DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: L448		
1. MEDICARE/MEDICAID PROVIDED (L1) 245310 2.STATE VENDOR OR MEDICAID NO (L2) 810313500	R NO.	3. NAME AND AE (L3) BENEDICT (L4) 1101 BLACH (L5) NEW BRIGH	DRESS OF FAC INE HEALTH X OAK DRIVI	CILITY CENTER	TE SURVEY AGENCY R INNSBRUCK (L6) 55112	Facility ID: 00940 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY03/28/8. ACCREDITATION STATUS:0 Unaccredited1 TJC2 AOA3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
 11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	105 (L18)	Compliance 1. Ac			And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director		
13.Total Certified Beds	105 (L17)		ents and/or Appli		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDOW	VN				15. FACILITY MEETS			
18 SNF 18/19 SNF 105	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA See Attached Remarks	RKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Magdalene Jares, HFE-NE	II	04/09/2014 (L19)			Anne Kleppe, Enforcement Specialist 05/06/2014 (L20)			
PAR	T II - TO BE	COMPLETED B	BY HCFA RE	GIONAI	L OFFICE OR SINGLE S			
 19. DETERMINATION OF ELIGIBILIT X 1. Facility is Eligible to Pa 2. Facility is not Eligible 			PLIANCE WITH ITS ACT:	I CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :		
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	. LTC AGREEM	IENT	26. TERMINATION ACTION:	: (L30)		
OF PARTICIPATION 02/26/1986	BEGINNING	G DATE	ENDING DAT	ΓE	VOLUNTARY 00 01-Merger, Closure	INVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· · · · ······ · · · · · · · · · · · ·		
25. LTC EXTENSION DATE:					03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	on <u>OTHER</u> 07-Provider Status Change		
(L27)	-	n of Admissions: uspension Date:	(L44)			00-Active		
		1	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	03/20/2014		(L33)	DETERMINATION APPI	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5310

On 03/28/14, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 01/30/14 standard survey, effective 03/10/14. Refer to the CMS 2567B for both health and life safety code.

Effective 03/10/14, the facility is certified for 105 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5310

May 6, 2014

Ms. Susan Ager, Administrator Benedictine Health Center Innsbruck 1101 Black Oak Drive New Brighton, Minnesota 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 March 10, 2014, the above facility is certified for:

105 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Are Klegepe

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

April 9, 2014

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

RE: Project Number S5310024

Dear Ms. Ager:

On February 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2014, effective March 28, 2014 and therefore remedies outlined in our letter to you dated February 14, 2014, 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.Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions about this letter.

Sincerely,

Are Klegese

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697 Email: <u>anne.kleppe@state.mn.us</u>

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00940	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/28/2014
Name of Facility		Street Address, City, State, Zip Code		
BENEDICTINE HEALTH CENTER INNSBRUCK		BRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5)) Date	(Y4) Item	(Y5) Date	(Y4) Item)	(Y5)	Date
	MN Rule 4658.0610 Sul			MN Rule 4658.0610 Su		Re	eg. #	21535 MN Rule4658.		
LSC		-	LSC		_		LSC			_
	21665 MN Rule 4658.1400	Correction Completed 03/28/2014		23010 MN Rule 4658.4635 A	Correction Completed _03/28/2014	Re	ea. #			Correction Completed
ID Prefix Reg. # LSC		-	Reg. #			_				
ID Prefix Reg. # LSC			ID Prefix Reg. # LSC			Re	eg. #			
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Re	eg. #			Correction Completed
Reviewed E State Agene		-	Date: 04/09/202	Signature of Su	rveyor:		329	982	Date: 03/28	3/2014
Reviewed E	By Reviewed	ІВу	Date:	Signature of Su	rveyor:				Date:	
	o Survey Completed or 1/30/2014 M: REVISIT REPORT (5			Check for any Uncc Uncorrected Defi Page 1 of 1				the Facility?	YES 44812	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245310	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/28/2014
Name of Facility			Street Address, City, State, Zip Code	
BENEDICTINE HEALTH CENTER INNSBRUCK		BRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date
	F0329 483.25(l)		Correction Completed 03/28/2014		F0371 483.35(i)		Correction Completed 03/28/2014	Reg	fix F0428 . # 483.60(c) SC		Correction Completed 03/28/2014
ID Prefix Reg. #		(Correction Completed 03/28/2014	ID Prefix Reg. #			Correction Completed 03/28/2014	ID Pre Reg	fix		Correction Completed
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed	Reg	fix . # SC		
Reg. #			Correction Completed				Correction Completed		fix . # SC		
Reg. #			Correction Completed	Reg. #				D	fix . # SC		
Reviewed I State Agen Reviewed I CMS RO	су	Reviewed GD/AK Reviewed		Date: 04/09/201 Date:	Signatur 4 Signatur		•		32982	Date: 03/2 Date:	28/2014
	to Survey Con 1/30/	-	:						s a Summary t to the Facilit		NO

DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: L448		
1. MEDICARE/MEDICAID PROVIDE (L1) 245310 2.STATE VENDOR OR MEDICAID N (L2) 810313500	R NO.	3. NAME AND AI (L3) BENEDICT (L4) 1101 BLACI (L5) NEW BRIG	DRESS OF FAC INE HEALTH K OAK DRIVI	CILITY I CENTER	TE SURVEY AGENCY R INNSBRUCK (L6) 55112	Facility ID: 00940 4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD		<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY03/28/8. ACCREDITATION STATUS:0 Unaccredited1 TJC2 AOA3 Other	2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30		
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	105 (L18)	Complianc		AS:	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	7. Medical Director		
13.Total Certified Beds	105 (L17)		pliance with Prog ents and/or Appli		* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS			
18 SNF 18/19 SNF 105	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:		
Magdalene Jares, HFE-NE	II	04/09/2014 (L19)			Anne Kleppe, Enforcement Specialist 05/06/2014 (L20)			
PAR	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S			
 19. DETERMINATION OF ELIGIBILI <u>X</u> 1. Facility is Eligible to Paralleligible 2. Facility is not Eligible 		20. COMPLIANCE WITH CIVIL RIGHTS ACT:			 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	I. LTC AGREEN	MENT	26. TERMINATION ACTION:	: (L30)		
OF PARTICIPATION 02/26/1986	BEGINNING		ENDING DAT	ГЕ	<u>VOLUNTARY</u> 00 01-Merger, Closure			
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	· · · · ·······		
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
	A. Suspension	n of Admissions:	(L44)		04-Other Reason for whitehawar	07-Provider Status Change 00-Active		
(L27)	B. Rescind S	uspension Date:	(L44)					
			(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
	(L28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
	(L32)	03/20/2014		(L33)	DETERMINATION APPI	ROVAL		

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5310

On 03/28/14, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility had achieved substantial compliance pursuant to the 01/30/14 standard survey, effective 03/10/14. Refer to the CMS 2567B for both health and life safety code.

Effective 03/10/14, the facility is certified for 105 skilled nursing facility beds.



