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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FU8X

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 **06/05/2017** (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:

X 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 :
Lisa Hakanson, HPR 07/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 08/30/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
06/20/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245310 July 14, 2017

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 May 23, 2017 the above facility is recommended 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

July 14, 2017

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

RE: Project Number S5310027

Dear Ms. Ager:

On April 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 13, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 5, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 10, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 23, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2017, effective May 23, 2017 and therefore remedies outlined in our letter to you dated April 26, 2017, will not be imposed.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: FU8X

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(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 **04/13/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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2 AOA 3 Other

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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

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To (b) :

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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)

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	105			
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17. SURVEYOR SIGNATURE Date :
Amy Charais, HFE NE II 05/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/20/2017 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

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02/26/1986
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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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1821

April 26, 2017

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

RE: Project Number S5310027

Dear Ms. Ager:

On April 13, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: Susanne.reuss@state.mn.us
Phone: (651) 201-3793 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 23, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 13, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 13, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

Enclosure

cc: Licensing and Certification File

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

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 _____	04/13/2017

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification 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	**F156 D Notice of rights, rules, services, charges.** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** Family members were informed about the coming end of therapy in care conferences before the denial letter was communicated via phone call and left in the patient room. This communication process (leaving in room) had been used with success with this family. Staff missed the statement in an email (with many other items) from the daughter that she would be out of town and the letter was not reviewed in time to appeal. However, the resident resumed therapy on April 7th and received a denial of coverage on April 20, 2017. The denial was issued and signed in person.	
F 156 SS=D	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section;	F 156	accepted Mindy 5-9-17	

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

Susan Agar — Administrator/CEO — 5/5/17

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 _____	04/13/2017

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 156	Continued From page 1 (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and	F 156	**How the facility will identify other residents having the potential to be affected by the same deficient practice** After review, it was determined that no other residents were affected. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur** We will follow the current written policy. A notice of non-coverage will be issued no later than 2 days before termination of all skilled services. A denial letter will be issued personally when possible to the client and responsible party. If the denial letter cannot be issued in person, the responsible party will be notified by telephone of the notice of non-coverage, date that skilled care will end and the telephone number for the QIO and the appeal process. If it is necessary to leave a voice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 156	Continued From page 2 as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email),	F 156	mail, a return call will be requested to ensure that the information was received. If a return call is not received, another call will be placed to the responsible party. A copy of the denial will be mailed to the responsible party with a request for a signature. A note will be entered into the medical record with the date and time of the verbal notification. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Signed denial letters are scanned into the medical record by the business office. Unsigned denial letters will be retained by the business office until a signed copy is received. **Include dates when corrective action will be completed.** May 3, 2017	

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 _____	04/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 156	Continued From page 3 and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.	F 156		

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F 156	Continued From page 4 (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.	F 156		

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F 156	Continued From page 5 (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 4 residents (R52) and/or responsible party were informed and provided the required notices of Medicare non-coverage upon termination of covered services.	F 156		

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F 156	Continued From page 6 Findings include: During interview on 4/10/17, at 5:17 p.m., family member (FM)-A stated R52 admitted to the facility following a hospital stay for rehabilitation. FM-A stated at the initial care conference the facility staff had explained R52 had to make progress to be on therapy which, was covered by Medicare. FM-A stated the facility staff had left forms that needed to be signed in R52's room, including the liability notice in a separate envelope. FM-A stated had not signed the liability notice due to not knowing what it was for. FM-A explained having sent an e-mail to the facility staff, which included the nurse transitional coordinator and licensed social worker (LSW), informing them she would be out of the country starting 1/27/17, and other family members were available. FM-A expressed frustration the family had with communication when asking several questions of staff, as the family was not familiar with the nursing home and therapy regulations. FM-A stated, wishing the facility staff would have helped by explaining more to get the family to understand. FM-A stated she thought the form was still inR52's room and no staff had followed up with the family about it. R52 admitted to the facility on 1/13/17, and had received both physical and occupational therapies from 1/14/17, through 1/31/17. During review of the Notice of Medicare Non-Coverage for services ending 1/31/17, provided by the business office manager (BOM) it was revealed the LSW had documented in the notice she had called FM-A and left a voice message about the notice and the last day of coverage however, the form had not been signed	F 156		

