. RN-B stated she had instructed staff if they could not perform positioning and cares timely for R25 they were to let RN-B know. On 5/5/16, at 1:33 p.m. NA-D stated NAs knew mostly what to do by the assignment sheets. NA-D stated if a resident does not want to use the toilet then the resident will be off loaded every two hours with the resident standing up for a bit. Nail Care: R87 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. 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. resident was observed seated in wheelchair and both hand fingernails were noted to have approximately ½ inch long with brown matter underneath them. On 5/5/16, at 7:30 a.m. to 9:20 a.m. the fingernails were still untrimmed and noted with	F 312		

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F 312	Continued From page 19 brown matter underneath. On 5/5/16, at 11:35 a.m. resident was observed seated on her wheelchair at the dining room table. R87's fingernails were still long and had brown matter underneath the nails. R87 remained in the dining room until 11:50 a.m. then observed licensed practical nurse (LPN)-A wheel resident down the hallway into her room. When LPN-A got resident into room resident indicated it was cold her room. LPN-A was observed wipe resident nose then wheeled resident to the living room for mass never offered the trim the fingernails or clean underneath. -At 12:24 p.m. a nursing assistant was observed wheel resident out of the living room and indicated was going to lay her down for a nap. When asked if she was assigned to R87 for the shift nursing assistant (NA)-M stated she was however was not a regular caregiver in the unit. NA-M verified the nails were long and dirty underneath. When asked who was responsible for trimming the fingernails, NA stated she did not know and directed surveyor to LPN-A. -At 12:29 p.m. registered nurse (RN)-A unit nurse manager stated resident was challenging when asked about nail care. RN-A and LPN-A verified resident bathe was Monday 5/2/16, evening and when looking through the Shower day Worksheet/Body Audit dated 5/2/16, nails had not been marked as trimmed. RN-A verified there was no documentation in the progress notes of resident refusing nail care. RN-A indicated she was surprised there was no documentation as a regular nurse worked Monday evening shifts when resident bath/shower was scheduled. RN-A verified in March and April 2016, all days bath/shower had been completed nail care had not been documented as completed.	F 312		

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F 312	Continued From page 20 -At 12:38 p.m. LPN-A stated "If it's not documented it was not done." -At 12:48 p.m. RN-A stated she would expect the nurses to document either in the weekly shower worksheet or in the progress notes if a resident bath had been completed and/or refused and nail care should be documented if done or not. RN-A acknowledged a resident care plan was supposed to be followed. R87's diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus without complications and depressive episodes obtained from the care plan dated 1/28/16. During review of the Care Area Assessments (CAAs) dated 2/4/16, revealed the ADL CAA had not triggered however the cognitive Loss/dementia CAA dated 2/4/16, indicated R87 had severe cognitive impairments, and had diagnosis of dementia and altered mental status. The CAA indicated resident may need assistance with making decisions regarding health and safety. R87's care plan dated 2/10/16, indicated resident had an alteration in ADLs related to needing assist with her cares due to Dementia, chronic lower extremity edema/wounds with pain, weakness and decreased range of motion. Goal "[R87] will be clean, neat and well groomed." Care plan indicated R87 needed one staff assist with grooming. R87's 14 day Minimum Data Set (MDS) dated 2/11/16, indicated resident required extensive physical assistance of one staff with personal hygiene. In addition, the MDS indicated resident did not reject care which included ADL's.	F 312		

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F 312	Continued From page 21 On 5/6/16, at 9:41 p.m. the assistant director of nursing (ADON) stated he would expect the staff to document all resident refusal and if there were a lot of incidences would have to be care planned. ADON further stated all staff was supposed to follow the plan of care for residents when providing cares. The facility Care Of Fingernails and Toenails policy dated 11/2015, directed staff to provide cleanliness and report any problematic conditions to the charge nurse during care.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R25) with a pressure ulcer received timely repositioning and the facility failed to ensure 1 of 3 resident (R166) who was identified at being at risk for pressure ulcers received timely repositioning. Findings include:	F 314	F314 D The facility did not provide care and services to prevent worsening of pressure ulcers for 1 of 3 residents (R25) reviewed for pressures ulcers. How corrective action will be accomplished for those residents found to have been affective by the deficient practice. New assessments including the Braden, Tissue Tolerance, and Bowel and Bladder assessments have been completed. Resident remains incontinent and requires repositioning every 3 hours.	

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F 314	Continued From page 22 R25 was continuously observed lying in bed on her back on 5/5/16, from 7:21 a.m. until 9:43 a.m. (two hours and 22 minutes). At 9:23 a.m. LPN-B was interviewed, stated all residents get repositioned every two hours. At 9:38 a.m., LPN-C stated R25 was repositioned according to her care plan and when needed. At that same time, nursing assistant (NA)-A stated he repositioned R25 every two hours. At 9:43 a.m. when licensed practical nurse (LPN)-B and LPN-C repositioned R25, R25 stated, "That feels good." At 11:34 a.m. R25 was observed lying on her right side in bed with LPN-B finishing up R25's pressure ulcers treatments with NA-A assisting. During the observation, R25 was observed to have open sores on her left hip area and on her bottom. Both appeared to have a light brown substance in them. LPN-B stated the pressure ulcer on the left had honey gel in it, and the ulcer on R25's bottom had packing in it. LPN-B was observed to place bandages over both pressure ulcers and applied tape to secure the bandages. LPN-B stated the evening shift staff completed treatments for pressure ulcers to R25's leg and heel. During transfer to the Broda chair (tilt and recline positioning chair) at 11:57 a.m., a small scab was observed on the top of R25's left foot. During the transfer NA-A stated R25 needed two staff with transfers and repositioning. NA-A stated R25 was repositioned every two hours. NA-A then proceeded to help R25 with her morning cares before pushing R25 out to dining room in her Broda chair to eat. The resident was continuously observed while she was assisted to eat brunch and when she was finished eating R25 was moved to another table to watch the moving playing for an hour. R25 was laid back down on the bed by LPN-B and NA-B	F 314	**How the facility will identify other residents having the potential to be affected by the same deficient practice.** Skin assessment, Braden and Tissue Tolerance are done upon admission, quarterly, annually and with a significant change. Care plans are reviewed and developed according to these assessments. **What measures will be put into place or systemic changes made to ensure**	

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F 314	Continued From page 23 lowered R25 back into her bed with the ceiling lift at 2:29 p.m. (R25 had been up in her Broda chair for two hours and 32 minutes with no offer by staff for repositioning). LPN-B told R25 staff would be back in two hours to reposition her. Five 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 bed and ROHO cushion in R25's wheel chair (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	F 314	**that the deficient practice will not recur.** Use quarterly care conference schedule to identify residents at risk. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Random audits will be done on residents who identify as requiring repositioning or needs for repositioning. . Random audits will be done on patients who identify as requiring repositioning or needs for repositioning weekly x 4. **Include dates when corrective action will be completed.** 06/10/2016	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 24 left leg was slowly healing. NP's visit note indicated, "Pressure ulcer of sacral region, unstageable ... Pressure ulcer of left hip, unstageable ... Pressure ulcer of other site [back of left lower leg/ankle] stage 4 ... Pressure ulcer of unspecified heel, unstageable." On 2/19/16, seen by NP for acute visit to evaluate and manage aspiration, wounds and S/P fracture of left femur. NP's visit note indicated pressure ulcer on left leg had increased in size with a new traumatic skin tear on R25's left leg. Nutrition assessment dated 2/29/16, indicated R25 required increased protein need for wound healing. Nutrition assessment dated 3/10/16, indicated, "No goal weight for R25 at this time due to hospice status-provide food and fluids for comfort. Goal skin will be free of infection." R25's significant change Minimum Data Set (MDS) dated 3/19/16, indicated R25 needed two staff assistance with bed mobility, transfer and toilet use, was always incontinent of bowel and bladder, and did not reject cares. The same MDS indicated R25 had one Stage 3 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) and one Stage 4 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) pressure ulcer which was not present upon admission or readmission and two unstageable (full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore,	F 314		

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	245310	A. BUILDING _____ B. WING _____	05/06/2016

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F 314	Continued From page 25 the true depth of the damage cannot be estimated until these are removed) pressure ulcers, one of these not present upon admission or readmission. One pressure ulcer measurement was indicated in the MDS as 8.2 centimeters (cm) x 2.6 cm. The MDS revealed the Stage 3 pressure ulcer had not been present 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 a pressure reducing device for chair, pressure reducing device for bed, turning/repositioning program, nutrition or hydration intervention, 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 was 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 toileting. 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'clock ...on the left trochanter pressure ulcer, unstageable, measuring about 2.5 cm x 2.6 cm x 5.5 cm ...On the lower posterior leg remain unchanged and measured 8.2 cm x 2.6 cm partial thickness skin loss ...Left heel ulcer, unstageable measure about 3.4 cm x 4.0 cm. On 3/31/16, for the routine NP monthly visit, NP's	F 314		

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F 314	Continued From page 26	F 314		

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, stage 3 since 2/9/16, increased in size since 3/10/16, a pressure ulcer on left trochanter, unstageable since 2/19/16, a pressure ulcer on left heel, unstageable since 1/18/16, increased in size since 3/10/16, and two wound areas on lower posterior leg.

R25 seen by physician on 4/26/16. the physician notes indicated, "Decubitus ulcers - Healing not expected because of end stage disease [Alzheimer's Disease]. Plan- Continue hospice services."

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.

During interview on 5/5/16, at 9:53 a.m. with registered nurse (RN)-B (facility's wound nurse) stated when R25's cast was taken off a pressure ulcer was found now healed. RN-B stated the pressure ulcer on R25's left heel from September 2015 was found when R25 was repositioned. RN-B stated residents that could not reposition themselves as R25 were repositioned every two hours. RN-B stated tissue tolerance assessments were completed every three months, upon admission, readmission and if pressure ulcer were found. RN-B verified the facility's tissue

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F 314	Continued From page 27 tolerance assessment completed 8/31/15, indicated at two hours R25's skin on her buttocks had been reddened and blanchable. RN-B stated the procedure for the tissue tolerance assessment was to try to get to the time frame of no skin redness. When asked why the facility did not position R25 any sooner than two hours to avoid redness and possible skin breakdown on R25's bottom RN-B stated, "I wanted to be practical, and if I put it any sooner [less than two hours repositioning] they [staff] will tell me it is not practical." RN-B stated the pressure ulcer on R25's left heel was now unstageable with eschar (a slough or piece of dead tissue that is cast off from the surface of the skin). RN-B stated she completed weekly wound assessments on R25's pressure ulcers. RN-B stated a Stage 2 pressure ulcer was found on R25's coccyx on 12/24/15, and was now unstageable with slough, tunneling and undermining. RN-B stated the Stage 2 pressure ulcer on R25's left trochanter (IT) was found upon wound rounds on 12/16/15, and was now unstageable with slough. RN-B stated R25's left lower outer leg pressure ulcer developed because the immobilizer was rubbing on R25's leg. When asked about R25's pressure ulcers developing RN-B stated R25 moves her legs and feet about and the friction and shearing caused the pressure ulcers. When asked to re-clarify RN-B stated "friction and shearing" is what caused R25's pressure ulcers and that R25 was a "complex case." RN-B stated R25 had a pressure reducing mattress and cushion in her Broda chair now as the chair hospice provided was too hard for R25 to sit in. RN-B was unable to give dates when the overlay mattress and ROHO cushion intervention had been put in place. RN-B stated she expected staff to reposition and check R25 for incontinence every two hours. Surveyor	F 314		

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F 314	Continued From page 28 informed RN-B during two separate continuous observations of over two hours, R25 had not been repositioned timely without the intervention from surveyor. RN-B stated she had instructed staff if they could not perform positioning and cares timely for R25 they were to let RN-B know. On 5/5/16, at 1:33 p.m. NA-D stated NAs knew mostly what to do by the assignment sheets. NA-D stated if a resident does not want to use the toilet then the resident will be off loaded every two hours with the resident standing up for a bit. NA-D stated R25 was repositioned every two hours. NA-D stated because of R25's open areas on her body she was laid back down in bed after brunch. NA-D stated R25 always lets staff reposition her and does not refuse. NA-D stated if R25 does not want to get up until later in the morning then she will be repositioned in bed. On 5/6/16, at 3:25 p.m. RN-B stated she took full responsibility for the ROHO chair cushion being found flattened. RN-B stated she checked the ROHO cushion every Monday morning. When asked if the inflatability of the ROHO cushion was being monitored by the nurses or checked by the NAs RN-B stated, "no, only by myself and I take full responsibility." When asked why nursing staff were not checking or monitoring RN-B stated, "Because I did not want to come in and check the cushion flat someday." During an interview on 5/5/16, at 3:37 a.m., the plant operations manager stated he did not know what a ROHO cushion was and was not responsible for maintaining them. During an interview on 5/5/16, at 3:41 p.m., the director of therapy stated the therapy department	F 314		

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F 314	Continued From page 29 will let nursing know how much to inflate the ROHO cushions and nursing is responsible for putting the information in the treatment record for monitoring. She stated nursing receives education on how to measure the space between the bottom of the seat and the ischial tuberosity to check for inflation. A review of R25's treatment record and medication record indicated there was no order to inflate or check for inflation of the ROHO cushion. ROHO Cushion Instructions provided by therapy dated 2003, Instructions for Adjustment indicated included 16 steps for achieving the highest possible level of performance and personal satisfaction for the ROHO cushion. Step 16 of the cushion instructions indicated, "Check Cushion Height Wiggle fingers to make sure there is approximately ½ inch of air between person and 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." Undated policy Pressure Ulcer and Non-Surgical Wound Documentation provided by the facility indicated "... 9. Initiate and implement appropriate measures in care plan; and update as treatment/interventions change... 12. General Wound and skin Care guidelines. Should be followed for all residents with potential and/or actual impairment of skin integrity... c. Turn/reposition up to every 2 hours while in bed and offload every 2 hour when in a chair."	F 314		

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F 315 F 315 SS=D	Continued From page 30 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely care and services with toileting was provided for 1 of 3 residents (R166) reviewed for urinary incontinence. Findings include: During continuous observation of R166 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 licensed practical nurse (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. Nursing assistant (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	F 315 F 315	**F315 D The facility did not ensure care and services were provided for 1 of 3 (R166) reviewed for incontinence.** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Resident was at an activity and NAR decided to wait until it was over to assist in toileting for a total of 2 ½ hour time lapse. **How the facility will identify other residents having the**	

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F 315	Continued From page 31 R166 at 11:45 a.m. 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 and had not approached R166 for toileting. 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 pushed R166 in wheelchair down the hall, into the elevator and down to the nurse's station on first floor where R166 reported to LPN-D that her teeth hurt when eating the ice cream. LPN-D asked R166 about the pain and R166 reiterated her teeth hurt when eating something cold. The health unit coordinator (HUC) was sitting there and asked R166 if she wanted to see the dentist and R166 responded, "I was going to see the dentist now." R166 continued to sit up near the nurse's station. At 2:49 p.m. NA-F came walking up the hall toward the nursing station and stood. NA-F was asked when R166 was going to be	F 315	**potential to be affected by the same deficient practice.** All residents are assessed on admission, quarterly, annually and with significant change for appropriate care and service allotment. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** We will continue to assess all residents on admission, quarterly, annually and with significant change for appropriate care and service allotment. **How the facility plans to monitor its performance to make sure that solutions are sustained.** All residents are assessed on admission with subsequent care conferences as needed to assess needs and services. **Include dates when corrective action will be completed.** 06/10/2016	

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F 315	Continued From page 32	F 315		

toileted next and NA-F answered that she was going home at 3:00 p.m. NA-F was asked what time the next shift coming on and if they were going to toilet R166 and NA-F stated she would toilet R166. At 2:50 p.m. surveyor notified LPN-D R166 had not been toileted for over two hours and asked if she would look at R166 with surveyor. LPN-D stated yes she would and that she expected R166 to be toileted after meals or when she laid down. LPN-D stated R166 had not laid down today because of the activity. LPN-D stated R166 laid down because she would be at risk for pressure ulcer.