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5310

May 6, 2014

Ms. Susan Ager, Administrator Benedictine Health Center Innsbruck 1101 Black Oak Drive New Brighton, Minnesota 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 March 10, 2014, the above facility is certified for:

105 - Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Are Klegepe

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

April 9, 2014

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

RE: Project Number S5310024

Dear Ms. Ager:

On February 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 30, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 30, 2014, effective March 28, 2014 and therefore remedies outlined in our letter to you dated February 14, 2014, 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.Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions about this letter.

Sincerely,

Are Klegese

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697 Email: <u>anne.kleppe@state.mn.us</u>

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245310	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/28/2014
Name of Facility		Street Address, City, State, Zip Code	
BENEDICTINE HEALTH CENTER INNSBRUCK		1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	

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

(Y4) Item		(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item		(Y5)	Date
ID Prefix	F0329 483.25(l)	Correction Completed 03/28/2014	ID Prefix		Correction Completed 03/28/2014	ID Prefix	F0428 483.60(c)		Correction Completed 03/28/2014
	465.25(1)			465.55(1)	-	LSC	485.60(C)		
ID Prefix Reg. #		Correction Completed 03/28/2014	ID Prefix Reg. #		Correction Completed _03/28/2014	ID Prefix			Correction Completed
ID Prefix Reg. # LSC			Reg. #		Correction Completed	Reg. #			Correction Completed
Reg. #					Correction Completed				Correction Completed
Reg. #			Reg. #						
Reviewed E	Зу	Reviewed By	Date:	Signature of Su	rveyor:			Date:	
State Agen		GD/AK	04/09/201			32	2982		8/2014
Reviewed E CMS RO	Зу	Reviewed By	Date:	Signature of Su	rveyor:			Date:	
Followup t	o Survey Com 1/30/2	-		Check for any Unco Uncorrected Defi				YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA / Identification Number 00940	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 3/28/2014	
Name	e of Facility		Street Address, City, State, Zip Code	
BENEDICTINE HEALTH CENTER INNSBRUCK		1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4)	Item		(Y5)	Date
ID Prefix	21000	Correction Completed 03/28/2014	ID Prefix	21015	Correction Completed 03/28/2014		ID Prefix	21535		Correction Completed 03/28/2014
	MN Rule 4658.0610 Su			MN Rule 4658.0610 Su				MN Rule4658		
LSC		-	LSC		-	_	LSC			
	21665 MN Rule 4658.1400	Correction Completed 03/28/2014		MN Rule 4658.4635 A	Correction Completed _03/28/2014		ID Prefix Reg. #			Correction Completed
LSC		-	LSC		-		LSC			
ID Prefix Reg. # LSC			Reg. #				ID Prefix Reg. # LSC			
ID Prefix Reg. # LSC			Reg. #				- <i>"</i>			
ID Prefix Reg. # LSC		Correction Completed	Reg. #		Correction Completed		Reg. #			
Reviewed E	By Reviewed	l Bv	Date:	Signature of Su	nyevor:				Date:	
State Agen		•	04/09/202	-	1 VC YOI.		32	982		8/2014
Reviewed E CMS RO			Date:	Signature of Su	rveyor:		52	<u>> 0 2</u>	Date:	<u>5, 2011</u>
	o Survey Completed of 1/30/2014			Check for any Unco Uncorrected Defi				the Facility?	YES	NO
JIAIE FUR	M: REVISIT REPORT ((פפונ		Page 1 of 1				Event ID: I	_44812	

DEPARTMENT OF HEALTH AND HUM	IAN SERVICES	CENTERS FOR MED	ICARE & MEDICAID SERVICES		
	CARE/MEDICAID CERTIFICATION				
PART	I - TO BE COMPLETED BY THE STA	TE SURVEY AGENCY	Facility ID: 00940		
 MEDICARE/MEDICAID PROVIDER NO. (L1) 245310 	3. NAME AND ADDRESS OF FACILITY (L3) BENEDICTINE HEALTH CENTE	R INNSBRUCK	4. TYPE OF ACTION: $\underline{2}$ (L8)		
2.STATE VENDOR OR MEDICAID NO.	(L4) 1101 BLACK OAK DRIVE		1. Initial2. Recertification3. Termination4. CHOW		
(L2) 810313500	(L5) NEW BRIGHTON, MN	(L6) 55112	5. Validation 6. Complaint 7. On-Site Visit 9. Other		
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)	 PROVIDER/SUPPLIER CATEGORY 01 Hospital 05 HHA 09 ESRD 	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 01/30/2014 (L34)	02 SNF/NF/Dual 06 PRTF 10 NF	14 CORF			
8. ACCREDITATION STATUS: (L10)	03 SNF/NF/Distinct 07 X-Ray 11 ICF/II	D 15 ASC	FISCAL YEAR ENDING DATE: (L35)		
0 Unaccredited1 TJC2 AOA3 Other	04 SNF 08 OPT/SP 12 RHC	16 HOSPICE	09/30		
11LTC PERIOD OF CERTIFICATION	10.THE FACILITY IS CERTIFIED AS:				
From (a):	A. In Compliance With	And/Or Approved Waivers Of	The Following Requirements:		
To (b):	Program Requirements Compliance Based On:	2. Technical Personnel6. Scope of Services Limit 3. 24 Hour RN 7. Medical Director			
12. Total Facility Beds 105 (L18)	*	—			
13.Total Certified Beds 105 (L17)	X B. Not in Compliance with Program Requirements and/or Applied Waivers		9. Beas Koom (L12)		
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS			
18 SNF 18/19 SNF 19 SN	F ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)		
105					
(L37) (L38) (L39)	(L42) (L43)				
16. STATE SURVEY AGENCY REMARKS (IF APPL)	CABLE SHOW LTC CANCELLATION DATE):				
See Attached Remarks					
17. SURVEYOR SIGNATURE	Date :	18. STATE SURVEY AGENCY	APPROVAL Date:		
Becky Wong, HFE NE II	02/28/2014 (L19)	Anne Kleppe, Enforcement Specialist			
PART II - TO B	E COMPLETED BY HCFA REGIONA	L OFFICE OR SINGLE ST	FATE AGENCY		
19. DETERMINATION OF ELIGIBILITY	20. COMPLIANCE WITH CIVIL	21. 1. Statement of Finan			
1. Facility is Eligible to Participate	RIGHTS ACT:	 Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
2. Facility is not Eligible (L21)				
22. ORIGINAL DATE 23. LTC AGR	EEMENT 24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION BEGINNI	NG DATE ENDING DATE	<u>VOLUNTARY</u> 00	INVOLUNTARY		
02/26/1986		01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimburse			
	ATIVE SANCTIONS	03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER		
A. Suspen	sion of Admissions:	04-Other Reason for Windrawar	07-Provider Status Change 00-Active		
(L27) B. Rescino	(L44) I Suspension Date:		00-ACHVC		
	(L45)				
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS			
	03001	Posted 03/18/2014	CO. L448		
(L28)	(L31)				
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL DATE				

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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

ID: L448 Facility ID: 00940

C&T REMARKS - CMS 1539 FORM	STATE AGENCY REMARKS
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CCN: 24-5310

At the time of the standard survey completed Janaury 30, 2014, the facility was not in substantial compliance and the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans Certified Mail # 7011 2000 0002 5143 8194

February 14, 2014

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

RE: Project Number S5310024

Dear Ms. Ager:

On January 30, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

Benedictine Health Center Innsbruck February 14, 2014 Page 2

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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792 Fax: (651) 201-3790

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 March 11, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 11, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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

Benedictine Health Center Innsbruck February 14, 2014 Page 3

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.