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F 156	Continued From page 7 and returned. On 4/12/17, at 11:06 a.m. the BOM indicated the notice was dated 1/27/17, and verified the notice did not have a family and/or resident signature. When asked what the policy was, BOM stated she would not answer that however thought for the short stay residents at the time of the discharge care conference the last day of coverage was identified and discussed. On 4/12/17, at 2:05 p.m. LSW stated she had called FM-A and left a voice message for her on 1/27/17, regarding the last covered day. LSW stated at the care conference on 1/19/17, the denial notice had been discussed. LSW stated not being informed the daughter was out of town. LSW explained that a notice was left in the room for R52's daughter to review. When asked for documentation about the denial notice being addressed, LSW reviewed the note dated 1/19/17, and verified the note did not address the denial notice had been discussed. When asked about following up to have the form signed and returned, LSW explained thinking about the family appealing and was not sure if it that would be followed up with the nurse transitional coordinator. -At 2:20 p.m. LSW stated it was an oversight, explaining she thought the nurse transitional coordinator had followed up with the family as she was also involved with resident paperwork and the process. LSW verified no subsequent attempts had been made to obtain a signed notice from family. On 4/12/17, at 2:32 p.m. the nurse transitional coordinator stated she would only do the denial notices for residents when LSW was not around,	F 156		

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F 156	Continued From page 8 which was not the case with R52. On 4/13/17, at 1:31 p.m. the administrator indicated expecting the LSW to have communicated an explanation of the form to family and to follow up to make sure the form was signed and returned. The facility Medicare Beneficiary Notices policy revised December 2011, directed "The facility must keep a copy of the unsigned notice on file while awaiting receipt of the signed notice. If the beneficiary does not return a signed copy, the facility must document the initial contact and subsequent attempts to obtain a signature in appropriate records or on the notice itself..."	F 156		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to determine if the practice of self administration of medications was safe for 1 of 1 resident (R118) observed to self administer a nebulizer treatment during a random observation. Findings include: On 4/12/17, at 10:10 a.m. during a random observation, R118's door to room was observed wide open and R118 was observed seated on the wheelchair in front of a bedside pull table. The	F 176	**F176 D Resident self-administer drugs if deemed safe. Self-Administration of Medications – Nebulizers** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** There was no harm came to resident. This was an isolated incident in which another resident was asking for pain medication and the nurse stepped out to give it. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** We reviewed all residents using nebulizers and their self-medication assessments to ensure they are accurate, and audit to ensure compliance.	

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F 176	Continued From page 9 nebulizer machine was heard running at the time however the nebulizer mask was laying on top of the bedside pull table by the bed as the machine was still running. At 10:16 a.m. registered nurse (RN)-B, who was standing by the medication cart, was approached and interviewed regarding R118 self administrating the nebulizer treatment. RN-B was not sure if R118 had an order to self-administer medication (SAM). RN-B applied a gown, went to R118's room and asked R118 if he had removed the nebulizer mask. R118 explained wanting to eat, so removed the mask. At 10:23 a.m., when RN-B exited R118's room, RN-B reviewed the orders and assessment dated 3/10/17, which indicated R118 was not to SAM and verified R118 did not have an order to SAM. R118's Other Clinical Assessments--Self-Administration Of Medication Assessment-*R dated 3/10/17, indicated "No (No further assessment needed" for the question "Does resident want to self-administer medications." R118's cardiac care plan dated 3/15/17, identified R118 with potential for alteration in cardiac output related to chronic obstructive pulmonary disease (COPD) and Parkinson's. The care plan directed staff to give medications as ordered by the medical doctor. On 4/13/17, at 7:36 a.m. the director of nursing stated the nurses were trained that all residents had to be assessed and have an order stating it was okay to self administer medications. The facility Self-medication administration policy dated 4/6/15, directed:	F 176	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur** We will retrain all licensed nurses in this practice. Criteria for self-medication will be reviewed and clarified as necessary. **How the facility plans to monitor its performance to make sure that solutions are sustained.** We will audit weekly x 2 and monthly x 3. We will report to Quality Council on results. **Include dates when corrective action will be completed.** May 23, 2017	