At 2:54 p.m. LPN-D and NA-F stood R166 up at the toilet and sink and removed R166's brief as R166 dribbled urine while standing. LPN-D confirmed R166's brief was wet with urine and that the yellow line on the brief was now blue. LPN-D stated R166's brief was "moderately wet." (It had been three hours and eight minutes from when NA-F said she had last toileted R166). LPN-D and surveyor observed R166's bottom to be non-smooth, all reddened on both buttocks and LPN-D stated R166's bottom was not open, just reddened, kind of chronic for her and that the skin nurse had looked at it. LPN-D applied treatment to R166's bottom. LPN-D stated R166 was toileted after meals, and that R166 usually came back from activity at 2:00 p.m. LPN-D stated the NA should have went up to the activity to get R166. After toileting R166 at 3:00 p.m. NA-F stated R166 could not tell NA-F when she had to go to the bathroom. When asked about the time frame for toileting R166, NA-F stated, "I knew she had went for exercise, but I was just going to wait until she got back."

R166's careplan dated 11/20/15, indicated R166

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F 315	Continued From page 33 was at a risk for pressure ulcers, had a diagnosis of dementia, was unable to reliably notify staff of need to toilet, and staff was to anticipate R166's needs. R166's careplan indicated R166 wore an incontinent product, needed assistance with cares, mobility, toileting and bowel and bladder incontinence. Short term goal for R166 was for skin to remain intact and free of redness. The care plan indicated R166 was to be toileted every two hours and as needed. The Care Area Assessment (CAA) summary dated 11/25/15, indicated R166 needed assistance with cares, mobility, toileting, bowel and bladder incontinence, wore an incontinent product and received treatment to her bottom every shift for prevention. The 11/25/15, CAA also indicated R166 had a pressure reducing mattress and w/c cushion for prevention of skin breakdown. The CAA further indicated staff were to anticipate R166's needs. It was unable to determine any voiding pattern in the review of the three-day bowel and bladder assessment completed in February 2016 due to incomplete data. R166's Minimum Data Set (MDS) dated 3/1/16, indicated R166 had a diagnosis of Alzheimer's disease and R166's cognition was severely impaired. The MDS indicated R166 did not reject cares and was at risk for developing pressure ulcers. The MDS also indicated R166 was on a turning/repositioning program, was always incontinent of bowel and bladder and was not on a toileting program. The MDS further indicated R166 needed extensive assistance with staff for transferring, locomotion on and off the unit, and extensive assistance of two staff with toileting.	F 315		

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F 315	Continued From page 34 Review of Nursing Progress Notes (PN) included: 4/26/16, PN indicated R166 had a red and small open area on the coccyx. 4/27/16, progress note PN indicated R166 had poor skin integrity and some areas of excoriation and redness on R166's bottom. The current May 2016 Physician Orders reviewed for R166 indicated R166 received Lasix every morning. R166's physician orders also indicated R166 received barrier cream, antibiotic ointment and Clotrimazole cream (antifungal) to R166's bottom three times a day for redness. R166's May 2016 Treatment Administration Record indicated R166 had received the barrier cream, Clotrimazole cream and antibiotic ointment. The undated Nursing Assistant Assignment Sheet for R166 indicated R166's mode of transportation was a w/c 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 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 color at a certain point of wetness. No reference to toileting was indicated in the	F 315		

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F 315	Continued From page 35 policy provided by the facility for Acitivities of Daily Living.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 1 residents (R21) who displayed negative behaviors directed at other residents on the unit. Findings include: R21's admission history and physical dated 11/19/15, indicated R21 had advanced dementia and "quite a few behaviors disturbances and quite a bit of difficulty with delirium as well." A review of R21's face sheet indicated diagnoses that included dementia with behavioral disturbance. A temporary care plan, undated indicated no behavior or mood concerns. R21's admission Minimum Data Set (MDS) dated 12/2/15, indicated he required assistance for transfers, toileting, dressing and grooming, and ambulated with staff supervision. A care plan dated 12/14/15, indicated he was severely cognitively impaired, had potential for pain related	F 323	**F323 D The facility did not ensure adequate supervision for 1of 1 resident (R217) reviewed for accidents.** **How corrective action will be accomplished for those residents found to have been affective by the deficient practice.** The residents had an altercation with another patient that did not result in any injury to either resident. Subsequent documentation following altercation did not show any changes in resident's baseline. All resident to resident altercations will be documented on for 72 hours by nursing.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 36 to a history of shoulder and back pain, incontinent of bowel and bladder, and demonstrated socially inappropriate/disruptive behaviors that included physical aggression toward staff and other residents, undressing in common areas, and defecating on the floor throughout the facility. The care plan directed staff to administer PRN (as needed) Ativan (a medication used to treat anxiety disorders), assess whether the behavior endangered other residents and intervene if needed, maintain a calm approach, and redirect 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 R21 was found on the floor in the hallway, a subsequent note dated 12/8/15, indicated R21 was wandering through the unit, into other residents rooms and taking their personal items and was observed a "couple of times" trying to hit other residents. On 12/9/15, R21 defecated on a chair in another resident ' s room. A noted dated 12/13/15, indicated R21 was constantly taking off his clothes, combative with re-direction, opened a window and pushed the	F 323	**How the facility will identify 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 put into place or systemic changes made to ensure that the deficient practice will not recur.** All residents will be identified by assessments quarterly, annually, upon admission and with significant change. Appropriate interventions will be documented if required. **How the facility plans to monitor its performance to**	

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	245310	A. BUILDING _____ B. WING _____	05/06/2016

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F 323	Continued From page 37 screen out and started pushing other resident's personal belongings out of the window. He also went into the clean linen room and defecated on the floor, wrapped it in a washcloth and put it in the cabinet. On 12/14/15, R21 grabbed the glasses off R14 and grabbed R14. An interdisciplinary team (IDT) review of the behavior indicated staff would continue to monitor R21. A Progress Note dated 12/16/15, indicated R21 was 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 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 9-1-1 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	F 323	**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	

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F 323	Continued From page 38	F 323		

was sent to the emergency room. No other interventions was 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.

A review of R21's Medication Administration History dated 11/25/15 through 12/1/15, indicated and order for Ativan 0.5 milligrams (mg) every six hours as needed, however the Ativan was only administered once on 12/17/15 even though R21 displayed signs of anxiety almost daily during the month of September. Further, while R21's care plan identified potential for pain and an alteration in toileting, there was no evidence the facility assessed the need for toileting when R21 urinated and defecated in inappropriate areas and removed his clothing, nor was there evidence the facility assessed the need for pain medication when R21 displayed behaviors

During an interview on 5/5/16, at 9:15 a.m., registered nurse (RN)-A stated R21 admitted to 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

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F 323	Continued From page 39	F 323		

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 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 abuse.

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 Innsbruck Resident Progress Notes dated 12/11/15 through 12/24/15, did not reflect either incident, nor was a facility event form completed even though R21's notes indicated R14 sustained and laceration and a scratch on 12/14/15, and was punched in the face on 12/19/15. Following the incident on 12/19/15, there was no evidence of follow up or monitoring for injures. Further, while R14 had been a victim of abuse on two separate dates, there was no care planned interventions to protect R14 from R21.

During an interview on 5/6/16, at 8:43 a.m., RN-A stated she would have expected staff to complete an incident form and document follow-up.

During interview on 5/6/16, at 9:40 a.m., the ADON stated there was no follow up completed for R14 following the altercations with R21. He

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F 323	Continued From page 40 further stated, the nurses who were present missed it and the interdisciplinary team missed it. A facility policy titled Benedictine health Center at Innsbruck, behavior Management Process, dated 11/20/15, was reviewed. The policy indicated effective management of behaviors through assessment and interventions is the goal of the program. The policy directed staff to Monitor and track symptoms and interventions, analyze documentation on an ongoing basis. If interventions were unsuccessful enroll resident in the behavior Management Program and track behaviors on the treatment sheet.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**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.	

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F 329	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide monitoring for antipsychotic medication side effects and effectiveness for 1 of 5 residents (R85) reviewed for unnecessary medications. In addition the facility failed to act upon consulting pharmacist's recommendation for 1 of 5 residents (R85) reviewed for unneccessary medications. Findings include: R85's diagnoses include but not limited to multiple sclerosis, adult personality disorder, anxiety disorder and hypertension obtained from Resident's face sheet dated 5/6/16. Review of R85's Physician Order Report dated 5/1/16 -5/31/16, revealed a physician order dated 1/27/15, for Haloperidol (an antipsychotic medication) 2 milligram (mg) per milliliter (ml) with instructions to give 0.5 ml sublingually at bedtime daily. Review of R85's medication administration record/treatment administration record (MAR/TAR) dated 2/1/16 through 5/6/16, lacked evidence of documentation for monitoring the side effects and effectiveness of anti-psychotic medication. Review of R85's medical record revealed consultant pharmacist communication to nursing	F 329	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.	

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F 329	Continued From page 42 dated 12/1/15, 1/4/16 and 4/1/16, with recommendation for side effect monitoring for Haloperidol. However R85's medical record lacked evidence that the consulting pharmacist's recommendations were acted upon by the facility staff. During interview on 5/5/16, at 12:10 p.m. licensed practical nurse (LPN)-G verified, was unable to locate anti-psychotic side effect monitoring sheet anywhere in R85's medical record. During interview on 5/6/16, at 8:37 a.m. registered nurse (RN)-C, acknowledged there was no side effect monitoring in place for anti-psychotic medication in R85's medical record. During interview on 5/6/16, at 11:27 a.m. the assistant director of nursing (ADON) stated he expected residents on psychotropic medications to be monitored for side effects and nurses are to document in the resident's TAR. ADON verified that R85's medical record lacked evidence of side effect monitoring for Haloperidol. ADON stated the expectation is that the facility to act upon the consulting pharmacist's recommendations. When ADON was asked if consulting pharmacist recommendation for side effect monitoring for Haloperidol were not acted upon, ADON stated he was not sure if they were. Facility's policy for antipsychotic medication monitoring and consulting pharmacist reviews was requested but none provided.	F 329	**How the facility will identity 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.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 43 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food sanitation procedures were followed to minimize the possibility of food borne illness in the main kitchen and in 3 of 4 kitchenettes. This had the potential to 98 of 99 who were served food and/or fluids out of 3 of 4 kitchenettes and the main kitchen Findings include Main kitchen On 5/3/16, at 11:49 a.m. to 12:06 p.m. during the initial kitchen tour with the registered dietician (RD) and culinary service cook both the inside of the ovens of the four burner stove were observed heavily soiled with black baked on substances. Both the RD and cook verified the ovens were not clean and the cook indicated she had not used the ovens recently. -The dishwasher was observed to have a light white flaky porous lime build up inside the dishwasher chute/air vent on the clean side. The substance was loose/flaky with touch.	F 371	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Findings of pharmacy review will be reviewed by quality council every 3 months. **Include dates when corrective action will be completed.** 06/10/2016 **F371 E The facility did not ensure food sanitation procedures were followed in the main kitchen and 1 of 4 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 vent	

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F 371	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.	F 371	resident was affected negatively. The oven in the kitchen was cleaned that day. The dishmachine vent 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 meetings with staff to educate them on new procedures have been completed. **How the facility will identify others residents having the potential to be affected by the same deficient practice.** Weekly checklist will be completed and reviewed by manager. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Manager will review weekly checklists to	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431	see that they are completed	

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F 431 SS=E	Continued From page 45 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 431	**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.	

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F 431	Continued From page 46 review, the facility failed to ensure undated or expired Mantoux solution was removed from medication refrigerators for 3 of 4 units to ensure that they were not used on residents. In addition, the facility failed to ensure expired medications were removed from the medication cart for 1 of 3 medication carts. Findings include: Villa Unit During medication room observation on 5/04/16, at 1:08 p.m. a multi dose vial of Aplisol (testing solution for determining possible exposure to tuberculosis) was found in the medication refrigerator. The vial was not dated when it had been opened or dispensed. Licensed practical nurse (LPN)-E verified it was not dated and said, "I thought they were supposed to date it. They must have taken it out of TCU [Transitional Care Unit]." Oak View Unit During medication room observation on 5/04/16, at 1:53 p.m. three vials of Aplisol were found in the medication refrigerator. The first vial was dated as opened on 2/7/16. The expiration date printed on the vial was 3/17. The second vial was dated as opened on 2/8/16. The expiration date printed on the vial was 3/17. The third vial was dated as opened on 3/25/16. The expiration date printed on the vial was 4/17. LPN-B verified the dates the Aplisol vials were opened. LPN-B stated, "It did not matter when the vial was opened. The vial does not have a different expiration date then the expiration date printed on the bottle." Garden Terrace Unit	F 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 as a part of their practice prior to giving medication. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Pharmacy nurse consultant completes a quarterly pharmaceutical audit and checks all fridges and medication carts throughout the facility. Night nurse will check medication carts and fridge on their neighborhood weekly on Fridays and remove any expired medications.	