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

Benedictine Health Center Innsbruck February 14, 2014 Page 4 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 April 30, 2014 (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 July 30, 2014 (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

Benedictine Health Center Innsbruck February 14, 2014 Page 5

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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205 Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Are Kleggse

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 02/14/2014 FORM APPROVED OMB NO: 0938-0391

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

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FORM CMS-2567(02-99) Previous Versions Obsolete

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 02/14/2014 FORM APPROVED OMB NO. 0938-0391

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 doing the AIMS. The assessment indicated the facility would continue to monitor quarterly and observe for side effects. A review of the medication orders on 1/30/14, revealed Zyprexa (olanzapine) 5 mg every evening for bipolar disorder, bul tacked specific target behaviors to monitor ror R33. R33's Target behaviors signs and symptoms were listed for Prozac and Thorazine (a sedating antipsychotic) as follows: Prozac- How many times during the shift resident refused care or self-isolated. Thorazine: How many times during the shift resident refused care or self-isolated. Thorazine: How many times during the shift resident refused care or self-isolated. Thorazine: How many times during the shift resident refused care or self-isolated. Thorazine: How many times during the shift resident refused care or self-isolated. Thorazine: How many times, activities or therapy and included the interventions below. **special instructions 1-redirect, 2-one to one staff, 3-activity with resident/patient, 4 - offer food, fluid, 5-tollet, 6-reposition, 7- adjust room temp, 8-back rub, 9-warn/cold pack, 10-music, 11-quiet environment, 12-aromatherapy, 13- lotion, 14- wall/ambulation, 15-reading, 16-pet therapy, 17-rest. The interventions were not specific to R33, as R33 did not receive Thorazine and R33 no longer ambulated. R33's medical record lacked evidence of specific target behaviors for R3. Also the medical record lacked evidence of user for R33. Also the medical record lacked evidence of user for R33. Also the medical record lacked evidence of and individualized behaviors for R33. Also the medical record lacked evidence of ase offic target behaviors for R33. Also the medical record lacked evidence of and record lacked evidence of a specific target behaviors for R33. Also the medical record lacked evidence of a specific target behaviors for R33. Also the medical record lacked evidence of a specific target behaviors for R33. Also the medication was	PRÉFIX	(FACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECT TAG CROSS-REFERENC		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	
manic episodes.	F 329	doing the AIMS. The facility would contin- observe for side eff A review of the mer- revealed Zyprexa (evening for bipolar target behaviors to R33's Target beha- listed for Prozac at antipsychotic) as fu- Prozac- How many- refused care or se Thorazine- How m- resident refused c therapy and include **special instructions staff, 3=activity with food, fluid, 5=toileft temp, 8=back rub, 11-quiet environm- lotion, 14= walk/ar- therapy, 17=rest. The interventions R33 did not receive ambulated. R33's of specific target to Zyprexa/Prozac u- and individualized medical record late why a gradual dos attempted for R33 Depakote use: On 9/2/13, Depak 250 mg every ever	the assessment indicated the nue to monitor quarterly and fects. dication orders on 1/30/14, (olanzapine) 5 mg every disorder, but lacked specific monitor for R33. vior signs and symptoms were nd Thorazine (a sedating oblows: y times during the shift resident lf-isolated. any times in a shift did the are, treatments, activities or led the interventions below. Ins 1=redirect, 2-one to one h resident/patient, 4= offer c, 6=reposition, 7= adjust room 9=warm/cold pack, 10=music, ent, 12=aromatherapy, 13= nbulation, 15=reading, 16=pet were not specific to R33, as re Thorazine and R33 no longer medical record lacked evidence behaviors for the se and lacked identified specific behaviors for R33. Also the cked evidence of justification for a reduction had notbeen a.		329			
								t Page 5 of 22

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

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 245310 B. WING 01/30/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 329 Continued From page 5 F 329 The Care Area Assessment (CAA) dated 9/13/13, the Psychotropic Medication Use indicated: on multiple behavior altering medications due to diagnosis of bipolar disease. The CAA also noted a decrease in the dose of Depakote and stated R33 was more alert based on nursing notes. Resident had no behavioral outbursts, and was to see psychologist on an as needed basis. A review of the medication orders on 1/30/14, revealed the Depakote for bipolar disorder lacked specific target behaviors to monitor for R33. On 1/30/14, at 11:05 a.m. registered nurse (RN)-B stated R33 did not always like to get out of his chair when he was supposed to off load every two hours, and when R33 refused it would be documented in the matrix (electronic medical record). On 1/30/14, at 1:47 p.m. certified nursing assistant (CNA)-C stated sometimes (R33) refused to lie down in the afternoon, and if R33 refused that would be documented. On 2/6/14, at 11:30 a.m. the consultant pharmacist stated that she had made the recommendation 3/25/13, and again 7/10/13, but her copy did not have the physician responses documented. The recommendation for a gradual dose reduction was sent to the previous provider and had included Zyprexa, Prozac and Depakote, but a new provider took over in August 2013 and responded with that note (new to us, need to get to know him), even though R33 was well known to the facility. The Psychotropic Medication Policy and Procedure, undated indicated: Facility ID: 00940 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: L44811 If continuation sheet Page 6 of 22

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				OMB NO.	0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMF	SURVEY	
		245310	B. WING			01/3	80/2014	
NAME OF F	ROVIDER OR SUPPLIER	<u></u>			REET ADDRESS, CITY, STATE, ZIP CODE			
BENEDIC	CTINE HEALTH CENT	ER INNSBRUCK			W BRIGHTON, MN 55112			
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	REGULATORY OR L Continued From pa -Physicians and m psychotropic media with the interdiscip appropriate use, e -The facility will ma state and federal r psychopharmacold term care facility to continued need, a risks and/or benef 1. Orders for p the treatment of s psychiatric conditi 2. Documents and identifies targ 4. Evaluates v interdisciplinary te psychoactive medi initiating, increasi during routine visi 6. Attempt a C discontinuation of no more than 3 m contraindicated. C separate quarters between attempts annually thereafted	age 6 id-level providers will use cations appropriately working linary team to ensure valuation and monitoring. ake every effort to comply with egulations related to the use of ogical medications i the long o include regular review for ppropriate dosage, side effects, its. osychotropic medication only for pecific medical and or ons or when the medication a rationale and diagnosis for use et symptoms with the input from the sam, effects and side effects of lication within one month of ng, or decrease or psychotropic medication after nonths unless clinically GDR must be attempted for 2 with at least one month s.) GDR must be attempted er or as the resident's clinical	F	329	CROSS-HEFENENCED TO THE AFT DEFICIENCY)			
	quarterly for grad be attempted qua contraindicated.	lypnotics will be reviewed lual dose reduction. GDR must arterly unless clinically						
	1. Monitors p any adverse effe somnolence of fu 2. Will monit behaviors on a d	unctional decline. or for the presence of target aily basis charting by exception y when the behavior are		E	acility ID: 00940 If cc		eet Page 7 of 2	