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F 176	Continued From page 10 1. Residents are asked within the first 7 days of admission if they would like to self-administer their medications, and their response is documented in their medical record. 2. The resident is assessed for competency and physically ability to self-administer medications. 3. A decision to permit self-administration is made by the Interdisciplinary team. 4. The physician is notified of resident's desire and of facility assessment process. 5. The physician orders must include drug name, dosage, route, and any special instructions...	F 176	**F282 D Services by qualified persons/per care plan** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No harm came to this resident. The care plan reflects resident's personalized care. Terminology was changed to clearly reflect that. Every document requested by the survey team was provided to them as far as facility staff understood. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** We reviewed all residents on an every two hour toileting plan and ensured that staff are compliant with cares. **What measures will be put into place or systemic changes made to ensure**	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 plan of care for 1 of 3 residents (R1) reviewed for urinary incontinence. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/28/17, indicated R1 was severely cognitively impaired, required extensive assist of 2 staff for bed mobility, transfers and toileting, and was always incontinent of bowel and bladder. A facility Observation Report, Bowel Assessment dated	F 282		

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F 282	Continued From page 11 2/9/17, indicated R1 was incontinent of bowel and needed total assist with peri care. A facility Observation Report, Bladder Assessment dated 2/9/15, indicated R1 was incontinent of bladder and required total assist with care. R1's care plan dated 1/30/17, indicated an alteration in activities of daily living (ADL's) related to needing assist with al aspects of care. The care plan directed staff to assist resident with assistance of two staff to check and change R1 "at least" every two hours and as needed. During continuous observations on 4/12/17, at 12:18 p.m., R1 was lying in bed. At 1:11 p.m., R1 remained in bed, no staff had entered R1's room. At 2:02 p.m., a staff member brought water into R1's room and left immediately after. At 2:30 p.m., staff had still not entered R1's room to check and change R1. At 2:47 p.m., nursing assistant (NA)- A entered R1's room. R1 was lying on back in bed and a strong bowel movement (BM) odor was present. NA-A removed R1's incontinent brief and R1 was noted to have a medium BM and urine in the incontinent brief. During an interview on 4/12/17, at 2:50 p.m., NA-A stated R1 should be changed every two hours. NA-A stated she had last toileted R1 two hours prior. During a second observation on 4/13/17, at 8:56 a.m., R1 was lying in bed, wide awake and incontinent brief was saturated with urine. During an interview on 4/13/17, at 11:49 a.m., the director of nursing stated if a resident has a toileting plan that directs staff to check and	F 282	**that the deficient practice will not recur.** Training will be provided to all nursing assistants. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Audits will be completed weekly x 2, monthly x 3 and thereafter reviewed based on the care conference schedule. **Include dates when corrective action will be completed.** May 23, 2017	

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F 282	Continued From page 12 change every two hours, she would expect staff to complete the care within an hour of the scheduled timeframe, even though, the care plan directed staff to check and change R1 "at least" every two hours. A facility policy regarding implementation of the care plan was requested, but not received.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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: Based on observation, interview and document review, the facility failed to provide a timely check and change program for 1 of 3 residents (R1) reviewed for urinary incontinence. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/28/17, indicated R1 was severely cognitively impaired, required extensive assist of 2 staff for bed mobility, transfers and toileting, and was always incontinent of bowel and bladder. A facility Observation Report, Bowel Assessment dated 2/9/17, indicated R1 was incontinent of bowel and required total assist with peri care. A facility Observation Report, Bladder Assessment dated 2/9/15, indicated R1 was incontinent of bladder and required total assist with care. A Benedictine Health Center at Innsbruck Resident Progress Note dated 3/26/17, indicated R1 had "redness" to her back and a 1.2 centimeter (cm) x 1.7 cm	F 312	**F312 D ADL care provided for dependent residents.** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No harm came to this resident. There was no current skin breakdown. The care plan reflects resident's personalized care. Every document requested by the survey team was provided to them. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** Reviewed all resident care plans on q 2 hour toileting and changed as indicated.	