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F 431	Continued From page 47 During medication room observation on 5/4/16, at 2:37 p.m. an undated vial of Aplisol was found in the medication refrigerator. The expiration date printed on the vial was 1/21/18. Registered nurse (RN)-C verified that the Aplisol had not been dated when opened. RN-C said, "Aplisol is good for 30 days after opened. This should have been dated. Yes we have used it." A multi-dose vial of Afluria influenza vaccine was found in the medication refrigerator. There was no date opened on it. The expiration date printed on the vial was 6/5/16. RN-C verified the Afluria was not dated when opened and said, "It is good for a year after it has been opened, I guess." During a medication observation on 5/5/16, at 8:18 a.m. LPN-G took out Senna 8.6 milligrams (mg) bottle from the medication cart and noted that Senna 8.6mg had an expiration date of 6/15 on the bottle. LPN-G verified the medication bottle labelled Senna 8.6mg was open, had expired and had about half tablets left in it. The medication cart was checked for expired medication and an open medication bottle labelled calcium with vitamin D 600mg was noted on the cart with an expiration date of 4/16. LPN-G verified the bottle labelled calcium with vitamin D 600mg was open, had expired and had about 3/4 of tablets in it. During interview on 5/4/16, at 3 p.m. the assistant director of nursing (ADON) stated, "Aplisol is good for 30 days after it has been opened. I expect the nurses to date the vial when they open it. I helped give all the Flu vaccines this fall. I think we dated all vials when we opened them. I am not sure how long they are good for after opening. I will have to find out."	F 431	**How the facility plans to monitor its performance to make sure that solutions are sustained.** Pharmacy nurse consultant completes a quarterly pharmaceutical audit and checks all fridges and medication carts throughout the facility. Night nurse will check medication carts and fridge on their neighborhood weekly and remove any expired medications. Pharmacy nurse consultant findings will be reviewed at quality council quarterly. **Include dates when corrective action will be completed.** 06/10/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 48 On 5/6/16, at 11:16 a.m. ADON stated the expectation is all expired medications to be removed from the residents' supply. Policy for medication storage and dating of Aplisol vials was requested but not provided. Undated Flu Vaccine Storage Instructions from McKesson Medical Surgical provided by the facility instructed staff, "Once entered, a multi-dose vial and any residual contents should be discarded after 28 days. " Par Pharmaceutical Aplisol package insert revised 7/2015 instructed staff "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The package insert for Afluria from CSL dated 7/27/10, directed staff " When using the multi-dose vial, shake the vial thoroughly before withdrawing each dose, and administer the dose immediately. Between uses, store the vial at 36 degrees Fahrenheit (F) to 46 degrees F). Once the stopper has been pierced, the vial must be discarded within 28 days. "	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	**F441 D The facility did not ensure adequate disinfection of blood glucose monitors for 2 of 2 residents (R275, R7) residing on 2 of 5 residents on 2of 4 units.** **How corrective action will be accomplished for those**	

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F 441	Continued From page 49 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 2 of 2 residents (R275, R7) observed who required blood glucose monitoring in 2 of 4 units. Findings include:	F 441	residents found to have been affective by the deficient practice. Education was provided per policy to keep device wet with disinfectant product for a full minute. **How the facility will identify others residents having the potential to be affected by the same deficient practice.** Random monthly audits will be conducted to ensure proper policy procedure is being followed. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Random monthly audits will be conducted to ensure proper policy procedure is being followed monthly x 6.	

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BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

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F 441	Continued From page 50 On 5/5/16, at 7:58 a.m. licensed practical nurse (LPN)-A was observed complete a blood sugar check for R275. LPN-A applied gloves cleaned the glucometer for 15 seconds using a Oxivir Tb disinfectant wipe, applied a stripe, approached R275 cleaned the finger then punctured it and squeezed a drop of blood into the stripe. LPN-A then told R275 his reading was 174. LPN-A was observed get back to the medication cart stationed across from the dining room and disposed of the used supplies then wiped the glucometer for 10 seconds with the Oxivir Tb wipe and put a dry glucometer away inside a small rectangular tote with all the blood sugar supplies on the top drawer of the medication cart. Glucometer was not visibly wet for one minute. LPN-A then removed gloves and washed hands. -At 8:16 a.m. LPN-A stated before and each use always cleaned the glucometer with the wipes for a few seconds around the screen and the area where the stripe was inserted. LPN-A acknowledged did not wipe the glucometer for a full minute as indicated in the container. During observation of glucose monitoring check on 5/3/16, at 3:49 p.m. LPN-F was observed to complete a blood sugar check on R7. After obtaining a blood sugar check on R7, LPN-F 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	F 441	**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	

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F 441	Continued From page 51	F 441		

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 dated 12/5/08, directed staff to " Pre-clean heavily soiled areas. Apply solution by cloth or disposable wipe to hard, non-porous environmental surfaces. All surfaces must remain wet for one-minute to kill bacteria, HIV-1, HBV and HCV. Use a five-minute contact time for Tb and a ten-minute contact time for fungi. Wipe surfaces dry, rinse or allow to air dry. "

The facility policy titled "Clean Glucose Meters"

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F 441	Continued From page 52 dated 2/8/10, directed staff to clean/wipe the glucometer with Oxivir Tb disinfectant wipes for five seconds and watch the glucometer to ensure that the machine remains wet with the Oxivir Tb disinfectant for one minute. If glucometer starts to dry before one minute the policy directed staff to wipe with another Oxivir Tb disinfectant wipe to ensure wetness for one full minute.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review 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 (F)-A stated facility was not clean. On 5/6/16, at 11:12 a.m. a tour of the facilty was conducted with the director of maintenance (DOM) and the director of housekeeping (DOH). TCU Unit	F 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 quote. We are replacing the cracked tiles in 151 and refinishing the surface. Doors are researched (special size and solid core) being ordered. We will then have to special order the replacements.	

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F 465	Continued From page 53 Room 104A On 5/4/16, at 8:42 a.m. the wall behind recliner was observed to have several small gouges in it. On 5/6/16, at 11:12 a.m. the DOM verified that gouges were present and stated that they have a guy who goes through the rooms monthly and does repairs. DOM unaware how long the gouges had been present. Garden unit Room 149 On 5/3/16, at 2:30 p.m. room 149A the floor of the room had multiple small cracks with black built up through out the room. On 5/6/16, at 11:19 a.m. the HOM stated they are aware of the problems with the floor cracking and were working on raising funds for replacement. HOM stated that there was not a bid yet for the replacement of the cracked floor tiles. Room 151 On 5/3/16, at 2:30 p.m. room 151A was observed to have missing trim at the base of the wall to the left of the bathroom door. The floor of the room had multiple small cracks with black built up through out the room. On 5/6/16, at 11:22 a.m. the HOM verified that the trim needed to be replaced and that they were aware of cracks on the floor. Room 165A On 5/3/16, at 1:50 p.m. the door to room 165A was observed to have a two and a 30 inch x 0.5 inch scrape across the middle of the inside door. The ceiling in the bathroom was stained with a round ring approximately 12 inches in diameter in the corner of the bathroom. On 5/6/16, at 11:23 a.m. the DOM verified that the door needed to be fixed and verified the water damage to the	F 465	During the interim, the identified doors on Garden Terrace were covered with Decoguard to prevent injury. All bathrooms on the Villa were checked for bad ceiling tiles and tiles were replaced as needed. Small gouges were repaired in listed room numbers by a chair rail. Additional chair rail material is on order and will be installed in affected rooms. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All long term rooms were assessed and a list made for repairs and replacement. **What measures will be put into place or systemic changes made to ensure**	

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F 465	Continued From page 54 bathroom ceiling. Room 166A On 5/3/16, at 6:47 p.m. the bathroom door was observed to have a weak spot that was oval in shape with rough edges and loose wood splinters. On 5/6/16, at 11:28 a.m. The HOM and DOM verified that this needed to be repaired. Villa unit Room 201A On 5/3/16, at 2:14 p.m. the ceiling tile in the bathroom was observed to be stained. On 5/6/16, the DOM verified there was water damage in the bathroom. Room 206 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. Oak View Unit Room 232B On 5/3/16, at 2:05 p.m. the door frames on both sides of the bathroom were observed to to have the paint scraped off the lower edges exposing bare metal. On 5/6/16, the DOM verified that it needed to be painted as it was an uncleanable surface. Room 238A On 5/3/16, at 5:25 p.m. the door frames on both sides of the bathroom were observed to to have the paint scraped off the lower edges exposing bare metal. The fan in the bathroom was very noisy. There was missing plaster on the wall by	F 465	**that the deficient practice will not recur.** Floor checks and ceiling tiles were added to monthly room checks that maintenance completes. The policy is written on how to and where to submit a work order. Education was provided to housekeeping staff in identifying and writing work orders. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Monthly room checks are completed and monitored. Work orders will be written for room corrections. TELS (electronic system) will help us keep track of the work done in each room and trend repairs completed. **Include dates when corrective action will be completed.** 7/15/2016	6/10/16 LD

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F 465	Continued From page 55 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. Reporting Environmental concerns policy requested, but not provided.	F 465		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST 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 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Angela.Kappenman@state.mn.usand Marian.Whitney@state.mn.us	K 000	APPROVED By Tom Linhoff at 7:46 am, Jun 09, 2016 RECEIVED JUN - 9 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Administrator 6/1/16

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING 01 - **MAIN BUILDING 01** B. WING _____	**05/04/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	**1101 BLACK OAK DRIVE** **NEW BRIGHTON, MN 55112**

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Benedictine Health Center at Innsbruck is a 2-story building with no basement. The building was built at 3 different times. The original building was constructed in 1965 and was determined to be of Type II (222) construction. In 1991 an addition was constructed to the north and was determined to be of Type I(222) construction. In 2005 the Transitional Care Unit (TCU) was added to the north that was determined to be of Type V(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building one was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19 and the TCU building was surveyed in accordance with LSC Chapter 18. Both buildings have a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in each resident room that is monitored for fire department notification. the facility has a capacity	K 000		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	Continued From page 2 of 105 census at the time of this survey was 97.. A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1965 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 80 of 105 residents and	K 018	**Main Building** **K18 E Rooms did not positively latch** **A description of what has 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 **Person responsible.** Plant Operations Manager	

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	245310	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 018	Continued From page 3 an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 0900 and 1700 on 5/04/2016 observations revealed that the following room doors did not positively latch: Room 206, 213, 243, 164, Janitor Room 2, Rm 144, and 141. The deficient practice was observed by the Director of Environmental Services (EA).	K 018		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 80 of the 105 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0900 and 1700 on 4/04/2016 observations revealed that smoke	K 025	**K25 D Smoke barriers had penetrations** **A description of what has been, or will be done to correct the deficiency.** Caulking completed on all penetrations **The actual or proposed completion date.** 5/16/16 **Person responsible.** Plant Operations Manager	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/04/2016

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K 025	Continued From page 4 barriers had penetrations at the following locations: Above the ceiling in the wall of stairwell C East wing to Villa above the ceiling Garden terrace above the nurses station Above the door at smoke compartment D Above door B-39 Stairwell B-1 penetration into the corridor and around the edges of the new sheetrock. The penetrations will all need to be sealed on both sides of the smoke barrier. The deficient practice was observed by the Director of Environmental Services (EA).	K 025		
K 033 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect all 105 residents. Findings include: On facility tour between 09:00 AM and 1700 on 05/04/2016, it was observed that: There was a quarter inch sized hole in the door leading into the sprinkler room. The hole was	K 033	**K33 C Hole in sprinkler room door** **A description of what has been, or will be done to correct the deficiency.** The door handle was replaced with a handle that fits and the opening is covered. **The actual or proposed completion date.** 5/16/16 **Person responsible.** Plant Operations Manager	

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K 033	Continued From page 5 located directly above the door knob. These deficiecies were observed by the Director of Environmental Services (EA).	K 033		
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain a clear and unobstructed exit stairway in accordance with NFPA 101 Life Safety Code (2000) section 7.2.2. This deficient practice could negatively affect the use of the exit stairway used by staff that would delay needed staff assistance to residents and visitors in the event of an emergency. Findings include: On facility tour between 09:00 AM and 1700 on 05/04/2016, It was observed, that there were several carts, handles, tools, and other equipment being stored in all levels of the exit stairwell. This deficient practice is restricting the exit capacity and the capability for this stairwell as a required egress. This deficient practice was verified by the Director of Environmental Services (EA).	K 034	**K34 E Exit stairway blocked** **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 **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	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility	K 038		

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K 038	Continued From page 6 failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect all 105 residents. Findings include: On facility tour between 09:00 AM and 1700 on 05/04/2016, it was observed that: The second floor exit door to the outside did not open freely and clearly. This deficiency was fixed during the remainder of the inspection. The Chapel exit door to the outside did not open freely and clearly. This deficiency was fixed during the remainder of the inspection. These deficiecies were observed by the Director of Environmental Services (EA).	K 038		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in 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.	K 052	**K52 F Fire alarm pull station obstructed by plant near chapel, fire alarm on OV obstructed.** **A description of what has been, or will be done to correct the deficiency.** Chapel is in New Building. Obstacles repositioned on Oak View to eliminate obstruction. **The actual or proposed completion date.** 5/16/16 **Person responsible.** Plant Operations Manager	

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K 052	Continued From page 7 FINDINGS INCLUDE: On 05/04/2016 between 0900 and 1700, while performing the facility tour it was observed that the fire alarm pull station located outside the chapel and next the the exit was obstructed by decorative trees and plants. Another pull station on the second floor in the 24 hour nurses station was obstructed by binders and books for patients reference. This finding was confirmed with the Director of Environmental Services (EA).	K 052		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD Is not met as evidenced by: Based on observation and interview, the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all patients. Findings include: On facility tour between 0900 and 1700 on 05/04/2016, observation revealed that the sprinkler head escutcheon plates on numerous sprinkler heads were missing or have been misplaced along the branch of the sprinkler head. This was noted in several rooms. This deficient practice was verified by the Director of Environmental Services (EA).	K 062	**K62 D Replace escutcheon plates.** **A description of what has been, or will be done to correct the deficiency.** The missing plates were replaced/secured on 5/5/16. **The actual or proposed completion date.** 5/5/16 **Person responsible.** Plant Operations Manager	

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K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 0900 and 1700 on 05/04/2016, based on review of available documentation it was revealed that there was no documentation for: a. The minimum 5 minute cool down period when testing the generator. This deficient practice was verified by the Director of Environmental Services (EA).	K 144	**K144 D Maintain emergency generator.** **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 cool-down. Our documentation did not show evidence of a 5 minute cool down after each run. We are now using the suggested form to document the cool-down time and other information for our generator tests. **The actual or proposed completion date.** 5/16/2016 **Person responsible.** Plant Operations Manager	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING 02 - NEW BLDG B. WING _____	05/04/2016

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST 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: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Angela.Kappenman@state.mn.usand Marian.Whitney@state.mn.us	K 000	APPROVED Thomas Linhoff By Tom Linhoff at 8:29 am, Jun 09, 2016 RECEIVED JUN - 9 2016 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

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

Administrator — 6/1/16

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Benedictine Health Center at Innsbruck is a 2-story building with no basement. The building was built at 3 different times. The original building was constructed in 1965 and was determined to be of Type II (222) construction. In 1991 an addition was constructed to the north and was determined to be of Type I(222) construction. In 2005 the Transitional Care Unit (TCU) was added to the north that was determined to be of Type V(111) construction. There is an attic in the new addition of the TCU that is of wood frame trussed construction and it full sprinklered. This facility was surveyed as two separate buildings because of different dates of construction. Building one was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19 and the TCU building was surveyed in accordance with LSC Chapter 18. Both buildings have a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in	K 000		

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K 000	Continued From page 2 each resident room that is monitored for fire department notification. the facility has a capacity of 105 census at the time of this survey was 97. A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1965 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on the observation and staff interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3, they did not fit tight in the frame or latch. This deficient practice could affect the safety of approximately 80 of 105 residents and an undetermined number of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include:	K 018	**K18 E Rooms did not positively latch** **A description of what has 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 **Person responsible.** Plant Operations Manager	