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

PRINTED: 02/14/2014 FORM APPROVED OMB NO: 0938-0391

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	•	245310	B. WING	·		30/2014		
	PROVIDER OR SUPPLIER	ER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP COD 1101 BLACK OAK DRIVE	E			
DENEDR				NEW BRIGHTON, MN 55112				
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F 329	Continued From pa present)	ige 7	F 32	29		· · · ·		
F 371 SS=F	monitoring that iden pharmacological in not successful, to c behaviors that supp or GDR. 483.35(i) FOOD PF	a system for behavior ntified behaviors, and the non- terventions that were or were levelop patterns or trends of ported decisions for treatment ROCURE, /SERVE - SANITARY	F 3	71				
:	considered satisfact authorities; and	om sources approved or ctory by Federal, State or local distribute and serve food ditions						
	by: Based on observa review, the facility t prepared in a sanit	NT is not met as evidenced tion, interview, and document ailed to ensure that food was ary environment for 93 of 94 e served food from the kitchen.			·			
	serve food in the tr dropped a pen on t without cleaning hi thermometer in foo temperatures of fo) p.m. DA-B was preparing to ansitional care unit. DA-B the floor and picked it up and s hands continued to place the ods and record the ods on the steam table. During ok touched his face and						

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Facility ID: 00940

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/14/2014 FORM APPROVED OMB NO 0938-0391

	CENTER	IS FOR MEDICARE	& MEDICAID SERVICES		0	<u>MB NO.</u>	0938-0391	
	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			245310	B. WING			01/3	30/2014
İ	NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
and the second s	BENEDIC	TINE HEALTH CENT	ER INNSBRUCK			101 BLACK OAK DRIVE IEW BRIGHTON, MN 55112		
	(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL				
	F 371	calcium from buildi Two toasters had b metal slots, and the had a brown film. The ceiling vent ab area had peeling a Three of the burne cook stove were m "Maintenance is su am not sure how lo they will come. We burners that do not The upright baking stove had a thick b exterior oven hand The large stand up and the mixer stan DM verified was no The undated facilit Cleaning Procedure employees will follo cleaning procedure The undated facilit identified, "Shelves and spills should b occurWalls, ceilit chipped and/or per washed, rinsed an	they could not keep the ng up in the sink. lack grimy film on the top e outer surfaces of the toasters ove the cook stove/counter nd chipping paint. r control knobs from the gas issing. The DM stated, upposed to be getting some. I ong they have known or when use the other knobs to control thave knobs." oven next to the gas cook lack debris build up. The les also had a grimy build up. o mixer had a brown film on top d had chipped paint which the ot a cleanable surface. y Equipment Operations and res policy indicated, "All ow standard operation and	F	371	We purchased new toasters. Maintenance cleaned and painted ceiling vent. New km for stove were purchased and installed. The side of the upright oven was cleaned with new oven cleaner purchased from Ecolab. The mixer stan was sanded and painted by Maintenance. What measures or systemic changes will be made to ens that the deficient practice v not recur? All staff will be in-serviced of hand washing, glove use and proper food storage. New cleaning schedules were made and a new monitoring check for food safety sanitation. How will we monitor its performance to make sure that solutions are sustained	h a d sure vill on le list	
		On 1/30/14, at 9:4	3 a.m. the DM verified the					

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 01/30/2014 **B WING** 245310 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK NEW BRIGHTON, MN 55112 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 371 F 371 Continued From page 8 F371 F The facility failed to rubbed a finger under his nose. Without performing washing his hands, DA-B donned ensure that food was served in a gloves, added utensils to the steam table, and sanitary manner in one of three served food to the residents on the unit. After the dining rooms (TCU) reviewed observations DA-B reported he was unaware for dining. The facility failed to touched his face and verified he should have washed his hands prior to donning gloves and ensure expired foods were serving the meal. A policy was requested for removed from the refrigerator. glove use in food service, but was not provided. The facility failed to ensure a On 1/30/14, at 9:02 a.m. a tour of the kitchen was clean food preparation area in conducted with a dietary aide (DA)-A the following the main kitchen. was noted: The walk in freezer noted an aluminum pan contained a large piece of meat was not covered labeled, or dated. The meat How will we correct for issue was approximately five in diameter by 20 inches cited? (") and 20" in length. DA-A stated, "It is pork, I Spoke with DA-B about don't know why it is in here. It should be touching his face and not covered." Another aluminum pan approximately 12" by 12" and 8" inches deep contained an washing his hands before uncovered food product; the cover for the pan putting on his gloves. He did was under the pan. DA-A explained, "It is ground n'ot realize he had touched his pork and it should also be covered." DA-A verified face but said he did wash his at 9:12 a.m. meats stored in the freezer should have been covered, dated, and labeled. hands before putting on the gloves. The DM was not asked At 9:12 a.m. the dietary manager (DM) arrived to supply a glove use policy but and continued the tour. The DM observed the it is available. DA-B was the inappropriately stored pork and stated, "The meat should not be stored like that and it wasn't there cook that stored the roast pork last night. It is to be labeled, covered, and then and ground pork in the freezer stored." without covering, labeling and dating. He was given On 1/30/14, at 9:15 a.m. during the environmental disciplinary action. DM was not tour of the kitchen with the DM the following additional concerns were observed: asked to supply a food storage policy but it is available. The rinsing sink had calcium buildup. The DM stated, "We can only scrub it" and because of the If continuation sheet Page 9 of 22 Event ID: L44811 Facility ID: 00940 FORM CMS-2567(02-99) Previous Versions Obsolete

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

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TATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		'E SURVEY IPLETED
		245310	B. WING _			/30/2014
	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COE 1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112	E	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETION DATE
F 428	 F 371 Continued From page 10 equipment was not clean. A policy for food storage was requested, but was not provided. F 428 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility consultant pharmacist failed to identify drug regimen irregularities for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include: Zyprexa/Prozac use: R33 was interviewed and observed on 1/27/14, a 6:20 p.m. R33 refused to participate in the Resident Council interview and displayed no ill behaviors. R33 was observed and interviewed on 1/30/14, a 11:30 a.m. R33 initially refused the interview, but then allowed the interview for psychotropic drug use. R33 stated he felt stable and comfortable on 		F 37	weekly by the DM or appropriate delegate.	e action d by 014. The	
			t .	F428 D Drug Regime How will we correct cited? The pharmacy consult identify drug regimen irregularities in her m visits. The resident st would not allow chan drug regimen.	for issue ant did onthly ated he	