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F 312	Continued From page 13 open area on the sacral area. R1's care plan dated 1/30/17, indicated an alteration in activities of daily living (ADL's) related to needing assist with all aspects of care. The care plan directed staff to assist R1 with two staff to check and change R1 "at least" every two hours and as needed. During continuous observations on 4/12/17, at 12:18 p.m., R1 was lying in bed. At 1:11 p.m., R1 remained in bed; no staff had entered R1's room. At 2:02 p.m., a staff member brought water into R1's room and left immediately after. At 2:30 p.m., staff had still not entered R1's room to check and change R1. At 2:47 p.m., nursing assistant (NA)- A entered R1's room. R1 was lying on back in bed and a strong bowel movement (BM) odor was present. NA-A removed R1's incontinent brief and noted a medium BM and urine in the incontinent brief. During an interview on 4/12/17, at 2:50 p.m., NA-A stated R1 should be changed every two hours. NA-A stated she had last toileted R1 two hours prior. During a second observation on 4/13/17, at 8:56 a.m., R1 was lying in bed, wide awake and the incontinent brief was saturated with urine. During an interview on 4/13/17, at 11:49 a.m., the director of nursing stated if a resident has a toileting plan that directs staff to check and change every two hours, she would expect staff to complete the care within an hour of the scheduled timeframe. A facility policy titled Benedictine Health Center at	F 312	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur** Training will be provided to all nursing assistants. **How the facility plans to monitor its performance to make sure that solutions are sustained.** Audits will be completed weekly x 2, monthly x 3 and thereafter reviewed based on the care conference schedule. **Include dates when corrective action will be completed.** May 23, 2017	

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F 312	Continued From page 14 Innsbruck, Bladder Management dated April 4, 2006 indicated a resident on a "stay Dry Program," should be taken to the bathroom or commode every two hours while awake.	F 312		
F 323 SS=E	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure mechanical lift slings were used in accordance with manufacturer guidelines to reduce the risk of	F 323	**F323 E Free of accidents hazards/supervision/devices** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No resident was harmed by using slings from manufacturers different than the equipment used. Slings were immediately changed for the 6 residents identified. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All residents who use mechanical lifts have been identified and have the	

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F 323	Continued From page 15 injury to residents and staff which had potential to affect 6 of 6 residents (R2, R12, R15, R23, R142, R179) who used a mechancial lift for transfers. Findings include: R12, during an observation on 4/13/17, at 8:12 a.m., nursing assistant (NA)-A and NA- B transferred R12 from bed to wheel chair using an EZ- Way brand Mechanical Lift device. R12 was transferred using a mechanical lift sling labeled Guldman basic high. R2, during review of a facility document titled Coconut/Oak View Assignement Sheets dated 4/11/17, indentified that R2 transferred with assist of two staff using a Hoyer lift, (A Hoyer Lift is a mchanical lift that allows a person to be lifted and transferred with a minimum of physical effort). R142, during review of a facility document titled Banana/Oak View Assignment Sheets dated 4/11/17, indentified R142 transferred with assist of two staff using a hoyer lift. R15, R23, R179. during review of a facility document titled Cherry unit/Oak View Assignment Sheets dated 4/11/17, indentified R15, R23 and R179 transferred with assist of two staff using a hoyer lift. During a tour of the Oakview unit on 4/13/17, at approximately 10:00 a.m., the director of nursing verified R2 ,R12, R15, R23, R142, and R179 had Guldman Brand mechincal lift slings in their rooms and the slings were being used for transfer with an EZ-Lift brand mechanical device. During the tour, the director of nursing stated she did not order the slings and stated she was not aware	F 323	appropriate sling based on the brand of mechanical lift they are using. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** All residents in rooms with ceiling lifts have correct and personalized slings in their rooms on back of doors. Similar bags and personalized EZ lift slings will be placed in rooms that do not have ceiling lifts. **How the facility plans to monitor its performance to make sure that solutions are sustained.** We will audit weekly x 2 and monthly x 3. We will report to Quality Council on results. **Include dates when corrective action will be completed.** May 23, 2017	

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F 323	Continued From page 16 they were specific to the manufacturer. A representative from the EZ- Way company was contacted on 4/13/17, at 1:20 p.m. The representative stated EZ-Way does not guarantee the safe use of their equipment with other manufacturers slings. The EZ-Way representative sent the following letter, dated March 24, 2014, via e-mail: "It has been brought to our attention that customers would like to understand the reasons we suggest to always use our EZ Way manufactured and tested slings or harnesses with our EZ Way engineered and manufactured lifting equipment. Our recommendation starts with the FDA's statement of policy and adheres to the strict guidelines to which they recommend; not only to keep residents, patients and staff safe, but for the protection of your facility as well. The EZ Lift is the engineered mechanical device which performs the lifting and transferring of your resident or patient, with a specific weight capacity that it is manufactured to. The EZ Way Sling is the soft good product which will surround your resident or patient in comfort and connects to the lift by loop straps. Together, the lift and the sling complete the total system which can then move your resident or patient. It's the complete "system" which the FDA audits us by. Here are some specifics that must be considered: EZ Way's manufacturing standards require	F 323		