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K 018	Continued From page 3 On the facility tour between 0900 and 1700 on 5/04/2016 observations revealed that the following room doors did not positively latch: Room 206, 213, 243, 164, Janitor Room 2, Rm 144, and 141. The deficient practice was observed by the Director of Environmental Services (EA).	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect 80 of the 105 patients and an undetermined amount of staff and visitors. Findings include: On the facility tour between 0900 and 1700 on 05/04/2016 observations revealed that smoke barriers had penetrations at the following locations: Above the ceiling in the wall of stairwell C East wing to Villa above the ceiling Garden terrace above the nurses station Above the door at smoke compartment D	K 025	**K25 F Smoke barriers had penetrations** **A description of what has been, or will be done to correct the deficiency.** Caulking completed on all penetrations **The actual or proposed completion date.** 5/16/16 **Person responsible.** Plant Operations Manager	

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K 025	Continued From page 4 Above door B-39 Stairwell B-1 penetration into the corridor and around the edges of the new sheetrock. The penetrations will all need to be sealed on both sides of the smoke barrier. The deficient practice was observed by the Director of Environmental Services (EA).	K 025		
K 034 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain a clear and unobstructed exit stairway in accordance with NFPA 101 Life Safety Code (2000) section 7.2.2. This deficient practice could negatively affect the use of the exit stairway used by staff that would delay needed staff assistance to residents and visitors in the event of an emergency. Findings include: On facility tour between 09:00 AM and 1700 on 05/04/2016, It was observed, that there were several carts, handles, tools, and other equipment being stored in all levels of the exit stairwell. This deficient practice is restricting the exit capacity and the capability for this stairwell as a required egress. This deficient practice was verified by the Director of Environmental Services (EA).	K 034	**K34 E Exit stairway blocked** **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 **Person responsible.** Plant Operations Manager	
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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K 038 SS=F	Continued From page 5 Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide and maintain the vertical opening protection required by NFPA 101 - 2000 edition, Sections 19.3.1.1, 8.2.5 .This deficient practice could affect all 105 residents. Findings include: On facility tour between 09:00 AM and 1700 on 05/04/2016, it was observed that: The second floor exit door to the outside did not open freely and clearly. This deficiency was fixed during the remainder of the inspection. The Chapel exit door to the outside did not open freely and clearly. This deficiency was fixed during the remainder of the inspection. These deficiecies were observed by the Director of Environmental Services (EA).	K 038	**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 station 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 right away. Obstacles repositioned on Oak View to eliminate obstruction. **The actual or proposed completion date.** 5/4/16 **Person responsible.** Plant Operations Manager	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in	K 052		

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	245310	A. BUILDING **02 - NEW BLDG** B. WING _____	05/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	**1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(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 performing the facility tour it was observed that the fire alarm pull station located outside the chapel and next the the exit was obstructed by decorative trees and plants. Another pull station on the second floor in the 24 hour nurses station was obstructed by binders and books for patients reference. This finding was confirmed with the Director of Environmental Services (EA).	K 052		
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained so that at least a local alarm will sound when the valves are closed, in accordance with NFPA 101 (2000), Chapter 9, Section 9.7.2.1 and NFPA 72 (1999) and NFPA 13 (1999).accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the	K 061		

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K 061	Continued From page 7 sprinkler system in compliance could allow for the failure of the fire sprinkler system and affect all the patients, visitors and staff of the facility. FINDINGS INCLUDE: On facility tour between 0900 to 1700 on 05/04/2016, observations revealed that the facility's fire sprinkler was not equipped with the required spare heads matching those that have been installed in the attic. This deficient practice was verified by the Director of Environmental Services (EA).	K 061	**K61 D Sprinklers-Spare Heads** **A description of what has been, or will be done to correct the deficiency.** The missing duplicate sprinkler heads for the attic sprinklers have been replaced. **The actual or proposed completion date.** 5/16/16 **Person responsible.** Plant Operations Manager	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all patients. Findings include: On facility tour between 0900 and 1700 on 05/04/2016, observation revealed that the sprinkler head escutcheon plates on numerous sprinkler heads were missing or have been misplaced along the branch of the sprinkler head. This was noted in several rooms. This deficient practice was verified by the Director	K 062	**K62 D Replace escutcheon plates.** **A description of what has been, or will be done to correct the deficiency.** The missing plate was installed on 5/5/16. More were ordered to replace the used plate. **The actual or proposed completion date.** 5/5/16 **Person responsible.** Plant Operations Manager	

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K 062	Continued From page 8 of Environmental Services (EA).	K 062		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 0900 and 1700 on 05/04/2016, based on review of available documentation it was revealed that there was no documentation for: a. The minimum 5 minute cool down period when testing the generator. This deficient practice was verified by the Director of Environmental Services (EA).	K 144	**K144 C Generator** **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 cool-down. Our documentation did not show evidence of a 5 minute cool down after each run. We are now using the suggested form to document 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	

Minnesota Department of Health

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 only a suggestion 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

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

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	05/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

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2 000	Initial Comments *****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.	2 000		

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2 565	Continued From page 1	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for 2 of 3 residents (R25, R166) for repositioning and incontinence care, and the facility failed to follow the careplan for 1 of 3 residents (R87) who was dependent upon staff for activities of daily living (ADLs). Findings include: Repositioning and incontinence care: R25 was continuously observed lying in bed on her back on 5/5/16, from 7:21 a.m. until 9:43 a.m. (two hours and 22 minutes). At 9:23 a.m. when asked how often R25 was repositioned licensed practical nurse (LPN)-B stated all residents get repositioned every two hours. Fifteen minutes later when asked LPN-C stated R25 was positioned according to care plan and if needed. At 9:43 a.m. LPN-B and LPN-C repositioned R25 slightly on the left side. R25 stated, "That feels good." No check or change of brief for incontinence was observed. At 11:34 a.m. on 5/5/16, R25 was observed lying on her right side in bed with LPN-B finishing up R25's pressure ulcers treatments with nursing assistant (NA)-A assisting. LPN-B stated R25's	2 565		

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2 565	Continued From page 2	2 565		

brief had been wet and with bowel movement. R25 was observed to have two large open holes, which appeared deep, one on R25's left hip area and one on her bottom which both appeared to have substance down in them. LPN-B stated the pressure ulcer on the left had honey gel in it, and the ulcer on the bottom had packing in it. LPN-B placed bandages over both holes to cover and applied tape to hold on the bandages. LPN-B stated the evening shift completed the treatments for R25's pressure ulcers on her leg and heel. As R25 was lowered into her Broda chair at 11:57 a.m. with the ceiling lift and the assistance of NA-A and LPN-B a small scab was observed on the top of R25's left foot. NA-A stated R25 needed two staff with transfers and repositioning. NA-A stated R25 was repositioned every two hours and was checked for incontinence every two hours. NA-A stated R25 usually had a bowel movement every evening before going to bed. NA-A stated R25 did not sit on the toilet but was check and changed, and when the brief's yellow line was designed to turn blue to indicate wetness. NA-A then proceeded to help R25 with her morning cares before pushing R25 out to dining room in her Broda chair to eat.

The resident was continuously observed while she was assisted to eat brunch and when she was finished eating R25 was moved to another table to watch the moving playing for an hour (R25 was toileted after meals according to the plan of care). R25 sat a table until LPN-B and NA-B lowered R25 back into her bed with the ceiling lift at 2:29 p.m. (R25 again had been up in her Broda chair for two hours and 32 minutes with no offer by staff for repositioning). After LPN-B and NA-B finished positioning R25 in bed with a neck pillow on top of a standard pillow and placed R25's lower legs on a heel lifter, and as they were

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2 565	Continued From page 3	2 565		

about to leave the room, Surveyor asked LPN-B and NA-B if they were going to toilet R25. LPN-B stated yes they would check and change R25 which LPN-B and NA-B at 2:39 p.m. proceeded to change R25's wet brief and perform incontinence cares and put a dry brief on R25. (At that time R25 had went two hours and 42 minutes without check and change for incontinence after the noon meal and without repostioning). LPN-B felt R25's brief and said the pad they had taken off of R25 was wet. NA-B stated when yellow line on the brief turns blue the brief was wet and needs to be changed. NA-B confirmed R25's brief had a blue line and had been wet. LPN-B and NA-B then placed a pillow on R25's right side turned R25 slightly to the left. R25 stated she was comfortable. LPN-B told R25 staff would be back in two hours to reposition her.

On 5/5/16, at 1:33 p.m. NA-D stated NAs knew mostly what to do by the assignment sheets. NA-D stated if a resident does not want to use the toilet then the resident will be off loaded every two hours with the resident standing up for a bit. NA-D stated R25 was repositioned every two hours. NA-D stated because of R25's open areas on her body she was laid back down in bed after 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.

R25's careplan dated 3/24/15, indicated R25 was to receive extensive assistance with two staff for

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2 565	Continued From page 4 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 ROHO cushion in R25's wheel chair (w/c). R25 did not receive the care and services in a timely manner for repositioniong and toileting. The undated Nursing Assistant (NA) 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 bladders. On 5/5/16, at 9:53 a.m. RN-B stated she had instructed staff if they could not perform positioning and cares timely for R25 they were to let RN-B know. 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.	2 565		

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2 565	Continued From page 5 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 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 pushed R166 in w/c down the hall, into the elevator and down to the nurse's station on first floor where R166 reported to LPN-D that her teeth hurt when eating the ice cream. LPN-D asked R166 about the pain and R166 reiterated her teeth hurt when eating something cold. The health unit coordinator (HUC) sitting there asked R166 if she wanted to see the dentist and R166 responded, "I was going to see the dentist now." R166 continued to sit up near the nurse's station. At 2:49 p.m. NA-F came walking up the hall toward the nursing station and stood. NA-F was asked when R166 was going to be toileted next and NA-F answered that she was going home at 3:00 p.m. NA-F asked what time the next shift coming on and if they were going to toilet R166. NA-F stated she would toilet R166. At 2:50 p.m.	2 565		

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2 565	Continued From page 6	2 565		

surveyor notified LPN-D that R166 had not been toileted for over two hours and asked if she would look at R166's skin with surveyor. LPN-D stated yes she would and that she expected R166 to be toileted after meals or when she lays down. LPN-D stated R166 had not laid down today because of the activity. LPN-D stated R166 laid down because she would be at risk for pressure ulcer.

At 2:54 p.m. LPN-D and NA-F stood R166 up at the toilet and sink and removed R166's brief as R166 dribbled urine while standing. LPN-D confirmed R166's brief was wet with urine and that the yellow line on the brief was now blue. LPN-D stated R166's brief was "moderately wet." (It now had been three hours and eight minutes from when NA-F said she had last toileted R166). LPN-D and surveyor observed R166's bottom to be non-smooth, reddened on both buttocks and LPN-D stated R166's bottom was not open, just reddened, and kind of chronic for her and that the skin nurse had looked at it. LPN-D applied treatment to R166's bottom. LPN-D stated R166 was toileted after meals, and that R166 usually came back from activity at 2:00 p.m. LPN-D stated the NA should have went up to the activity to get R166.

After toileting R166 at 3:00 p.m. NA-F stated R166 could not tell NA-F when she had to go to the bathroom. When asked about the time frame for toileting R166, NA-F stated, "I knew she had went for exercise, but I was just going to wait until she got back."

R166's care plan dated 11/20/15, indicated R166 was at a risk for pressure ulcers, had a diagnosis of dementia, was unable to reliably notify staff of need to toilet, and staff was to anticipate R166's

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2 565	Continued From page 7 needs. R166's care plan indicated R166 wore an incontinent product, needed assistance with cares, mobility, toileting and bowel and bladder incontinence. Short term goal for R166 was for skin to remain intact and free of redness. The care plan indicated R166 was to be repositioned and toileted every two hours and as needed. R166 did not receive the care and services as r166 was not toileted and repositioned every two hours. 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 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 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.	2 565		

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2 565	Continued From page 8 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 ½ inch long with brown matter underneath them. On 5/5/16, at 12:24 p.m. a nursing assistant (NA)-M was observed wheel resident out of the living room and indicated was going to lay her down for a nap. When asked if she was assigned to R87 for the shift the NA-M stated she was, however, she was not a regular caregiver in the unit. NA-M verified the nails were long and dirty underneath. When asked who was responsible for trimming the fingernails, NA-M stated she did not know and directed surveyor to licensed practical nurse (LPN)-A. -At 12:29 p.m. registered nurse (RN)-A unit nurse manager stated resident was challenging when asked about nail care. RN-A and LPN-A verified resident bathe was Monday 5/2/16, evening and when looking through the Shower day Worksheet/Body Audit dated 5/2/16, nails had not been marked as trimmed. RN-A verified there was no documentation in the progress notes of resident refusing nail care. RN-A indicated she was surprised there was no documentation as a regular nurse worked Monday evening shifts when resident bath/shower was scheduled. RN-A verified in March and April 2016, all days bath/shower had been completed nail care had not been documented as completed. -At 12:38 p.m. LPN-A stated "If it's not documented it was not done."	2 565		

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2 565	Continued From page 9 -At 12:48 p.m. RN-A acknowledged a resident care plan was supposed to be followed. R87's diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus without complications and depressive episodes obtained from the care plan dated 1/28/16. During review of the Care Area Assessments (CAAs) dated 2/4/16, revealed the ADL CAA had not triggered, however, the cognitive loss/dementia CAA dated 2/4/16, indicated R87 had severe cognitive impairments and had diagnoses of dementia and altered mental status. The CAA indicated the resident may need assistance with making decisions regarding health and safety. R87's care plan dated 2/10/16, indicated resident had an alteration in ADLs related to needing assist with her cares due to dementia, chronic lower extremity edema/wounds with pain, weakness and decreased range of motion. Goal "[R87] will be clean, neat and well groomed." Care plan indicated R87 needed one staff assist with grooming. R87's 14 day Minimum Data Set (MDS) dated 2/11/16, indicated resident required extensive physical assistance of one staff with personal hygiene. In addition the MDS indicated resident did not reject care which included ADLs. On 5/6/16, at 9:41 p.m. the assistant director of nursing (ADON) stated all staff were supposed to follow the plan of care for residents when providing cares. A care plan policy was requested. SUGGESTED METHOD OF CORRECTION:	2 565		

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2 565	Continued From page 10 The director of nursing could in-service all staff to follow care plans in regards to specific resident cares and services. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to re-assess for and implement interventions to reduce aggressive behaviors for 1 of 1 residents (R21) who had altercations with other residents on the unit. In addition, the facility failed to implement interventions to safe guard 1 of 1 residents (R14) who was at risk for injury related to other residents behaviors. Findings include: R21's admission history and physical dated	2 570		

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2 570	Continued From page 11 11/19/15 indicated He had advanced dementia and "quite a few behaviors disturbances and quite a bit of difficulty with delirium as well." A review of R21's face sheet indicated diagnoses that included dementia with behavioral disturbance. A temporary care plan, undated indicated no behavior or mood concerns. R21's admission minimum data set (MDS) dated 12/2/15 indicated he required assistance for transfers, toileting, dressing and grooming, and ambulated with staff supervision. A care plan dated 12/14/15 indicated he was severely cognitively impaired and demonstrated socially inappropriate/disruptive behaviors that included physical aggression toward staff and other residents. The care plan directed staff to administer PRN (as needed) Ativan (a medication used to treat anxiety disorders), assess whether the behavior endangered other residents and intervene if needed, maintain a calm approach, and redirect 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 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 progress note dated 12/8/15 indicated R21 was wandering through the unit, into other residents rooms and taking their personal items and was observed a "couple of times"trying to hit other residents. On 12/14/15 R21 grabbed the glasses off R14 and grabbed R14. An interdisciplinary team (IDT) review of the behavior indicated staff would continue to monitor R21. A progress noted dated 12/16/15 indicated R21 was	2 570		