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

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED
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F 428	during the interview A nursing progress Zyprexa was starte when discussing cu R33 had been press (mg) at bedtime an upon re-admission the Physician Orde ordered for depress The quarterly Minin 3/14/13, identified I with cares and was also noted R33 dis delusions, no beha others, no rejection noted R33 had ider concentrating on re watching the televis The pharmacy drug 3/25/13, going forw identified: - On 3/25/13, a cor recommendation w R33 had been on F recommended a G was dated 8/30/13 recommendation w recommendation, s the practice and R3 mg. The declination multiple psych med med at a time." The irregularity of the ta was on Zyprexa an	a displayed no ill behaviors note dated 7/26/10, noted the d because R33 became tearful irrent mental status. cribed Zyprexa 5 milligrams d Prozac 40 mg every morning to the facility on 4/27/11, per rs. The medication was sion and altered mental status. num Data Set (MDS) dated R33 as needing assistance non-ambulatory. The MDS olayed no hallucinations, no viors directed toward self or of cares. R33's mood section ntified concerns with eading the newspaper or sion. g regimen was reviewed from ard and the following was usultant pharmacy as completed and indicated Prozac 40 mg since 5/1/10, and DR. The physician response (five months after the as made), and declined the since the patient was new to a3 stated he had been on 60 n stated "will not change at one time. Will take down 1 e pharmacist did not report the arget behaviors for R33 as R33 d not Thorazine and R33 did	F 4	428 What measures or s changes will be made that the deficient pr not recur? Documentation guida GDR was created. A nurses will document positive and negative effects for two weeks GDR. Target behav and symptoms were a ensure they are appro- the current medication How will we monitor performance to male that solutions are su Pharmacy consultant monthly and will con make recommendation appropriate. Date when correction will be completed. March 10. Director responsible.	le to ens actice w ance for 11 licens t the s side s during ior signs audited t opriate to on. or its ke sure istained tinue to ons as ve action of Nursi	ure /ill ed any 5.00 D ? rs n ng
FORM CMS-25	567(02-99) Previous Versions		I	Facility ID: 00940	continuatio	on sheet Page 12 of 2

	MENT OF HEALTH	AND HUMAN SERVICES				FORM A	02/14/2014 PPROVED)938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		245310	B. WING			01/3	0/2014
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT	ER INNSBRUCK			01 BLACK OAK DRIVE EW BRIGHTON, MN 55112		
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F 428	the Zyprexa. - On 7/10/13, the c repeated recomme gradual dose reduc declined by the phy- note as follows "net to know him, new f without the medical not report the irreg for R33 as R33 wa Thorazine, R33 wa Thorazine, R33 wa not have specific to the Zyprexa. A 60 Day Geriatric 12/9/13, indicated medications or bel diagnosis: Depakc and continue follow Services NP progra address the antips The Minimum Data indicated R33 was depression, no ha behaviors directed rejection of cares R33 required exte two people for bed dressing and toile ambulated. The care plan data "Psychotropic met	age 12 arget behaviors identified for onsultant pharmacist left a endation (from 3/25/13) for a ction of Zyprexa. Which was ysician 8/30/13, with a written ed to monitor patient and get to us, patient states gets manic tition." Again the pharmacist did ularity of the target behaviors is on Zyprexa and not as non-ambulatory, and R33 did arget behaviors identified for Services progress note dated behaviors "no change in recent naviors" and listed "Bipolar the/Zyprexa/fluoxetine (Prozac) w up." The 60 Day Geriatric ess note dated 1/24/14, did not sychotic medications. a Set (MDS) dated 12/12/13, a cognitively intact with minimal llucinations, no delusions, no I toward self or others, no during the look back period. nsive assistance with assist of a mobility, transfers, bathing, t use, and R33 no longer ed 12/12/13, indicated, dication use. Potential for of decreased activities of daily		428			
	living, isolation fall	ls, changes in mood, behavior, Zyprexa and Depakote (consults ded for ongoing evaluation of		Fa	cility ID: 00940 If continu	ation sheet	Page 13 of 22

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	MENT OF HEALTH	HAND HUMAN SERVICES			· . ·		FORM A MB NO. 0)2/14/2014 PPROVED 938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE	(X3) DATE SURVEY COMPLETED				
		245310	B. WI		•	-	01/30)/2014
NAME OF F	PROVIDER OR SUPPLIER	1			REET ADDRESS, CITY, STA	TE, ZIP CODE		
BENEDIC	CTINE HEALTH CEN	TER INNSBRUCK			1 BLACK OAK DRIVE W BRIGHTON, MN 55	i112		
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				F 428				
F 428	psychotropic med Movement Scale (needed, Monitor v	ication. Abnormal Involunta (AIMS) every 5 months and rital signs weekly and as port abnormalities, monitor f	ry as				2	
	weight changes and report changes in Alteration in moor	nd dehydration, monitor and mood, condition and behav I state related bipolar disorce a history of episodes of repe	ior. ler			·		
	anxious and or he social service) and outside psychiatric psychiatry, medic	ealth complaints (should let d nursing know of schedule c appointments, offer in hou ations as ordered. Monitor f m of possible effects of refu	d ise or					•
	medications." The not provided by th	e care plan was requested t ne facility.	but					
	revealed Zyprexa evening for bipola target behaviors t	edication orders on 1/30/14 (olanzapine) 5 mg every ar disorder, but lacked spec to monitor for R33. avior signs and symptoms w	ific					•
	listed for Prozac a antipsychotic) as Prozac- How man refused care or s	and Thorazine (a sedating follows: ny times during the shift res elf-isolated.	ident					•
	resident refused therapy and inclu **special instructi	many times in a shift did the care, treatments, activities of ded the interventions below ions 1=redirect, 2-one to on rith resident/patient, 4= offer	or v. e					
	food, fluid, 5=toile temp, 8=back rut 11-quiet environn lotion, 14= walk/a	et, 6=reposition, 7= adjust ro b, 9=warm/cold pack, 10=m nent, 12=aromatherapy, 13 ambulation, 15=reading, 16	oom usic, =					* . •
	R33 did not recei ambulated. R33	s were not specific to R33, a ive Thorazine and R33 no k s medical record lacked ific target behaviors for the	onger			·		
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (PLE CONSTRUCTIO		(X3) DATE SURVEY COMPLETED			
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NAME OF I	PROVIDER OR SUPPLIER	L		STREET ADDRESS	S, CITY, STATE, ZIP (CODE		
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F 428	Continued From pa Zyprexa/Prozac us behaviors for R33. lacked evidence of dose reduction not Depakote use: On 9/2/13, Depako 250 mg every ever medication was oro manic episodes. The Care Area Ass the Psychotropic M multiple behavior a diagnosis of bipola a decrease in the of R33 was more aler Resident had no bu see psychologist o A review of the me revealed the Depa lacked specific targ the efficacy of the On 1/30/14, at 11.1 (RN)-B stated R33 of his chair when h every two hours, a be documented in	age 14 e and lacked identified specific Also the medical record justification for why a gradual had been attempted for R33. te 125 mg every morning and ing were ordered for R33. The dered for bipolar disorder with essment (CAA) dated 9/13/13, ledication Use indicated: on litering medications due to r disease. The CAA also noted dose of Depakote and stated t based on nursing notes. ehavioral outbursts, and was to n an as needed basis. dication orders on 1/30/14, kote for the bipolar disorder get behaviors to staff monitor	F 42	28	DEFICIENCY)			
	assistant (CNA)-C refused to lie down refused that would							5 5 7
	The Psychotropic Procedure indicate		1	Facility ID: 00940		f continua	tion sheet	Page 15 of 22