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F 323	Continued From page 17 testing each sling and harness style well beyond the rated weight capacity of the item; 1,000 lbs. for washable slings and harnesses and 660 and 1,000 lbs. for disposable slings and harnesses. We also test the usage and compatibility of each design to verify the safety of the design when used with our lifting equipment. This testing ensures that the products are safe to use, and supports why the FDA maintains their position of using accessory products manufactured and tested by the manufacturer of the lifts EZ Way manufactures over 1000 slings and harnesses in different materials, sizes and unique configurations, so we match best to your resident and/or patient needs. We do not approach this as a universal "one size fits all", because of the varied needs of patients your caregiving staff will encounter. EZ Way uses a 4-point articulating hanger bar providing additional comfort for the resident and/or patient. EZ Way Slings are engineered and manufactured for this specific configuration to complete the "system" with both comfort and safety in mind. Alternating between other manufacturers' 4-point hanger or 2-point hanger systems may change the positioning of how a patient is situated in a sling and compromise either comfort, safety or possibly both.'	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	**F329 D Drug Regimen is free from unnecessary drugs** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No harm came to this resident. The evening sleep monitoring was initiated on the date when the drug was initiated. On 4/21, the overnight monitoring was initiated	

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F 329	Continued From page 18 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 329	and continues to be documented. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** After review, there are no other residents that were affected. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** Overnight sleep monitoring will be initiated as a separate task on the electronic record. **How the facility plans to monitor its performance to make sure that solutions are sustained.** We will audit weekly x 2, and monthly x 3. The consulting pharmacist conducts monthly audits that are reviewed at Quality Council. **Include dates when corrective action will be completed.** May 23, 2017	

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F 329	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure monitoring of medication side effects and sleep monitoring for Trazodone (an antidepressant medication) was completed for 1 of 5 residents (R258), who was reviewed for unnecessary medications. Findings include: R258's Care Area Assessment (CAA) dated 3/6/17, indicated R258 was severely cognitively impaired, required assistance for all activitties of daily living, and had a diagnosis of insomnia. The CAA stated R258 would be observed for medication side effects, proper dosing and continued need. R258's care plan dated 3/8/17, indicated being at risk for complications of psychotropic drugs and received Trazodone at bedtime for insomnia. The interventions for nursing included to observe for adequate sleep, observe for side effects, proper dosing and continued need. On 4/12/17, at 10:19 a.m., R258 was participating in a Wellness Class. R258 was able to participate in the class. R258's Medication Administration History dated 2/27/17 through 3/27/17, indicated Trazodone was given every evening. Documentation of hours slept indicated R258 slept from zero to two hours nightly, but did not identify any side effect monitoring. During an interview on 4/11/17, at 1:45 p.m., licensed practical nurse (LPN)-A stated sleep was	F 329		

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F 329	Continued From page 20 documented in the treatment record. LPN-A stated R258 had been receiving Trazodone every evening and sleep monitoring had not been done. LPN-A stated that sleep and side effect monitoring should have been initiated on admission. LPN-A stated when a medication for sleep was initiated, sleep tracking was to be started when the order was transcribed by health unit coordinator or registered nurse (RN). The RN should have initiated sleep monitoring as a nursing order. LPN-A stated sleep monitoring had not been completed since admission. On 4/13/17, at 3:15 p.m. director of nursing (DON) stated the numbers, zero to two hours nightly, may indicate hours of sleep. When asked if R258 had been sleeping zero to two hours per night, the DON did not respond. The interpretation of the numbers was unclear. The Facility Policy/Procedure dated 3/11/13, Sleep Monitoring indicated patients or residents admitted on existing hypnotic/sleep medications will be reviewed or assessed on admission for appropriateness and recommendations made to the provider. The procedure directed staff to report and record sleep patterns.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 371	**F371 E Food procure store/prepare/service – Sanitary** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.**	