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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 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. During an interview on 5/5/16, t 9:15 a.m., registered nurse (RN)- A stated R21 admitted to the facility in November 2015. She stated he had	2 570		

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2 570	Continued From page 13 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 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 abuse. 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 notes indicated R14 sustained a laceration and a scratch on 12/14/15 and was punched in the face	2 570		

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2 570	Continued From page 14 on 12/19/15. Further, while R14 had been a victim of abuse on two separate dates, there was no care planned interventions implemented to direct staff to protect R14 from R21. During an interview on 5/6/16, at 8:43 a.m., RN-A stated she would have expected staff to complete an incident form and document follow-up. During in interview on 5/6/16, at 9:40 a.m., the ADON stated there was no follow up completed for R14 following the altercations with R21. He further stated, the nurses who were present missed it and the interdisciplinary team missed it. A policy for care planning was requested but none received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and	2 830		

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2 830	Continued From page 15 plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate supervision for 1 of 1 residents (R21) who displayed negative behaviors directed at other residents on the unit. Findings include: R21's admission history and physical dated 11/19/15, indicated R21 had advanced dementia and "quite a few behaviors disturbances and quite a bit of difficulty with delirium as well." A review of R21's face sheet indicated diagnoses that included dementia with behavioral disturbance. A temporary care plan, undated indicated no behavior or mood concerns. R21's admission Minimum Data Set (MDS) dated 12/2/15, indicated he required assistance for transfers, toileting, dressing and grooming, and ambulated with staff supervision. A care plan dated 12/14/15, indicated he was severely cognitively impaired, had potential for pain related to a history of shoulder and back pain, incontinent of bowel and bladder, and demonstrated socially inappropriate/disruptive behaviors that included physical aggression toward staff and other residents, undressing in common areas, and defecating on the floor	2 830		

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2 830	Continued From page 16 throughout the facility. The care plan directed staff to administer PRN (as needed) Ativan (a medication used to treat anxiety disorders), assess whether the behavior endangered other residents and intervene if needed, maintain a calm approach, and redirect 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 R21 was found on the floor in the hallway, a subsequent note dated 12/8/15, indicated R21 was wandering through the unit, into other residents rooms and taking their personal items and was observed a "couple of times" trying to hit other residents. On 12/9/15, R21 defecated on a chair in another resident ' s room. A noted dated 12/13/15, indicated R21 was constantly taking off his clothes, combative with re-direction, opened a window and pushed the screen out and started pushing other resident's personal belongings out of the window. He also went into the clean linen room and defecated on the floor, wrapped it in a washcloth and put it in the cabinet. On 12/14/15, R21 grabbed the glasses off R14 and grabbed R14. An interdisciplinary team (IDT) review of the behavior	2 830		

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2 830	Continued From page 17 indicated staff would continue to monitor R21. A Progress Note dated 12/16/15, indicated R21 was 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 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 9-1-1 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 was 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. A review of R21's Medication Administration History dated 11/25/15 through 12/1/15, indicated	2 830		

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2 830	Continued From page 18 and order for Ativan 0.5 milligrams (mg) every six hours as needed, however the Ativan was only administered once on 12/17/15 even though R21 displayed signs of anxiety almost daily during the month of September. Further, while R21's care plan identified potential for pain and an alteration in toileting, there was no evidence the facility assessed the need for toileting when R21 urinated and defecated in inappropriate areas and removed his clothing, nor was there evidence the facility assessed the need for pain medication when R21 displayed behaviors During an interview on 5/5/16, at 9:15 a.m., registered nurse (RN)-A stated R21 admitted to 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	2 830		

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2 830	Continued From page 19	2 830		

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 abuse.

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 Innsbruck Resident Progress Notes dated 12/11/15 through 12/24/15, did not reflect either incident, nor was a facility event form completed even though R21's notes indicated R14 sustained and laceration and a scratch on 12/14/15, and was punched in the face on 12/19/15. Following the incident on 12/19/15, there was no evidence of follow up or monitoring for injures. Further, while R14 had been a victim of abuse on two separate dates, there was no care planned interventions to protect R14 from R21.

During an interview on 5/6/16, at 8:43 a.m., RN-A stated she would have expected staff to complete an incident form and document follow-up.

During interview on 5/6/16, at 9:40 a.m., the ADON stated there was no follow up completed for R14 following the altercations with R21. He further stated, the nurses who were present missed it and the interdisciplinary team missed it.

A facility policy titled Benedictine health Center at Innsbruck, behavior Management Process, dated 11/20/15, was reviewed. The policy indicated effective management of behaviors through assessment and interventions is the goal of the program. The policy directed staff to Monitor and track symptoms and interventions, analyze

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2 830	Continued From page 20 documentation on an ongoing basis. If interventions were unsuccessful enroll resident in the behavior Management Program and track behaviors on the treatment sheet. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff on the assessment process for resident's who have challenging behaviors and exhibit aggression towards others. An audit could be developed to ensure the proper assessment and interventions have been implemented after each aggressive behavior. The results of the audit could be reported to the quality assurance committee during the quarterly meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be	2 840		

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2 840	Continued From page 21 checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely care and services with toileting was provided for 1 of 3 residents (R166) reviewed for urinary incontinence. Findings include: During continuous observation of R166 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.	2 840		

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2 840	Continued From page 22 During interview with licensed practical nurse (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. Nursing assistant (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. 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 and had not approached R166 for toileting. 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 pushed R166 in wheelchair down the hall, into the elevator and down to the nurse's station on first floor where R166 reported to LPN-D that her teeth hurt when eating the ice cream. LPN-D	2 840		

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2 840	Continued From page 23	2 840		

asked R166 about the pain and R166 reiterated her teeth hurt when eating something cold. The health unit coordinator (HUC) was sitting there and asked R166 if she wanted to see the dentist and R166 responded, "I was going to see the dentist now." R166 continued to sit up near the nurse's station. At 2:49 p.m. NA-F came walking up the hall toward the nursing station and stood. NA-F was asked when R166 was going to be toileted next and NA-F answered that she was going home at 3:00 p.m. NA-F was asked what time the next shift coming on and if they were going to toilet R166 and NA-F stated she would toilet R166. At 2:50 p.m. surveyor notified LPN-D R166 had not been toileted for over two hours and asked if she would look at R166 with surveyor. LPN-D stated yes she would and that she expected R166 to be toileted after meals or when she laid down. LPN-D stated R166 had not laid down today because of the activity. LPN-D stated R166 laid down because she would be at risk for pressure ulcer.

At 2:54 p.m. LPN-D and NA-F stood R166 up at the toilet and sink and removed R166's brief as R166 dribbled urine while standing. LPN-D confirmed R166's brief was wet with urine and that the yellow line on the brief was now blue. LPN-D stated R166's brief was "moderately wet." (It had been three hours and eight minutes from when NA-F said she had last toileted R166). LPN-D and surveyor observed R166's bottom to be non-smooth, all reddened on both buttocks and LPN-D stated R166's bottom was not open, just reddened, kind of chronic for her and that the skin nurse had looked at it. LPN-D applied treatment to R166's bottom. LPN-D stated R166 was toileted after meals, and that R166 usually came back from activity at 2:00 p.m. LPN-D stated the NA should have went up to the activity

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2 840	Continued From page 24 to get R166. After toileting R166 at 3:00 p.m. NA-F stated R166 could not tell NA-F when she had to go to the bathroom. When asked about the time frame for toileting R166, NA-F stated, "I knew she had went for exercise, but I was just going to wait until she got back." R166's careplan dated 11/20/15, indicated R166 was at a risk for pressure ulcers, had a diagnosis of dementia, was unable to reliably notify staff of need to toilet, and staff was to anticipate R166's needs. R166's careplan indicated R166 wore an incontinent product, needed assistance with cares, mobility, toileting and bowel and bladder incontinence. Short term goal for R166 was for skin to remain intact and free of redness. The care plan indicated R166 was to be toileted every two hours and as needed. The Care Area Assessment (CAA) summary dated 11/25/15, indicated R166 needed assistance with cares, mobility, toileting, bowel and bladder incontinence, wore an incontinent product and received treatment to her bottom every shift for prevention. The 11/25/15, CAA also indicated R166 had a pressure reducing mattress and w/c cushion for prevention of skin breakdown. The CAA further indicated staff were to anticipate R166's needs. It was unable to determine any voiding pattern in the review of the three-day bowel and bladder assessment completed in February 2016 due to incomplete data. R166's Minimum Data Set (MDS) dated 3/1/16, indicated R166 had a diagnosis of Alzheimer's disease and R166's cognition was severely impaired. The MDS indicated R166 did not reject cares and was at risk for developing pressure ulcers. The MDS also indicated R166 was on a	2 840		

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2 840	Continued From page 25 turning/repositioning program, was always incontinent of bowel and bladder and was not on a toileting program. The MDS further indicated R166 needed extensive assistance with staff for transferring, locomotion on and off the unit, and extensive assistance of two staff with toileting. Review of Nursing Progress Notes (PN) included: 4/26/16, PN indicated R166 had a red and small open area on the coccyx. 4/27/16, progress note PN indicated R166 had poor skin integrity and some areas of excoriation and redness on R166's bottom. The current May 2016 Physician Orders reviewed for R166 indicated R166 received Lasix every morning. R166's physician orders also indicated R166 received barrier cream, antibiotic ointment and Clotrimazole cream (antifungal) to R166's bottom three times a day for redness. R166's May 2016 Treatment Administration Record indicated R166 had received the barrier cream, Clotrimazole cream and antibiotic ointment. The undated Nursing Assistant Assignment Sheet for R166 indicated R166's mode of transportation was a w/c 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 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	2 840		

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2 840	Continued From page 26 say something about toileting and repositioning and should reflect the care plan. ADON stated the briefs staff can tell when wet the line changes color at a certain point of wetness. No reference to toileting was indicated in the policy provided by the facility for Acitivities of Daily Living. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who require assistance with toileting receive timely services. The director of nursing (DON) or designee could educate staff as appropriate. The director of nursing (DON) or designee could monitor or audit to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 840		
2 860	MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 3 residents (R87) reviewed for	2 860		

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2 860	Continued From page 27 activities of daily living (ADLs) and who was dependent on staff for nail care Findings include: 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. 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. resident was observed seated in wheelchair and both hand fingernails were noted to have approximately ½ inch long with brown matter underneath them. On 5/5/16, at 7:30 a.m. to 9:20 a.m. the fingernails were still untrimmed and noted with brown matter underneath. On 5/5/16, at 11:35 a.m. resident was observed seated on her wheelchair at the dining room table. R87's fingernails were still long and had brown matter underneath the nails. R87 remained in the dining room until 11:50 a.m. then observed licensed practical nurse (LPN)-A wheel resident down the hallway into her room. When LPN-A got resident into room resident indicated it was cold her room. LPN-A was observed wipe resident nose then wheeled resident to the living room for mass never offered the trim the fingernails or clean underneath. -At 12:24 p.m. a nursing assistant was observed wheel resident out of the living room and indicated was going to lay her down for a nap.	2 860		

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2 860	Continued From page 28 When asked if she was assigned to R87 for the shift nursing assistant (NA)-M stated she was however was not a regular caregiver in the unit. NA-M verified the nails were long and dirty underneath. When asked who was responsible for trimming the fingernails, NA stated she did not know and directed surveyor to LPN-A. -At 12:29 p.m. registered nurse (RN)-A unit nurse manager stated resident was challenging when asked about nail care. RN-A and LPN-A verified resident bathe was Monday 5/2/16, evening and when looking through the Shower day Worksheet/Body Audit dated 5/2/16, nails had not been marked as trimmed. RN-A verified there was no documentation in the progress notes of resident refusing nail care. RN-A indicated she was surprised there was no documentation as a regular nurse worked Monday evening shifts when resident bath/shower was scheduled. RN-A verified in March and April 2016, all days bath/shower had been completed nail care had not been documented as completed. -At 12:38 p.m. LPN-A stated "If it's not documented it was not done." -At 12:48 p.m. RN-A stated she would expect the nurses to document either in the weekly shower worksheet or in the progress notes if a resident bath had been completed and/or refused and nail care should be documented if done or not. RN-A acknowledged a resident care plan was supposed to be followed. R87's diagnoses included dementia without behavioral disturbance, type 2 diabetes mellitus without complications and depressive episodes obtained from the care plan dated 1/28/16. During review of the Care Area Assessments (CAAs) dated 2/4/16, revealed the ADL CAA had not triggered however the cognitive	2 860		

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2 860	Continued From page 29 Loss/dementia CAA dated 2/4/16, indicated R87 had severe cognitive impairments, and had diagnosis of dementia and altered mental status. The CAA indicated resident may need assistance with making decisions regarding health and safety. R87's care plan dated 2/10/16, indicated resident had an alteration in ADLs related to needing assist with her cares due to Dementia, chronic lower extremity edema/wounds with pain, weakness and decreased range of motion. Goal "[R87] will be clean, neat and well groomed." Care plan indicated R87 needed one staff assist with grooming. R87's 14 day Minimum Data Set (MDS) dated 2/11/16, indicated resident required extensive physical assistance of one staff with personal hygiene. In addition the MDS indicated resident did not reject care which included ADL's. On 5/6/16, at 9:41 p.m. the assistant director of nursing (ADON) stated he would expect the staff to document all resident refusal and if there were a lot of incidences would have to be care planned. ADON further stated all staff was supposed to follow the plan of care for residents when providing cares. The facility Care Of Fingernails and Toenails policy dated 11/2015, directed staff to provide cleanliness and report any problematic conditions to the charge nurse during care. SUGGESTED METHOD FOR CORRECTION: The DON could insure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The DON could conduct audits to	2 860		

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2 860	Continued From page 30 ensure the care is being provided as indicated and take action as needed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 860		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R25) with a pressure ulcer received timely repositioning. Findings include: R25 was continuously observed lying in bed on her back on 5/5/16, from 7:21 a.m. until 9:43 a.m. (two hours and 22 minutes). At 9:23 a.m. LPN-B	2 900		

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2 900	Continued From page 31	2 900		

was interviewed, stated all residents get repositioned every two hours. At 9:38 a.m., LPN-C stated R25 was repositioned according to her care plan and when needed. At that same time, nursing assistant (NA)-A stated he repositioned R25 every two hours. At 9:43 a.m. when licensed practical nurse (LPN)-B and LPN-C repositioned R25, R25 stated, "That feels good." At 11:34 a.m. R25 was observed lying on her right side in bed with LPN-B finishing up R25's pressure ulcers treatments with NA-A assisting. During the observation, R25 was observed to have open sores on her left hip area and on her bottom. Both appeared to have a light brown substance in them. LPN-B stated the pressure ulcer on the left had honey gel in it, and the ulcer on R25's bottom had packing in it. LPN-B was observed to place bandages over both pressure ulcers and applied tape to secure the bandages. LPN-B stated the evening shift staff completed treatments for pressure ulcers to R25's leg and heel. During transfer to the Broda chair (tilt and recline positioning chair) at 11:57 a.m., a small scab was observed on the top of R25's left foot. During the transfer NA-A stated R25 needed two staff with transfers and repositioning. NA-A stated R25 was repositioned every two hours. NA-A then proceeded to help R25 with her morning cares before pushing R25 out to dining room in her Broda chair to eat. The resident was continuously observed while she was assisted to eat brunch and when she was finished eating R25 was moved to another table to watch the moving playing for an hour. R25 was laid back down on the bed by LPN-B and NA-B lowered R25 back into her bed with the ceiling lift at 2:29 p.m. (R25 had been up in her Broda chair for two hours and 32 minutes with no offer by staff for repositioning). LPN-B told R25 staff would be back in two hours to reposition her. Five