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

PRINTED: 02/14/2014
FORM APPROVED
OMB NO. 0938-0391

			וחד	(X3) DATE SURVEY				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE				COMPLETED		
		245310	B. WING	I		01/:	01/30/2014	
NAME OF PROVIDER OR SUPPLIER				S	STREET ADDRESS, CITY, STATE, ZIP CODE			
DEVEDI	STINE UPATTLE OF NT			1	101 BLACK OAK DRIVE			
BENEDICTINE HEALTH CENTER INNSBRUCK				N	NEW BRIGHTON, MN 55112			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	1V	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI		(X5) COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		CROSS-REFERENCED TO THE APPROF		DATE	
ind					DEFICIENCY)			
F (00			-	100	•		•	
F 428	Continued From pa	-	F f	428				
		d-level providers will use						
		cations appropriately working						
		linary team to ensure						
	appropriate use, ev	valuation and monitoring.						
	- The facility will ma	ke every effort to comply with egulations related to the use of						
	state and rederal re	gical medications in the long						
	torm oaro facility to	include regular review for						
		propriate dosage, side effects,						
	risks and/or benefit							
		sychotropic medication only for					-	
	the treatment of sp							
	psychiatric conditio	ons or when the medication						
		rationale and diagnosis for use						
	and identifies targe	et symptoms						
		ith the input from the						
		am, effects and side effects of						
		cation within one month of					-	
		g, or decreasing dose and						
	during routine visits							
		DR decrease or						
		osychotropic medication after onths unless clinically						
		DR must be attempted for 2					-	
		with at least one month						
) GDR must be attempted						
		or as the resident's clinical						
	condition warrants.							
		pnotics will be reviewed						
		al dose reduction. GDR must	[
-		terly unless clinically						
	contraindicated.							
	NURSING							
		ychotropic drug use daily noting			· · · · ·			
	any adverse effect							
	somnolence of fun							
	2. Will monitor	for the presence of target						
	behaviors on a dai	ly basis charting by exception						
	(i.e., charting only	when the behavior are						

Facility ID: 00940

If continuation sheet Page 16 of 22

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

PRINTED:	02/14/2014
FORM	APPROVED
	0038-0301

CENTEF	RS FOR MEDICARE	& MEDICAID SERVICES			<u>_</u>	<u>IMB NO.</u>	0938-0391
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
245310		B. WING		01/30/2014			
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS,	CITY, STATE, ZIP CODE		
BENEDICTINE HEALTH CENTER INNSBRUCK				1101 BLACK OAK NEW BRIGHTON	· •		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CO	DER'S PLAN OF CORRECTIC DRECTIVE ACTION SHOULI FERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	monitoring that ide pharmacological in not successful, to c	a system for behavior ntified behaviors, and the non- terventions that were or were levelop patterns or trends of ported decisions for treatment		28			
F 463 SS=D	or GDR. 483.70(f) RESIDEN ROOMS/TOILET/E The nurses' station resident calls throu from resident room facilities. This REQUIREME by: Based on observa review, the facility f non-functioning cal	NT CALL SYSTEM - ATH must be equipped to receive gh a communication system s; and toilet and bathing NT is not met as evidenced tion, interview and document	F	identify light for reviewed How wi cited? The call function call ligh cord wa mainten cord, th	The facility failed to a non-functioning call one of 35 residents od, R132. ill we correct for issu l light in question was ning: the button on the at was working but the as not. When nance staff tried to fix he box broke and had t	e the o	
	Findings include: When observed or light for R132 in row working. Nursing a call light was not fu maintenance depa to request an imme When interviewed maintenance empl call light in room 22	1/28/14, at 9:34 a.m. the call om 220 was checked and not ssistant (NA)-B confirmed the inctioning and called the rtment at 9:35 a.m. on 1/28/14, ediate repair. on 1/28/14, at 2:05 p.m. oyee (ME)-B, confirmed the 20 was not functioning and in -B said the call light cord was		fixed in system 10 wee comme many c cogniti directo	aced. The call light w mmediately. Our curre covered all call lights eks. The surveyor ented that there were n calls from this unit due ive limitations and the or concurred; the istrator was not presen	ent in ot e to ES	

Facility ID: 00940

If continuation sheet Page 17 of 22

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B WING 245310 01/30/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1101 BLACK OAK DRIVE BENEDICTINE HEALTH CENTER INNSBRUCK **NEW BRIGHTON, MN 55112** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 463 F 463 Continued From page 17 What measures or systemic not the problem but that he needed to replace the changes will be made to ensure entire call light box in the room. that the deficient practice will not recur? When interviewed on 1/30/14, at 10:15 a.m. Call lights are checked every 10 during the environmental tour, the director of environmental service, (DES) and the weeks in a room audit, call administrator indicated R132 was not capable of lights that are not functioning using the call light. When interviewed on 1/30/14, are recorded in the maintenance at 10:16 a.m. the director of maintenance explained that call lights are checked randomly. book on each neighborhood and checked by maintenance staff The facility policy titled, Plant daily, and the Arial call light Operations/Services, dated 11/2001, pages five system alerts staff when the call and six indicated there was a program of preventative maintenance and routine inspections light is not working. We will are completed to maintain a safe and comfortable revise the room audit and check environment. Routine inspection of environmental call lights in all bedrooms and safety devices was to include resident call system bathrooms monthly. and alternative plan if call system was How will we monitor its nonfunctional. performance to make sure The facility document titled, Daily Schedule that solutions are sustained? Checklist dated 1/23/14, indicated call lights were The revised room audit form randomly checked in four rooms that day. Rooms will be reviewed to monitor 127, 149, 206, and 241 had been found to have properly functioning call lights. The checklist for trends in call light functioning. the call light audits had four empty spaces to Date when corrective action write randomly selected rooms for auditing. There will be completed. was not system in place to ensure all of the New system will be started on rooms were audited for functioning call lights. March 10. Director of On 1/31/14, the facility faxed additional Environmental Services is documentation the Daily Schedule Checklist responsible. dated 12/2/13, indicated call lights in rooms 121, 119, 159, 220, and 258 were checked and "ok". Inspection comments: "220 missing light bulb Fixed." F 465 F 465 483.70(h)