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F 371	Continued From page 21 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to safely store potentially hazardous foods to prevent the possibility of food borne illness. This had the potential to affect 97 of 99 residents who were served food out of the kitchen. Findings include: On 4/10/17, from 11:43 a.m. to 12:14 p.m. during the initial kitchen tour with the culinary services director (CSD) the following food items were observed stored in the walk in / reach in cooler in clear re-useable plastic containers with the following use by dates: -Black olives use by 3/30/17. -Prunes use by 4/1/17 -Fruit use by 4/9/17 -Bacon bits use by 3/3/17 -Potato salad use by 3/30/17 -Coleslaw use by 3/30/17 -Jelly Cranberries use by 3/26/17	F 371	No resident was affected negatively. All the food items were disposed of immediately. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All foods that are outdated will be disposed of immediately. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** The duty of checking the refrigerators daily for outdated items has been put on the cook's daily duties. **How the facility plans to monitor its performance to make sure that solutions are sustained.** The Culinary Services Director will add checks to the weekly audit. **Include dates when corrective action will be completed.** Mav 5. 2017	

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F 371	Continued From page 22 -Cheese use by 3/29/17 The CSD verified the findings and stated staff were supposed to date everything when opened. When asked when the food was supposed to be disposed off, CSD stated the food was supposed to be disposed after 7 days "used by date" and stated food should be dated and initialed by staff. The food identified above was observed to be removed from the walk in cooler and reach in cooler in the kitchen and disposed of. On 4/12/17, at 12:54 p.m., the CSD stated the last time potato salad was served was on 4/5/17, and coleslaw had last been served on 4/8/17. CSD was not sure if the staff had used the opened containers. The CSD stated, "bottom line, "the staff were supposed to remove food from the refridgerator within 7 days of being opened or by the use by date. The undated Aviands Food & Service Management Date Marking Ready-To-Eat, Potentially Hazardous Food policy directed: 2. Label and date any processed, ready-to-eat, potentially hazardous foods when opened, if they are to be held for more than 24 hours. 3. The Product name and the date the product is prepared or opened must be written clearly on the label. 5. Serve or discard refrigerated, ready-to-eat, potentially hazardous foods within seven (7) day calendar days or less from the day of preparation, including the day of preparation..."	F 371		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review	F 428	**F428 D Drug Regimen Review, Report Irregular, Act ON** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** The consulting pharmacist recommendation was received and it was	

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F 428	Continued From page 23 (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 428	corrected on 4/21. Our policy states that we must address pharmacy recommendations within 45 days and this was accomplished. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** After review, there are no other residents that were affected. **What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur** Overnight sleep monitoring will be initiated as a separate task on the electronic record.	

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F 428	Continued From page 24 the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon the pharmacist's recommendation for monitoring the side effects of Trazodone (an antidepressant medication) for 1 of 5 residents (R258) who was reviewed for unnecessary medications. Findings include: R258 was observed on 4/12/17, at 10:19 a.m. R258 was participating in a Wellness Class. R258 was able to lift the right leg slightly as requested by instructor. R258 displayed no signs of discomfort. The Treatment Administration Record (TAR) History dated 2/27/17 through 3/27/17, lacked documentation of hours of sleep and side effect monitoring. A Medication Administration History dated 2/27/17 through 3/27/17, indicated Trazodone was given every evening. Documentation of hours slept indicated R258 slept from zero to two hours nightly. A Consultant Pharmacist Communication to Nursing dated 3/1/17, indicated R258 received Trazodone 25 mg (milligrams) for insomnia and recommended side effect monitoring and sleep	F 428	**How the facility plans to monitor its performance to make sure that solutions are sustained.** We will audit weekly x 2, and monthly x 3. The consulting pharmacist conducts monthly audits that are reviewed at Quality Council. **Include dates when corrective action will be completed.** May 23, 2017	