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2 900	Continued From page 32 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 bed and ROHO cushion in R25's wheel chair (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 left hip, 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		

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	00940	A. BUILDING: _____ B. WING _____	05/06/2016

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2 900	Continued From page 33 seen by NP for acute visit to evaluate and manage aspiration, wounds and S/P fracture of left femur. NP's visit note indicated pressure ulcer on left leg had increased in size with a new traumatic skin tear on R25's left leg. Nutrition assessment dated 2/29/16, indicated R25 required increased protein need for wound healing. Nutrition assessment dated 3/10/16, indicated, "No goal weight for R25 at this time due to hospice status-provide food and fluids for comfort. Goal skin will be free of infection." R25's significant change Minimum Data Set (MDS) dated 3/19/16, indicated R25 needed two staff assistance with bed mobility, transfer and toilet use, was always incontinent of bowel and bladder, and did not reject cares. The same MDS indicated R25 had one Stage 3 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) and one Stage 4 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) pressure ulcer which was not present upon admission or readmission and two unstageable (full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) pressure ulcers, one of these not present upon admission or readmission. One pressure ulcer measurement was indicated in the MDS as 8.2 centimeters (cm) x 2.6 cm. The MDS revealed the Stage 3 pressure ulcer had not been present	2 900		

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2 900	Continued From page 34 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 a pressure reducing device for chair, pressure reducing device for bed, turning/repositioning program, nutrition or hydration intervention, 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 was 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 toileting. 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'clock ...on the left trochanter pressure ulcer, unstageable, measuring about 2.5 cm x 2.6 cm x 5.5 cm ...On the lower posterior leg remain unchanged and measured 8.2 cm x 2.6 cm partial thickness skin loss ...Left 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, stage 3 since 2/9/16, increased in size since	2 900		

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2 900	Continued From page 35 3/10/16, a pressure ulcer on left trochanter, unstageable since 2/19/16, a pressure ulcer on left heel, unstageable since 1/18/16, increased in size since 3/10/16, and two wound areas on lower posterior leg. R25 seen by physician on 4/26/16. the physician notes indicated, "Decubitus ulcers - Healing not expected because of end stage disease [Alzheimer's Disease]. Plan- Continue hospice services." 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. During interview on 5/5/16, at 9:53 a.m. with registered nurse (RN)-B (facility's wound nurse) stated when R25's cast was taken off a pressure ulcer was found now healed. RN-B stated the pressure ulcer on R25's left heel from September 2015 was found when R25 was repositioned. RN-B stated residents that could not reposition themselves as R25 were repositioned every two hours. RN-B stated tissue tolerance assessments were completed every three months, upon admission, readmission and if pressure ulcer were found. RN-B verified the facility's tissue tolerance assessment completed 8/31/15, indicated at two hours R25's skin on her buttocks had been reddened and blanchable. RN-B stated the procedure for the tissue tolerance assessment was to try to get to the time frame of no skin redness. When asked why the facility did not position R25 any sooner than two hours to avoid redness and possible skin breakdown on R25's bottom RN-B stated, "I wanted to be	2 900		

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2 900	Continued From page 36 practical, and if I put it any sooner [less than two hours repositioning] they [staff] will tell me it is not practical." RN-B stated the pressure ulcer on R25's left heel was now unstageable with eschar (a slough or piece of dead tissue that is cast off from the surface of the skin). RN-B stated she completed weekly wound assessments on R25's pressure ulcers. RN-B stated a Stage 2 pressure ulcer was found on R25's coccyx on 12/24/15, and was now unstageable with slough, tunneling and undermining. RN-B stated the Stage 2 pressure ulcer on R25's left trochanter (IT) was found upon wound rounds on 12/16/15, and was now unstageable with slough. RN-B stated R25's left lower outer leg pressure ulcer developed because the immobilizer was rubbing on R25's leg. When asked about R25's pressure ulcers developing RN-B stated R25 moves her legs and feet about and the friction and shearing caused the pressure ulcers. When asked to re-clarify RN-B stated "friction and shearing" is what caused R25's pressure ulcers and that R25 was a "complex case." RN-B stated R25 had a pressure reducing mattress and cushion in her Broda chair now as the chair hospice provided was too hard for R25 to sit in. RN-B was unable to give dates when the overlay mattress and ROHO cushion intervention had been put in place. RN-B stated she expected staff to reposition and check R25 for incontinence every two hours. Surveyor informed RN-B during two separate continuous observations of over two hours, R25 had not been repositioned timely without the intervention from surveyor. RN-B stated she had instructed staff if they could not perform positioning and cares timely for R25 they were to let RN-B know. On 5/5/16, at 1:33 p.m. NA-D stated NAs knew mostly what to do by the assignment sheets. NA-D stated if a resident does not want to use the	2 900		

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2 900	Continued From page 37 toilet then the resident will be off loaded every two hours with the resident standing up for a bit. NA-D stated R25 was repositioned every two hours. NA-D stated because of R25's open areas on her body she was laid back down in bed after brunch. NA-D stated R25 always lets staff reposition her and does not refuse. NA-D stated if R25 does not want to get up until later in the morning then she will be repositioned in bed. On 5/6/16, at 3:25 p.m. RN-B stated she took full responsibility for the ROHO chair cushion being found flattened. RN-B stated she checked the ROHO cushion every Monday morning. When asked if the inflatability of the ROHO cushion was being monitored by the nurses or checked by the NAs RN-B stated, "no, only by myself and I take full responsibility." When asked why nursing staff were not checking or monitoring RN-B stated, "Because I did not want to come in and check the cushion flat someday." During an interview on 5/5/16, at 3:37 a.m., the plant operations manager stated he did not know what a ROHO cushion was and was not responsible for maintaining them. During an interview on 5/5/16, at 3:41 p.m., the director of therapy stated the therapy department will let nursing know how much to inflate the ROHO cushions and nursing is responsible for putting the information in the treatment record for monitoring. She stated nursing receives education on how to measure the space between the bottom of the seat and the ischial tuberosity to check for inflation. A review of R25's treatment record and medication record indicated there was no order to inflate or check for inflation of the ROHO cushion.	2 900		

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2 900	Continued From page 38 ROHO Cushion Instructions provided by therapy dated 2003, Instructions for Adjustment indicated included 16 steps for achieving the highest possible level of performance and personal satisfaction for the ROHO cushion. Step 16 of the cushion instructions indicated, "Check Cushion Height Wiggle fingers to make sure there is approximately ½ inch of air between person and 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." Undated policy Pressure Ulcer and Non-Surgical Wound Documentation provided by the facility indicated "... 9. Initiate and implement appropriate measures in care plan; and update as treatment/interventions change... 12. General Wound and skin Care guidelines. Should be followed for all residents with potential and/or actual impairment of skin integrity... c. Turn/reposition up to every 2 hours while in bed and offload every 2 hour when in a chair." 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	2 900		

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2 900	Continued From page 39 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 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 pushed R166 in w/c down the hall, into the elevator and down to the nurse's station on first floor where R166 reported to LPN-D that her teeth hurt when eating the ice cream. LPN-D asked R166 about the pain and R166 reiterated her teeth hurt when eating something cold. The health unit coordinator (HUC) sitting there asked R166 if she wanted to see the dentist and R166 responded, "I was going to see the dentist now." R166 continued to sit up near the nurse's station.	2 900		

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2 900	Continued From page 40 At 2:49 p.m. NA-F came walking up the hall toward the nursing station and stood. Surveyor asked NA-F when R166 was going to be toileted next and NA-F answered that she was going home at 3:00 p.m. Surveyor asked NA-F asked if what time the next shift coming on was going to toilet R166 and NA-F stated she would toilet R166. At 2:50 p.m. surveyor notified LPN-D R166 had not been toileted for over 2 hours and asked if she would look at R166's skin with surveyor. LPN-D stated yes she would and that she expected R166 to be toileted after meals or when she lays down. LPN-D stated R166 had not laid down today because of the activity. LPN-D stated R166 laid down because she would be at risk for pressure ulcer. At 2:54 p.m. LPN-D and NA-F stood R166 up at the toilet and sink and removed R166's brief as R166 dribbled urine while standing. LPN-D confirmed R166's brief was wet with urine and that the yellow line on the brief was now blue. LPN-D stated R166's brief was "moderately wet." (It had been 3 hours and 8 minutes from when NA-F said she had last toileted R166). LPN-D and surveyor observed R166's bottom to be non-smooth, all reddened on both buttocks and LPN-D stated R166's bottom was not open, just reddened, kind of chronic for her and that the skin nurse had looked at it. LPN-D applied treatment to R166's bottom. LPN-D stated R166 is toileted after meals, and that R166 usually came back from activity at 2 p.m. LPN-D stated the NA should have went up to the activity to get R166. After toileting R166 at 3:00 p.m. NA-F stated R166 could not tell NA-F when she had to go to the bathroom. When asked about the time frame for toileting R166, NA-F stated, "I knew she had went for exercise, but I was just going to wait until	2 900		

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2 900	Continued From page 41 she got back." The following day on 5/5/16, at 1:45 p.m. NA-D stated she made sure she toileted or repositioned her resident before they went to an activity so she could keep them within the two hour repositioning/toileting schedule. R166's MDS dated 3/1/16, indicated R166 had a diagnosis of Alzheimer's disease and R166's cognition was severely impaired. The MDS indicated R166 did not reject cares and was at risk for developing pressure ulcers. The MDS also indicated R166 was on a turning/repositioning program, was always incontinent of bowel and bladder and was not on a toileting program. The MDS further indicated R166 needed extensive assistance with staff for transferring, locomotion on and off the unit, and extensive assistance of two staff with toileting. The CAA summary R166 dated 11/25/15, indicated R166 needed assistance with cares, mobility, toileting, bowel and bladder incontinence, wore an incontinent product and received treatment to her bottom every shift for prevention. The 11/25/15, CAA also indicated R166 had a pressure reducing mattress and w/c cushion for prevention of skin breakdown. The CAA further indicated staff were to anticipate R166's needs. It was unable to determine any voiding pattern in the review of the three-day bowel and bladder assessment completed in February 2016 due to incomplete data. R166's careplan dated 11/20/15, indicated R166 was at a risk for pressure ulcers, had a diagnosis of dementia, was unable to reliably notify staff of need to toilet, and staff was to anticipate R166's needs. R166's careplan indicated R166 wore an	2 900		

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2 900	Continued From page 42	2 900		

incontinent product, needed assistance with cares, mobility, toileting and bowel and bladder incontinence. Short term goal for R166 was for skin to remain intact and free of redness. The careplan indicated R166 was to be repositioned and toileted every two hours and as needed.

The undated Nursing Assistant Assignment Sheet for R166 indicated R166's mode of transportation was a w/c 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.

The current May 2016 Physician Orders reviewed for R166 indicated R166 received Lasix every morning. R166's physician orders also indicated R166 received barrier cream, antibiotic ointment and Clotrimazole cream (antifungal) to R166's bottom three times a day for redness. R166's May 2016 Treatment Administration Record indicated R166 had received the barrier cream, Clotrimazole cream and antibiotic ointment.

Review of Nursing Progress Notes (PN) included:
4/27/16, progress note PN indicated R166 had poor skin integrity and some areas of excoriation and redness on R166's bottom.
4/26/16, PN indicated R166 had a red and small open area on the coccyx.
12/13/15, PN indicated R166's Braden skin risk assessment was 16, was at risk for skin breakdown, and would be repositioned and toileted every two hours. The PN indicated R166 had a pressure reducing cushion in w/c and bed.
12/7/15, PN indicated R166 needed extensive assistance for activities of daily living and staff were to anticipate R166's needs.
12/3/15, PN indicated R166's Braden skin risk assessment was 15 which was suggestive of high

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2 900	Continued From page 43 risk for skin break down and staff would anticipate R166's needs by repositioning R166 every two hours in the w/c for one full minute. 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 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 color at a certain point of wetness. Undated policy Pressure Ulcer and Non-Surgical Wound Documentation provided by the facility indicated "... 9. Initiate and implement appropriate measures in care plan; and update as treatment/interventions change... 12. General Wound and skin Care guidelines. Should be followed for all residents with potential and/or actual impairment of skin integrity... c. Turn/reposition up to every 2 hours while in bed and offload every 2 hour when in a chair." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures for the appropriate care and services for pressure ulcers. The director of nursing or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		

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2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R25) reviewed for pressure ulcers received timely repositioning and failed to ensure 1 of 3 resident (R166) reviewed for urinary incontinence, identified at risk for pressure ulcers received timely repositioning. Findings include: R25 was continuously observed lying in bed on her back on 5/5/16, from 7:21 a.m. until 9:43 a.m. (two hours and 22 minutes) when licensed practical nurse (LPN)-B and LPN-C repositioned R25. R25 stated, "That feels good." LPN-B had been interviewed at 9:23 a.m. and stated all residents get repositioned every two hours. At 9:38 a.m., LPN-C stated R25 was positioned according to her care plan and when needed. At that same time, NA-A stated he repositioned R25 every two hours. At 11:34 a.m. R25 was observed lying on her right side in bed with LPN-B finishing up R25's pressure ulcers treatments with nursing assistant	2 905		

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2 905	Continued From page 45 (NA)-A assisting. LPN-B stated R25's brief had been soiled with urine and feces. During the observation, R25 was observed to have open sores on her left hip area and on her bottom. Both appeared to have a light brown substance in them. LPN-B stated the pressure ulcer on the left had honey gel in it, and the ulcer on R25's bottom had packing in it. LPN-B was observed to place bandages over both pressure ulcers and applied tape to secure the bandages. LPN-B stated the evening shift staff completed treatments for pressure ulcers to R25's leg and heel. During transfer to the Broda chair (tilt and recline positioning chair) at 11:57 a.m., a small scab was observed on the top of R25's left foot. During the transfer NA-A stated R25 needed two staff with transfers and repositioning. NA-A stated R25 was repositioned every two hours and was checked for incontinence every two hours. NA-A then proceeded to help R25 with her morning cares before pushing R25 out to dining room in her Broda chair to eat. The resident was continuously observed while she was assisted to eat brunch and when she was finished eating R25 was moved to another table to watch the moving playing for an hour. On 5/5/16, at 1:33 p.m. NA-D stated NAs knew mostly what to do by the assignment sheets. NA-D stated if a resident does not want to use the toilet then the resident will be off loaded every two hours with the resident standing up for a bit. NA-D stated R25 was repositioned every two hours. NA-D stated because of R25's open areas on her body she is laid back down in bed after brunch. NA-D stated R25 always lets staff reposition her and does not refuse. NA-D stated if R25 does not want to get up until later in the morning then she will be repositioned in bed. At 1:53 p.m. NA-E stated the assignment sheet is how she knew what to do for R25. At 1:59 p.m. NA-C stated she followed the	2 905		