Facility ID: 00940

If continuation sheet Page 18 of 22

PRINTED: 02/14/2014

FORM APPROVED

PRINTED: 02/14/2014 FORM APPROVED

<u> </u>	RS FOR MEDICARE	& MEDICAID SERVICES			. (<u>IMR NO.</u>	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245310	B. WING		·	01/	30/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DENEDI				11	101 BLACK OAK DRIVE		
BENEDI	CTINE HEALTH CENT			N	EW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 465 SS=E	SAFE/FUNCTION/ E ENVIRON The facility must pr	ovide a safe, functional,	F4	⊦65			
	by: Based on observa review, the facility f homelike environm well as the kitchen, residents residing i Findings include: The following envir identified during the 1/30/14, at 10:00 a Garden Terrace: Room 158-B had a drawer that had a s across the surfaces Room 166-A the inf scraped and expos entire width of the o Oakview: 1) The main door fr station had numero extending from the up the door frames 2) Room 242-A had missing the outer p at the base of the p	onmental issues were e environmental tour on m. night stand and clothes ix and a four-inch scratch s. erior of the room door was ed the wood underneath the loor and two inches wide. ames across from the nurses' us splintered areas bilaterally floor of the frame to three feet			 F465 E The facility failed to maintain a sanitary environmet for 3 of 4 units observed, Oak View, Garden Terrace and the Villa. How will we correct for issue cited? On Garden Terrace, a differen night stand was placed in the room furniture v rearranged so that the resident chair could pass through. We installed a protective piece on the door. On Oak View, we will repair the door after ordering and receiving more materials. The cord on the bed was replaced is same day and the tape and sig removed. We have removed the old caulking and re-caulked the tape and sig found others in similar shape and did the same to them. 	t vas he the ns he	

Facility ID: 00940

If continuation sheet Page 19 of 22

PRINTED: 02/14/2014 FORM APPROVED OMB NO. 0938-0391

<u> </u>	15 FUR MEDICARE	& MEDICAID SERVICES	r		<u> </u>	NID NO.	0900-0091
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245310	B. WING			01/:	30/2014
NAME OF F	PROVIDER OR SUPPLIER	· ·	••••••	s	TREET ADDRESS, CITY, STATE, ZIP CODE		
DENED	TINE HEALTH CENT				101 BLACK OAK DRIVE		
BENEDI	TINE REALIN CENT			N	NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 465	not pushing bed up 3) Room 254-A the plunger which was half way hanging of 4) Room 258-A a ra paint scrape at whe 5) Room 244-A a b long vertical scrape In addition, the resi scratched measurin 6) Room 241-A and toilet caulking was The Villa: 1) The personal sp the tiles around the stall was black with tiles. 2) The brick firepla sharp edges. 3) Room 201-A a w stained on the met portion of the chair The administrator, service (DES), and (DOM), were prese tour, The DOM ex findings were on a The DES stated du expectation that sta housekeeping issu The facility Plant O dated 11/01, indica services was respon	 a "Avoid electrical mishaps by against the wall." bathroom held a large black positioned by the door and ut of a plastic bag. adiator with a seven inch long bellevel. athroom wall had a six inches to left of the sink. dent's clothes cupboard was ng five inches. d room 236-A the bathroom black and crumbling. a shower grout surrounding entire bottom of the shower pinkish black spots on the ce in the dining room had wheelchair was soiled and al hardware and seating director of environmental the director of maintenance ent during the environmental plained that some of the list of items needing attention. aring the tour that it was her aff notify her right away of any es that needed attention. 	F	465	On the Villa, we have ordered replacement base for the show in spa room; they will be installed upon delivery. We filed rough spots on the brick fireplace in the dining room to smooth the edges. The wheelchair was washed immediately. All wheelchair are washed at least once per month. Resident rooms mentioned are repaired. Kitchen - The grout used for kitchen floor is a dark color. The floor has been cleaned at will be scrubbed with a specialized floor scrubber. T walls, the pipes and equipme were washed. The trash containers were replaced. What measures or systemic changes will be made to ens that the deficient practice v not recur?	wer o rs the nd the ant sure	

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Facility ID: 00940

If continuation sheet Page 20 of 22

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PRINTED: 02/14/2014 FORM APPROVED OMB NO: 0938-0391

	10 T OT MILDICATL	& MEDICAID SERVICES			0	MR NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION		E SURVEY IPLETED
		245310	B. WING	ì		01/	30/2014
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	ER INNSBRUCK			1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	maintenance and "r completed to maint environment." A Daily Schedule Cl indicated routine au twenty randomly set were checked for no deemed "OK." A Housekeeping Au checklist for housek in need of repair no cleaning. On 1/30/14, at 9:15 tour of the kitchen w additional concerns 1) The floors had a grouted areas of the clean in the dishwas the vegetable freeze located by the cooki counters, at the floo edges of the floors a The floor undernea had thick black debr 2) The walls were la black marks and dus 3) The garbage disp yellowish-brown buil 4) All of the trash co	outine inspections are ain a safe and comfortable hecklist dated 1/23/14, dits were completed on lected rooms and these rooms eeded repairs and were dit dated 1/14/16, included a keeping staff to check anything ted during resident room a.m. during the environmental with the DM the following were observed: black debris buildup in the e tiles and the tiles were not shing area, storage area by er, food preparation areas ng and food preparation r drains, and at the outer adjunct to the walls. th the stove and upright oven is. rgely covered with brown and st.	F	465		iore en s vate is le list he will s, ? be n 1	
	The undated facility	Equipment Operations and					ľ

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Facility ID: 00940

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If continuation sheet Page 21 of 22

PRINTED: 02/14/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTR			(X3) DATE SURVEY COMPLETED	
		245310	B. WING				01/3	30/2014
	PROVIDER OR SUPPLIER	ER INNSBRUCK		1101 BLAC	DRESS, CITY, STATE, ZIP CC K OAK DRIVE GHTON, MN 55112	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT.OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (E	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION S SS-REFERENCED TO THE A DEFICIENCY)	SHOULD I	BE	(X5) COMPLETION DATE
F 465	employees will follo cleaning procedure The undated facility identified: "Shelves and other should be wiped of Kitchen floor maint meal. Spills need to Sweep the floor, pu a dustpan to remov Walls, ceilings and and/or peeling pain washed thoroughly soiled surfaces mu and as required. Garbage container." On 1/30/14, at 9:43	es policy indicated, "All ow standard operation and es for equipment." Y Cleaning Guidelines policy surfaces: splashes and spills	F	465	DEFICIENCY)			
	567(02-99) Previous Versions	; Obsolete Event ID:L44811		Facility ID: 0094	10 ¹⁴ oc	ntinuatio	n shoot F	Page 22 of 22

DEPART	MENT OF HEALTH	AND HUMAN SERVI & MEDICAID SERVI	CES CES	Ŧ63	10023	FORM	01/31/2014 APPROVED 0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM	R/CLIA	1. 1	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		245310		B. WING		01/2	B/2014
	ROVIDER OR SUPPLIER			RESS, CITY, S _ACK OAK	STATE, ZIP CODE		
DENEDI					MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S		K 000			
	FIRE SAFETY						
	Minnesota Departm time of this survey, was found to be in s the requirements fo Medicare/Medicaid 483.70(a), Life Safe edition of National F	at 42 CFR, Subpart by from Fire, and the Fire Protection Assoc D1, Life Safety Code	At the Center ce with 2000 iation				
	2-story building with was built at 3 difference was constructed in be of Type II (222) of addition was constru- determined to be of 2005 the Transition	Center at Innsbruck no basement. The least times. The origina 1965 and was deterr construction. In 1991 ucted to the north an Type I(222) construct al Care Unit (TCU) w s determined to be o	ouilding al building nined to an d was ction. In ras added				
	buildings because of construction. Buildin to March 1, 2003. T accordance with LS	veyed as two separa of different dates of ng one was construc herefore, it was surv C Chapter 19 and th ed in accordance wit	ted prior eyed in e TCU				
	sprinkler system. The system that consist corridors and areas each resident room department notification of 105 census at the	a complete automative ne facility has a fire a s of smoke detection open to the corridor that is monitored for tion. the facility has a e time of this survey	alarm in the s and in fire a capacity was 96.	NATURE	TITLE	12	(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.