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F 428	Continued From page 25 monitoring needed to be documented. The facility failed to address the CP communication. The Care Area Assessment (CAA) dated 3/6/17, indicated R258 was severely cognitively impaired, required assistance with dressing, bed mobility, transfers, toilet use, grooming, and had a diagnosis of insomnia. The CAA stated R258 would be observed for medication side effects, proper dosing and continued need. R258's care plan dated 3/8/17, indicated R258 was at risk for complications of psychotropic drugs, received Trazodone at bedtime for insomnia. The interventions for nursing included to observe for adequate sleep, observe for side effects, proper dosing and continued need. An interview was conducted on 4/11/17, at 1:45 p.m. with licensed practical nurse (LPN)-A. LPN-A stated sleep was documented in the TAR. LPN-A stated R258 had been receiving Trazodone every evening and sleep monitoring had not been done. LPN-A stated that sleep and side effect monitoring should have been initiated on admission. LPN A stated when a medication for sleep was initiated, sleep tracking was to be started when the order was transcribed by health unit coordinator or registered nurse (RN). The RN should have initiated sleep monitoring as a nursing order. LPN-A stated sleep monitoring had not been done since admission. On 4/13/17, at 3:15 p.m. director of nursing (DON) stated the numbers (zero to two hours) may indicate hours of sleep. When asked if R258 had been sleeping zero to two hours per night, the DON did not respond. The interpretation of the numbers was unclear.	F 428		

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F 428	Continued From page 26 The Facility Policy/Procedure dated 3/11/13, Sleep Monitoring indicated patients or residents admitted on existing hypnotic/sleep medications will be reviewed or assessed on admission for appropriateness and recommendations made to the provider. The procedure directed staff to report and record sleep patterns. The facility failed to act in response to the pharmacist's MRR which identified incomplete side effect monitoring of the Trazadone.	F 428		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441	**F441 D Infection control, prevent spread, linens** **How corrective action will be accomplished for those residents found to have been affected by the deficient practice.** No resident was harmed. This was an isolated incident found after reviewing many instances of hand washing protocol. **How the facility will identify other residents having the potential to be affected by the same deficient practice.** All staff are trained to follow the hand washing policy.	

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	245310	A. BUILDING _____ B. WING _____	04/13/2017

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 441	Continued From page 27 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 441	**What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.** We will auditing and perform on-the-spot training if issues arise. Training will be provided for all appropriate staff. **How the facility plans to monitor its performance to make sure that solutions are sustained.** We will audit weekly x 2, and monthly x 3. Results of audits will be reported at Quality Council. **Include dates when corrective action will be completed.** May 23, 2017	

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F 441	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the standards of hand hygiene for infection control during cares for 2 of 4 residents (R175, R12) observed for cares. Findings include: R175 was admitted to the facility on 1/31/15, with diagnoses of spinal stenosis, aftercare for spinal fusion, chronic low back pain and dementia. R175 required extensive assist of two staff and mechanical stand assist for toilet use and transfer; extensive assist of one staff for grooming, dressing and bathing. On 4/13/17, at 8:18 a.m. R175 had been under continuous observation for 38 minutes when NA-A approached to offer morning cares, permission to observe was obtained from R175. NA-A gathered supplies and water in a basin, put on gloves and gave R175 a washcloth and instructed R175 to wash face. NA-A then washed arms and legs, then removed gloves, but did not perform hand hygiene (HH). NA-A put on new gloves and lotioned extremities and took off gloves, but did not perform HH, then put on antithromboic hose (compression socks to knees). At 8:31 a.m. NA-A stated would like to put R175 on the toilet, and needed to get help, NA-A lowered the bed and left the room without performing HH. NA-A returned to room with NA-B and both put on gloves, R175 was sat upright in bed and was put into stand assist and taken to bathroom and lowered to the stool. NA-A and NA-B took off gloves and put on new gloves without performing HH. NA-B performed pericare, then removed gloves. R175 was put into a wheelchair. NA-B left room, taking the stand assist, but did not perform HH. NA-A took off gloves, did not perform hand hygiene, put on new	F 441		

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F 441	Continued From page 29 gloves and set up for brushing teeth. R175 brushed own teeth and NA-A assisted R175 to hold the emesis basin (kidney shaped small basin) and cup of water to rinse and spit after tooth brushing. NA-A then cleaned up supplies, took off gloves, and used waterless hand sanitizer. NA-A then took R175 to dining room and brought R175 continental breakfast. On 4/13/17, at 12:21 p.m. NA-A stated hands should be washed every other time gloves are changed. NA-A stated the hand sanitizer had been used once (correct), but was unaware of the infection control standard of hand hygiene between every glove change. On 4/13/17, at 1:41 p.m. the assistant director of nursing (ADON) stated the expectation for hand hygiene was after dirty gloves [to clean area]. ADON verified the standard is HH after every glove change. R12's quarterly Minimum Data Set (MDS) dated 2/12/17, indicated R12 had an indwelling foley catheter, was incontinent of bowel and required extensive assistance to complete activities of daily living. During an observation on 4/13/17, at 7:17 a.m., nursing assistant (NA)-B assisted R12 with morning cares. NA-B entered R12's room and without washing hands, donned a pair of gloves. NA-B filled a basin of water and assisted R12 to wash face. NA-B then changed R12's catheter bag from a night time bag to a leg bag. NA-B cleaned the connection part with an alcohol wipe and changed gloves, but did not wash hands. NA-B then removed R12's incontinent brief which had BM in it. NA-B removed gloves and left the room to get wet wipes. NA-B returned with the wipes, again donned a pair of gloves without	F 441		