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2 905	Continued From page 46	2 905		

assignment sheet for R25 and that she had not performed any cares for R25 today as nights had and that the replacement for the call in NA-A had helped R25. R25 was laid back down on the bed by LPN-B and NA-B lowered R25 back into her bed with the ceiling lift at 2:29 p.m. (R25 had been up in her Broda chair for two hours and 32 minutes with no offer by staff for repositioning). LPN-B told R25 staff would be back in two hours to reposition her. Five 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, lotion R25 and to help R25 feel beautiful. 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 significant change Minimum Data Set (MDS) dated 3/19/16, indicated R25 needed two staff assistance with bed mobility, transfer and toilet use, was always incontinent of bowel and bladder, and did not reject cares. The same MDS indicated R25 had one Stage 3 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) and one Stage 4 (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The

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2 905	Continued From page 47 ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) pressure ulcer which was not present upon admission or readmission and two unstageable (full-tissue thickness loss in which the base of the ulcer is covered by slough or an eschar and, therefore, the true depth of the damage cannot be estimated until these are removed) pressure ulcers, one of these not present upon admission or readmission. One pressure ulcer measurement was indicated in the MDS as 8.2 centimeters (cm) x 2.6 cm. The MDS revealed the Stage 3 pressure ulcer had not been present 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 a pressure reducing device for chair, pressure reducing device for bed, turning/repositioning program, nutrition or hydration intervention, 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 was 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 toileting. 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'clock ...on the left trochanter pressure ulcer, unstageable, measuring about 2.5 cm x 2.6 cm x 5.5 cm ...On the lower posterior leg	2 905		

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2 905	Continued From page 48 remain unchanged and measured 8.2 cm x 2.6 cm partial thickness skin loss ...Left 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 ROHO 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 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 was 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 had had some weight loss due to eating less well due to	2 905		

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2 905	Continued From page 49 progressive dementia. The 9/16/15, PN by the wound nurse indicated R25 had a partial skin loss on posterior left thigh with the wound base covered with slough erythema (redness) around. The PN also indicated the skin loss was most probably due to the cast R25 had had for broken tibia. The wound nurse further indicated R25 had a Stage 2 pressure ulcer develop on R25's left heel. The pressure ulcer measured 4.9 cm (centimeters) x 5.9 cm. R25 was seen by CNP on 9/30/15, for monthly visit. Notes from the NP visit indicated the open area on back of thigh from splint was healing and there was a newly developed intact blood blister on back of left heel (Stage 2 pressure ulcer). NP notes also indicated numerous bruises on extremities and a skin tear on R25's left wrist. Nutritional note for R25 dated 10/15/15, indicated increased demand for protein for wound healing related to (r/t) unstageable pressure ulcer on left thigh and a Stage 2 pressure ulcer on the left heel. Interventions included were a high calorie, protein diet, juice supplement, vitamin C fortified juice every meal and a daily multi vitamin. R25 was seen by CNP on 11/17/15, for monthly visit. NP note indicated the Stage 2 pressure ulcer on R25's left heel was healing. Therapy notes for R25 indicated R25 was referred to physical therapy (PT) from 11/24/15, through 12/7/15, since R25 had a history of left femur fracture and left tibia-fibula fracture and had not been ambulatory for the past year. The notes also indicated R25 was in non weight bearing left lower extremity immobilizer and was	2 905		

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2 905	Continued From page 50 transferred with hoyer lift. R25 was seen by CNP on 12/3/15, for post hospital visit to evaluate and manage fracture of left femur fracture. NP notes indicated R25 was admitted to hospital on 11/19/15, after fall in the nursing home. PT and OT (therapies) evaluation and treatment post hospitalization. The 12/3/15, NP visit notes also indicated there was a newly developed open area on coccyx less than 0.5 cm and multiple bruises on R25's extremities and the 0.5 cm open area on inner left thigh calf was covered with wound dressing and the left heel blood blister (intact) was being reabsorbed, was covered. A Nutrition note dated 12/7/15, indicated the goal for R25 was for skin to heal and to remain intact. Another Nutrition note dated 1/5/16, received order for 1/5 for Protein Powder 1 scoop three times a day for wound healing. A Nutrition note dated 1/6/16, indicated goal was for skin to heal and remain intact. R25 was seen by physician on 12/28/15, to evaluate and manage fracture of left femur fracture. Physician note indicated R25's left heel blood blister was intact was deep tissue injury and was being reabsorbed. The physician note indicated the open area on coccyx had increased in size and there was now an open area on trochanter. The Physician note also indicated R25's pain control was okay, edema had improved, and indicated R25 had decubitus ulcers: "Left ankle from immobilizer, Left trochanter, the coccyx and to continue with current wound treatments." R25 was seen by CNP on 1/22/16, for monthly	2 905		

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2 905	Continued From page 51 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 visit note indicated, "Pressure ulcer of sacral region, unstageable ... Pressure ulcer of left hip, unstageable ... Pressure ulcer of other site [back of left lower leg/ankle] stage 4 ... Pressure ulcer of unspecified heel, unstageable." R25 was seen by CNP on 2/19/16, for acute visit to evaluate and manage aspiration, wounds and S/P fracture of left femur. NP visit note indicated pressure ulcer on left leg had increased in size with a new traumatic skin tear on R25's left leg. Nutrition assessments dated 2/29/16, indicated increased protein for increased demand for protein for wound healing. NA dated 3/10/16, indicated, "No goal weight for R25 at this time due to hospice status-provide food and fluids for comfort. Goal skin will be free of infection." R25 was seen by CNP for monthly visit on 3/31/16. NP visit note indicated, "resident's declining condition including hospice care, treatment of multiple wound, and plan of care to maintain comfort." Nutritional progress note dated 4/13/16, indicated R25 had pressure ulcer on her coccyx, stage 3 since 2/9/16, increased in size since 3/10/16, a pressure ulcer on left trochanter, unstageable since 2/19/16, a pressure ulcer on left heel, unstageable since 1/18/16, increased in size since 3/10/16, and two wound areas on lower posterior leg. R25 seen by physician for regulatory visit on 4/26/16. Physician notes indicated, "Decubitus ulcers - Healing not expected because of end	2 905		

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2 905	Continued From page 52 stage disease [Alzheimer's Disease]. Plan-Continue hospice services." The current Physician Orders for R25 provided by the facility 5/6/16, included: - General wound care: PRN changes for disturbed or saturated dressings dated 4/15/16 Replace packing strips every other day with complete wound care procedure; once a day, every other day dated 3/23/16, document drainage, saturation and catheter; Once a day dated 3/21/16 - Apply air overlay mattress to bed due to Braden score of 13 with risk factors resulting in an increased risk of skin breakdown, Special Instructions: Check that the mattress was inflated dated 1/29/16, turn and position Instructions: License staff to ensure that resident was turned and repositioned every two hourly. Off load every two hours when in a chair for a full minute dated 6/4/15. During interview with registered nurse (RN)-B (who was also the wound nurse) on 5/5/16, at 9:53 a.m. stated when R25's cast was taken off a pressure ulcer was found and that it was now healed. RN-B stated the pressure ulcer on R25's left heel from September 2015 was found when R25 was repositioned. RN-B stated residents that could not reposition themselves as R25 were repositioned every two hours. RN-B assessments for tissue tolerance were completed every three months, upon admission, readmission and if pressure ulcer were found wound nurse would help with the nurses. RN-B verified the facility's tissue tolerance assessment completed 8/31/15, indicated at two hours R25's skin on her buttocks had been reddened and blanchable. RN-B stated	2 905		

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2 905	Continued From page 53	2 905		

the procedure for the tissue tolerance assessment was to try to get to the time frame of no skin redness. When asked why the facility did not position R25 any sooner than two hours to avoid redness and possible skin breakdown on R25's bottom RN-B stated, "I wanted to be practical, and if I put it any sooner [less than two hours repositioning] they [staff] will tell me it is not practical." RN-B stated the pressure ulcer on R25's left heel was now unstageable with eschar (a slough or piece of dead tissue that is cast off from the surface of the skin). RN-B stated she completed weekly wound assessments on R25's pressure ulcers. RN-B stated a Stage 2 pressure ulcer was found on R25's coccyx on 12/24/15, and was now unstageable with slough, tunneling and undermining. RN-B stated the Stage 2 pressure ulcer on R25's left trochanter (IT) was found upon wound rounds on 12/16/15, and was now unstageable with slough. RN-B stated R25's left lower outer leg pressure ulcer developed because the immobilizer was rubbing on R25's leg. RN-B stated the nurses had been routinely taking the immobilizer off to check R25's skin every shift and found the pressure ulcer. When asked about R25's pressure ulcers developing RN-B stated R25 moves her legs and feet about and the friction and shearing caused the pressure ulcers. When asked to re-clarify RN-B stated "friction and shearing" is what caused R25's pressure ulcers and that R25 was a "complex case." RN-B stated R25 had a pressure reducing mattress and cushion in her Broda chair now as the chair hospice provided was too hard for R25 to sit in. RN-B was unable to give dates when the overlay mattress and ROHO cushion intervention had been put in place. RN-B stated she expected staff to reposition and check R25 for incontinence every two hours. Surveyor told RN-B staff during two continuous observations of over two hours

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2 905	Continued From page 54 R25 had not been checked and changed without intervention from surveyor. RN-B stated she had instructed staff if they could not perform positioning and cares timely for R25 they were to let RN-B know. Later in the afternoon occupational therapy stated they had not been informed of the ROHO cushion being put in place for R25. On 5/6/16, at 3:25 p.m. RN-B stated she had seen the scab of top of R25's left foot and had covered it with white dressing. RN-B stated she thought the strap of R25's heel protector's boots had caused it by being too tight. RN-B stated she had instructed staff to not put the boots on so tight. RN-B stated R25's left foot is swollen and stated the scab was caused from the tension of the strap and that she had created a nursing order for a pad to be put on the top of R25's left foot to protect it. R25 stated it was just a scab and not draining. RN-B stated she took full responsibility for the ROHO chair cushion being found flattened. RN-B stated she checked the ROHO cushion every Monday morning. When asked if the inflatability of the ROHO cushion was being monitored by the nurses or checked by the NAs RN-B stated, "no, only by myself and I take full responsibility." When asked why nursing staff were not checking or monitoring RN-B stated, "Because I did not want to come in and check the cushion flat someday." ROHO Cushion Instructions provided by therapy dated 2003, Instructions for Adjustment indicated included 16 steps for achieving the highest possible level of performance and personal satisfaction for the ROHO cushion. Step 16 of the cushion instructions indicated, "Check Cushion Height Wiggle fingers to make sure there is approximately ½ inch of air between person and	2 905		

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2 905	Continued From page 55	2 905		

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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2 905	Continued From page 56	2 905		

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 pushed R166 in w/c down the hall, into the elevator and down to the nurse's station on first floor where R166 reported to LPN-D that her teeth hurt when eating the ice cream. LPN-D asked R166 about the pain and R166 reiterated her teeth hurt when eating something cold. The health unit coordinator (HUC) sitting there asked R166 if she wanted to see the dentist and R166 responded, "I was going to see the dentist now." R166 continued to sit up near the nurse's station. At 2:49 p.m. NA-F came walking up the hall toward the nursing station and stood. Surveyor asked NA-F when R166 was going to be toileted next and NA-F answered that she was going home at 3:00 p.m. Surveyor asked NA-F asked if what time the next shift coming on was going to toilet R166 and NA-F stated she would toilet R166. At 2:50 p.m. surveyor notified LPN-D R166 had not been toileted for over 2 hours and asked if she would look at R166's skin with surveyor. LPN-D stated yes she would and that she expected R166 to be toileted after meals or when she lays down. LPN-D stated R166 had not laid down today because of the activity. LPN-D stated R166 laid down because she would be at risk for pressure ulcer.

At 2:54 p.m. LPN-D and NA-F stood R166 up at the toilet and sink and removed R166's brief as

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2 905	Continued From page 57 R166 dribbled urine while standing. LPN-D confirmed R166's brief was wet with urine and that the yellow line on the brief was now blue. LPN-D stated R166's brief was "moderately wet." (It had been 3 hours and 8 minutes from when NA-F said she had last toileted R166). LPN-D and surveyor observed R166's bottom to be non-smooth, all reddened on both buttocks and LPN-D stated R166's bottom was not open, just reddened, kind of chronic for her and that the skin nurse had looked at it. LPN-D applied treatment to R166's bottom. LPN-D stated R166 is toileted after meals, and that R166 usually came back from activity at 2 p.m. LPN-D stated the NA should have went up to the activity to get R166. After toileting R166 at 3:00 p.m. NA-F stated R166 could not tell NA-F when she had to go to the bathroom. When asked about the time frame for toileting R166, NA-F stated, "I knew she had went for exercise, but I was just going to wait until she got back." The following day on 5/5/16, at 1:45 p.m. NA-D stated she made sure she toileted or repositioned her resident before they went to an activity so she could keep them within the two hour repositioning/toileting schedule. R166's MDS dated 3/1/16, indicated R166 had a diagnosis of Alzheimer's disease and R166's cognition was severely impaired. The MDS indicated R166 did not reject cares and was at risk for developing pressure ulcers. The MDS also indicated R166 was on a turning/repositioning program, was always incontinent of bowel and bladder and was not on a toileting program. The MDS further indicated R166 needed extensive assistance with staff for transferring, locomotion on and off the unit, and	2 905		

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2 905	Continued From page 58 extensive assistance of two staff with toileting. The CAA summary R166 dated 11/25/15, indicated R166 needed assistance with cares, mobility, toileting, bowel and bladder incontinence, wore an incontinent product and received treatment to her bottom every shift for prevention. The 11/25/15, CAA also indicated R166 had a pressure reducing mattress and w/c cushion for prevention of skin breakdown. The CAA further indicated staff were to anticipate R166's needs. It was unable to determine any voiding pattern in the review of the three-day bowel and bladder assessment completed in February 2016 due to incomplete data. R166's careplan dated 11/20/15, indicated R166 was at a risk for pressure ulcers, had a diagnosis of dementia, was unable to reliably notify staff of need to toilet, and staff was to anticipate R166's needs. R166's careplan indicated R166 wore an incontinent product, needed assistance with cares, mobility, toileting and bowel and bladder incontinence. Short term goal for R166 was for skin to remain intact and free of redness. The careplan indicated R166 was to be repositioned and toileted every two hours and as needed. The undated Nursing Assistant Assignment Sheet for R166 indicated R166's mode of transportation was a w/c 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. The current May 2016 Physician Orders reviewed for R166 indicated R166 received Lasix every morning. R166's physician orders also indicated R166 received barrier cream, antibiotic ointment and Clotrimazole cream (antifungal) to R166's	2 905		