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F 441	Continued From page 30 washing hands and cleaned R12's bottom. NA-B removed gloves and left the room again to get a mechanical lift from the hallway. NA-B re-entered the room and with the assistance of another staff member, transferred R12 into a wheel chair. NA-B went into the bathroom and picked up R12's toothbrush, applied toothpaste and handed it to R12. During an interview on 4/13/17, at 8:12 a.m., NA-B stated, "I wash my hands after I'm done with cares." During an interview on 4/13/17, at 8:20 a.m., registered nurse (RN)-D stated staff should wash hands before and after cares or between residents. RN-D stated staff should also wash hands after cleaning stool. During an interview on 4/13/17, at 11:48 a.m., the director of nursing stated staff should wash hands upon entering a room, in between glove changes, after touching anything soiled and prior to leaving the room. A facility policy titled Benedictine Health Center at Innsbruck, Hand Hygiene, dated 11/16/16, indicated: There are situations in nursing homes which may lead to a higher rate of infectious disease, there fore associates in these settings have a special concern to prevent the spread of infection through proper hand hygiene. The policy directed staff to wash hands after removal of gloves. after direct contact with blood, body fluids or excretions, between direct care of residents and whenever hands are visible soiled.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING **02 - TCU** B. WING _____	**04/13/2017**

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	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 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 NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING **02 - TCU** B. WING _____	**04/13/2017**

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 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. 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 types of construction. Building one was constructed prior to March 1, 2003. Both buildings were surveyed in accordance with LSC Chapter 19 of the LSC (2012).	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 2 The building has 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 of 105 census at the time of this survey was 100. 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		

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 _____	**04/13/2017**

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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator/CEO — (X6) DATE: 5/5/17

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. 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 types of construction. Building one was constructed prior	K 000		

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

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K 000	Continued From page 2 to March 1, 2003. Both buildings were surveyed in accordance with LSC Chapter 19 of the LSC (2012). The building has 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 of 105 census at the time of this survey was 100. 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 223 SS=B	NFPA 101 Doors with Self-Closing Devices Doors with Self-Closing Devices Doors in an exit passageway, stairway enclosure, or horizontal exit, smoke barrier, or hazardous area enclosure are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: * Required manual fire alarm system; and * Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and * Automatic sprinkler system, if installed; and * Loss of power.	K 223	**Main Building** **K223 B Doors with self-closing devices.** **A description of what has been, or will be done to correct the deficiency.** Utility room (Room 157B) door handle and door collar were replaced on 4/18/17 and the closer was adjusted for proper closing. **The actual or proposed completion date.** 4/18/17 **Person responsible.** Plant Operations Manager	

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K 223	Continued From page 3 18.2.2.2.7, 18.2.2.2.8, 19.2.2.2.7, 19.2.2.2.8 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility did not maintain self-closing doors in exit passageways, stairway enclosures, horizontal exits, smoke barriers, or hazardous areas. 19.2.2.2.7, 19.2.2.2.8. This deficient practice could affect residents in the smoke compartment. Findings include: On a facility tour between the hours of 1000 and 1400 on April 13, 2017, observation revealed that the Soiled utility room door (room 157B) in the 1st floor corridor, did not self-close and positively latch. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 223		

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

May 9, 2017

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

RE: Project Number S5462031

Dear Ms. Ager:

On April 13, 2017, a survey was completed at your facility. You have alleged that the deficiencies cited on that survey by the Minnesota Department of Health, Licensing and Certification Program staff have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

Sincerely,

Gloria Derfus

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 651-201-3792
Fax: 651-215-9697

cc: Licensing and Certification File

POCA HEALTH SURVEY.ORC