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2 905	Continued From page 59 bottom three times a day for redness. R166's May 2016 Treatment Administration Record indicated R166 had received the barrier cream, Clotrimazole cream and antibiotic ointment. Review of Nursing Progress Notes (PN) included: 4/27/16, progress note PN indicated R166 had poor skin integrity and some areas of excoriation and redness on R166's bottom. 4/26/16, PN indicated R166 had a red and small open area on the coccyx. 12/13/15, PN indicated R166's Braden skin risk assessment was 16, was at risk for skin breakdown, and would be repositioned and toileted every two hours. The PN indicated R166 had a pressure reducing cushion in w/c and bed. 12/7/15, PN indicated R166 needed extensive assistance for activities of daily living and staff were to anticipate R166's needs. 12/3/15, PN indicated R166's Braden skin risk assessment was 15 which was suggestive of high risk for skin break down and staff would anticipate R166's needs by repositioning R166 every two hours in the w/c for one full minute. 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 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 color at a certain point of wetness. Undated policy Pressure Ulcer and Non-Surgical	2 905		

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2 905	Continued From page 60 Wound Documentation provided by the facility indicated "... 9. Initiate and implement appropriate measures in care plan; and update as treatment/interventions change... 12. General Wound and skin Care guidelines. Should be followed for all residents with potential and/or actual impairment of skin integrity... c. Turn/reposition up to every 2 hours while in bed and offload every 2 hour when in a chair." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could development and implement policies and procedures for the appropriate care and services for pressure ulcers. The director of nursing or designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 905		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure food sanitation procedures were followed to minimize the possibility of food borne illness in the main kitchen and in 3 of 4 kitchenettes. This had the potential to 98 of 99 who were served food and/or	21015		

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21015	Continued From page 61 fluids out of 3 of 4 kitchenettes and the main kitchen Findings include Main kitchen On 5/3/16, at 11:49 a.m. to 12:06 p.m. during the initial kitchen tour with the registered dietician (RD) and culinary service cook both the inside of the ovens of the four burner stove were observed heavily soiled with black baked on. Both the RD and cook verified the ovens were not clean and the cook indicated she had not used the ovens recently. -The dishwasher was observed to have a light white flaky porous lime build up inside the dishwasher chute/air vent on the clean side. The substance was loose/flaky with touch. 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.	21015		

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21015	Continued From page 62 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. SUGGESTED METHOD OF CORRECTION: The dietary director and/or the director of nursing (DON), could develop and implement policies and procedures related to the cleanliness of the kitchen and the kitchenette areas outside of the main kitchen. The DON or designee could provide educations to the staff. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		

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21375	Continued From page 63 This MN Requirement is not met as evidenced by: Based on observation, staff interview and document review, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 2 of 2 residents (R275, R7) observed who required blood glucose monitoring in 2 of 4 units. Findings include: On 5/5/16, at 7:58 a.m. licensed practical nurse (LPN)-A was observed complete a blood sugar check for R275. LPN-A applied gloves cleaned the glucometer for 15 seconds using a Oxivir Tb disinfectant wipe, applied a stripe, approached R275 cleaned the finger then punctured it and squeezed a drop of blood into the stripe. LPN-A then told R275 his reading was 174. LPN-A was observed get back to the medication cart stationed across from the dining room and disposed of the used supplies then wiped the glucometer for 10 seconds with the Oxivir Tb wipe and put a dry glucometer away inside a small rectangular tote with all the blood sugar supplies on the top drawer of the medication cart. Glucometer was not visibly wet for one minute. LPN-A then removed gloves and washed hands. -At 8:16 a.m. LPN-A stated before and each use always cleaned the glucometer with the wipes for a few seconds around the screen and the area where the stripe was inserted. LPN-A acknowledged did not wipe the glucometer for a full minute as indicated in the container. During observation of glucose monitoring check on 5/3/16, at 3:49 p.m. LPN-F was observed to complete a blood sugar check on R7. After obtaining a blood sugar check on R7, LPN-F	21375		

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21375	Continued From page 64 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	21375		

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21375	Continued From page 65 dated 12/5/08, directed staff to " Pre-clean heavily soiled areas. Apply solution by cloth or disposable wipe to hard, non-porous environmental surfaces. All surfaces must remain wet for one-minute to kill bacteria, HIV-1, HBV and HCV. Use a five-minute contact time for Tb and a ten-minute contact time for fungi. Wipe surfaces dry, rinse or allow to air dry. " The facility policy titled "Clean Glucose Meters" dated 2/8/10, directed staff to clean/wipe the glucometer with Oxivir Tb disinfectant wipes for five seconds and watch the glucometer to ensure that the machine remains wet with the Oxivir Tb disinfectant for one minute. If glucometer starts to dry before one minute the policy directed staff to wipe with another Oxivir Tb disinfectant wipe to ensure wetness for one full minute. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review infection control practices during personal care and educate staff. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented in order to reduce the risk of infection. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the	21540		

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resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to provide monitoring for antipsychotic medication side effects and effectiveness for 1 of 5 residents (R85) reviewed for unnecessary medications. In addition the facility failed to act upon consulting pharmacist's recommendation for 1 of 5 residents (R85) reviewed for unneccessary medications.

Findings include:

R85's diagnoses include but not limited to multiple sclerosis, adult personality disorder, anxiety disorder and hypertension obtained from Resident's face sheet dated 5/6/16.

Review of R85's Physician Order Report dated 5/1/16 -5/31/16, revealed a physician order dated 1/27/15, for Haloperidol (an antipsychotic

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21540	Continued From page 67 medication) 2 milligram (mg) per milliliter (ml) with instructions to give 0.5 ml sublingually at bedtime daily. Review of R85's medication administration record/treatment administration record (MAR/TAR) dated 2/1/16 through 5/6/16, lacked evidence of documentation for monitoring the side effects and effectiveness of anti-psychotic medication. Review of R85's medical record revealed consultant pharmacist communication to nursing dated 12/1/15, 1/4/16 and 4/1/16, with recommendation for side effect monitoring for Haloperidol. However R85's medical record lacked evidence that the consulting pharmacist's recommendations were acted upon by the facility staff. During interview on 5/5/16, at 12:10 p.m. licensed practical nurse (LPN)-G verified, was unable to locate anti-psychotic side effect monitoring sheet anywhere in R85's medical record. During interview on 5/6/16, at 8:37 a.m. registered nurse (RN)-C, acknowledged there was no side effect monitoring in place for anti-psychotic medication in R85's medical record. During interview on 5/6/16, at 11:27 a.m. the assistant director of nursing (ADON) stated he expected residents on psychotropic medications to be monitored for side effects and nurses are to document in the resident's TAR. ADON verified that R85's medical record lacked evidence of side effect monitoring for Haloperidol. ADON stated the expectation is that the facility to act upon the consulting pharmacist's recommendations. When	21540		

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21540	Continued From page 68 ADON was asked if consulting pharmacist recommendation for side effect monitoring for Haloperidol were not acted upon, ADON stated he was not sure if they were. Facility's policy for antipsychotic medication monitoring and consulting pharmacist reviews was requested but none provided. SUGGESTED METHOD FOR CORRECTION: The director of nurses' could inservice staff regarding the importance of assessing for the side effects of medications. She could audit records to assure that when residents are prescribed antipyschotic medications, monitoring of side effects is initiated and adverse effects are assessed. This could be reported and discusssed at quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty One (21) day	21540		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure undated or expired Mantoux solution was removed from medication refrigerators for 3 of 4 units to ensure	21610		

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21610	Continued From page 69	21610		

that they were not used on residents. In addition, the facility failed to ensure expired medications were removed from the medication cart for 1 of 3 medication carts.

Findings include:

Villa Unit
During medication room observation on 5/04/16, at 1:08 p.m. a multi dose vial of Aplisol (testing solution for determining possible exposure to tuberculosis) was found in the medication refrigerator. The vial was not dated when it had been opened or dispensed. Licensed practical nurse (LPN)-E verified it was not dated and said, "I thought they were supposed to date it. They must have taken it out of TCU [Transitional Care Unit]."

Oak View Unit
During medication room observation on 5/04/16, at 1:53 p.m. three vials of Aplisol were found in the medication refrigerator. The first vial was dated as opened on 2/7/16. The expiration date printed on the vial was 3/17. The second vial was dated as opened on 2/8/16. The expiration date printed on the vial was 3/17. The third vial was dated as opened on 3/25/16. The expiration date printed on the vial was 4/17. LPN-B verified the dates the Aplisol vials were opened. LPN-B stated, "It did not matter when the vial was opened. The vial does not have a different expiration date then the expiration date printed on the bottle."

Garden Terrace Unit
During medication room observation on 5/4/16, at 2:37 p.m. an undated vial of Aplisol was found in the medication refrigerator. The expiration date printed on the vial was 1/21/18. Registered nurse

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21610	Continued From page 70 (RN)-C verified that the Aplisol had not been dated when opened. RN-C said, "Aplisol is good for 30 days after opened. This should have been dated. Yes we have used it." A multi-dose vial of Afluria influenza vaccine was found in the medication refrigerator. There was no date opened on it. The expiration date printed on the vial was 6/5/16. RN-C verified the Afluria was not dated when opened and said, "It is good for a year after it has been opened, I guess." During a medication observation on 5/5/16, at 8:18 a.m. LPN-G took out Senna 8.6 milligrams (mg) bottle from the medication cart and noted that Senna 8.6mg had an expiration date of 6/15 on the bottle. LPN-G verified the medication bottle labelled Senna 8.6mg was open, had expired and had about half tablets left in it. The medication cart was checked for expired medication and an open medication bottle labelled calcium with vitamin D 600mg was noted on the cart with an expiration date of 4/16. LPN-G verified the bottle labelled calcium with vitamin D 600mg was open, had expired and had about 3/4 of tablets in it. During interview on 5/4/16, at 3 p.m. the assistant director of nursing (ADON) stated, "Aplisol is good for 30 days after it has been opened. I expect the nurses to date the vial when they open it. I helped give all the Flu vaccines this fall. I think we dated all vials when we opened them. I am not sure how long they are good for after opening. I will have to find out." On 5/6/16, at 11:16 a.m. ADON stated the expectation is all expired medications to be removed from the residents' supply. Policy for medication storage and dating of Aplisol	21610		

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21610	Continued From page 71 vials was requested but not provided. Undated Flu Vaccine Storage Instructions from McKesson Medical Surgical provided by the facility instructed staff, "Once entered, a multi-dose vial and any residual contents should be discarded after 28 days. " Par Pharmaceutical Aplisol package insert revised 7/2015 instructed staff "Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency." The package insert for Afluria from CSL dated 7/27/10, directed staff " When using the multi-dose vial, shake the vial thoroughly before withdrawing each dose, and administer the dose immediately. Between uses, store the vial at 36 degrees Fahrenheit (F) to 46 degrees F). Once the stopper has been pierced, the vial must be discarded within 28 days. " SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure medications including vaccination solution, are appropriately stored and not expired. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21610		

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21685	Continued From page 72	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance 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. On 5/6/16, at 11:12 a.m. a tour of the facilty was conducted with the director of maintenance (DOM) and the director of housekeeping (DOH). TCU Unit Room 104A On 5/4/16, at 8:42 a.m. the wall behind recliner was observed to have several small gouges in it. On 5/6/16, at 11:12 a.m. the DOM verified that gouges were present and stated that they have a guy who goes through the rooms monthly and does repairs. DOM unaware how long the gouges had been present.	21685		

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21685	Continued From page 73 Garden unit Room 149 On 5/3/16, at 2:30 p.m. room 149A the floor of the room had multiple small cracks with black built up through out the room. On 5/6/16, at 11:19 a.m. the HOM stated they are aware of the problems with the floor cracking and were working on raising funds for replacement. HOM stated that there was not a bid yet for the replacement of the cracked floor tiles. Room 151 On 5/3/16, at 2:30 p.m. room 151A was observed to have missing trim at the base of the wall to the left of the bathroom door. The floor of the room had multiple small cracks with black built up through out the room. On 5/6/16, at 11:22 a.m. the HOM verified that the trim needed to be replaced and that they were aware of cracks on the floor. Room 165A On 5/3/16, at 1:50 p.m. the door to room 165A was observed to have a two and a 30 inch x 0.5 inch scrape across the middle of the inside door. The ceiling in the bathroom was stained with a round ring approximately 12 inches in diameter in the corner of the bathroom. On 5/6/16, at 11:23 a.m. the DOM verified that the door needed to be fixed and verified the water damage to the bathroom ceiling. Room 166A On 5/3/16, at 6:47 p.m. the bathroom door was observed to have a weak spot that was oval in shape with rough edges and loose wood splinters. On 5/6/16, at 11:28 a.m. The HOM and DOM verified that this needed to be repaired.	21685		

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21685	Continued From page 74 Villa unit Room 201A On 5/3/16, at 2:14 p.m. the ceiling tile in the bathroom was observed to be stained. On 5/6/16, the DOM verified there was water damage in the bathroom. Room 206 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. Oak View Unit Room 232B On 5/3/16, at 2:05 p.m. the door frames on both sides of the bathroom were observed to to have the paint scraped off the lower edges exposing bare metal. On 5/6/16, the DOM verified that it needed to be painted as it was an uncleanable surface. Room 238A On 5/3/16, at 5:25 p.m. the door frames on both sides of the bathroom were observed to to have the paint scraped off the lower edges exposing bare metal. The fan in the bathroom was very noisy. There was missing plaster on the wall by 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	21685		

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21685	Continued From page 75 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. Reporting Environmental concerns policy requested, but not provided.	21685		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the call light was within reach for 1 of 1 resident (R18) who was at risk for falls. Findings include:	21810		

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21810	Continued From page 76 On 5/03/16, at 1:28 p.m. R18 was observed sitting upright in a Broda chair (a tilt and recline positioning chair). The Broda chair was three feet from the edge of R18's bed. The call light was lying across the bed. R18 was unable to reach the call light. R18 stated could not move his chair. R18 stated "I use my call light to get the staff. I am supposed to ring it, not attempt to get up." At 1:31 p.m. nursing assistant (NA)-E answered the call light. NA-E gave the call light to R18. NA-E stated, "Therapy brought him back to the room. I don't know why they did not give him his call light." NA-E said R18 used the call light. "Whenever I get [R18] up I make sure [R18] has the call light because [R18] cannot call out loud enough to be heard." NA-E verified R18 was unable to move Broda chair. NA-E stated R18 was a fall risk, because R18 would reach for things and can fall out of the bed. NA-E stated, "I make sure all my residents have their call lights." R18's 4/19/16, admission Minimum Data Set (MDS) indicated R18 was severely cognitively impaired, and required assistance of two staff for bed mobility, transfers, and toilet use. The care plan dated 4/22/16, indicated R18 was at risk for falls and instructed staff to keep call light in reach at all times. During interview on 5/3/16, at 1:40 p.m. licensed practical nurse (LPN)-C stated, "I checked in with him this morning. He can and does use the call light. He should have had the call light in place." During interview on 5/3/16, at 1:53 p.m. assistant director of nursing (ADON) said, "All residents should have a call light within reach. I expect all staff including therapists to make sure residents	21810		

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21810	Continued From page 77 have their call lights." Policy for call lights requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe environment. The DON or designee, could coordinate with staff to conduct periodic audits of areas residents frequent to ensure a call lights are within reach. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		