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES			FORM	01/31/2014 APPROVED 0.0938-0391
STATEMEN		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		PLE CONSTRUCTION G 02 - NEW BLDG	(X3) DATE S COMPLI	URVEY ETED
		245310		B. WING		01/2	8/2014
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
BENEDI	CTINE HEALTH CEI	NIER INNSBRUCK		LACK OAP	, MN 55112	31	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1		K 000			
	further detailed inve that The supply and	vritten in past survey estigation it has beer I return for the 1965 C- 06-18, letter from	found building				
	The requirement at MET.	42 CFR, Subpart 48	3.70(a) is				
5							
L						If continuation	1

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 2 of 2

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	& MEDICAID SERVICES		5310023		APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3 01 - Main Building 01	(X3) DATE SUI COMPLET	
	245310	B. WING		01/28	/2014
NAME OF PROVIDER OR SUPPLIER BENEDICTINE HEALTH CE		RESS, CITY, S	STATE, ZIP CODE		
DEREDIOTINE INERCENTION			, MN 55112		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000 INITIAL COMMEN	TS	K 000			
FIRE SAFETY					
Minnesota Departr time of this survey was found to be in the requirements f Medicare/Medicaid 483.70(a), Life Saf edition of National (NFPA) Standard 7 Chapter 19 Existin Benedictine Health 2-story building wit was built at 3 differ was constructed in be of Type II (222) addition was const determined to be of 2005 the Transition	I at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association I01, Life Safety Code (LSC), g Health Care. In Center at Innsbruck is a the no basement. The building rent times. The original building 1965 and was determined to construction. In 1991 an ructed to the north and was of Type I(222) construction. In thal Care Unit (TCU) was added as determined to be of Type	*			
buildings because construction. Build to March 1, 2003. accordance with L building was surve Chapter 18.	rveyed as two separate of different dates of ing one was constructed prior Therefore, it was surveyed in SC Chapter 19 and the TCU yed in accordance with LSC e a complete automatic fire				
sprinkler system. T system that consis corridors and area each resident roor department notifica of 105 census at th	The facility has a fire alarm ts of smoke detection in the s open to the corridors and in in that is monitored for fire ation. the facility has a capacity he time of this survey was 96.	NATURE	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.

DEPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV	ICES				. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPLE	
		245310		B. WING		01/2	8/2014
	ROVIDER OR SUPPLIER				STATE, ZIP CODE		
BENEDI	CTINE HEALTH CEI	NTER INNSBRUCK		ACK OAK	, MN 55112		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1		K 000			
	further detailed inve that The supply and	written in past survey estigation it has beer d return for the 1965 C- 06-18, letter from	n found building				
	The requirement at MET.	t 42 CFR, Subpart 48	33.70(a) is				
	149						
		8					
					1 44921	If continuction	sheet Page 2 of 2

FORM CMS-2567(02-99) Previous Versions Obsolete

Printed: 01/31/2014



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8194

February 14, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5310024

Dear Ms. Ager:

The above facility was surveyed on January 27, 2014 through January 30, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Benedictine Health Center Innsbruck February 14, 2014 Page 2 and the Time Period For Correction.

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

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792 Fax: (651) 201-3790

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Sincerely,

Ame Klegge

Anne Kleppe, Enforcement Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure(s) cc: Original - Facility Licensing and Certification File

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00940	B. WING		01/3	0/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT		CK OAK DR GHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depart Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of f lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided that the Department with notice of assessme	hearing on any assessments n non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
	this Department's s and the following co Please indicate in y correction that you	"S: 29,and 30, 2014, surveyors of taff, visited the above provider prrection orders are issued. our electronic plan of have reviewed these orders, e when they will be completed.		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware. to	

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

TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00940	B. WING		01/3	0/2014
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT		ACK OAK DF NGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	lge 1	2 000			
				The assigned tag number app far left column entitled "ID Pro- The state statute/rule out of co- listed in the "Summary Statem Deficiencies" column and repl Comply" portion of the correct This column also includes the which are in violation of the st after the statement, "This Rule as evidence by." Following the findings are the Suggested Mc Correction and Time period for PLEASE DISREGARD THE H THE FOURTH COLUMN WH STATES, "PROVIDER'S PLAI CORRECTION." THIS APPL FEDERAL DEFICIENCIES OF WILL APPEAR ON EACH PAC THERE IS NO REQUIREMEN SUBMIT A PLAN OF CORRE VIOLATIONS OF MINNESOT STATUTES/RULES.	efix Tag." ompliance is nent of aces the "To ion order. findings ate statute e is not met e surveyors ethod of r Correction. IEADING OF ICH N OF IES TO NLY. THIS GE. NT TO CTION FOR	
21000	MN Rule 4658.061 Requirements-Hygi	0 Subp. 4 Dietary Staff iene.	21000			
	wash their hands a their arms with soa washing facility before as often as is necessafter smoking, eating handling soiled equi	Dietary staff must thoroughly nd the exposed portions of p and warm water in a hand ore starting work, during work ssary to keep them clean, and ng, drinking, using the toilet, or ipment or utensils. Dietary ir fingernails clean and				

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00940	B. WING	01/	01/30/2014	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT		ACK OAK DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21000	Continued From pa	age 2	21000			
	by: Based on observati failed to ensure that sanitary environme were served food fit Findings include: On 1/27/14, at 4:30 serve food in the tra dropped a pen on t without cleaning his thermometer in foo temperatures of foot the process the coor rubbed a finger uno performing washing gloves, added uten served food to the observations DA-B touched his face ar washed his hands p serving the meal. A glove use in food s SUGGESTED MET Dietary Manager co policies and educat appropriate hand h donning gloves. Th standardize the pol educate nursing an were monitoring/cle potentially hazardo revise the admission how long food will the) p.m. DA-B was preparing to ansitional care unit. DA-B he floor and picked it up and s hands continued to place the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00940	B. WING		01/	30/2014
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
BENEDIC	CTINE HEALTH CENT		ACK OAK DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
21000	Continued From pa	age 3	21000			
	(21) days.					
21015	MN Rule 4658.061 Requirements- Sa	0 Subp. 7 Dietary Staff nitary conditi	21015			
	procedures and co	conditions. Sanitary nditions must be maintained ir e dietary department at all	1			
	by: Based on observat review, the facility f prepared in a sanit	ent is not met as evidenced ion, interview, and document failed to ensure that food was ary environment for 93 of 94 e served food from the kitchen				
	Findings include:					
	conducted with a d was noted: The wa aluminum pan cont was not covered la was approximately (") and 20" in length don't know why it is covered." Another 12" by 12" and 8" in uncovered food pro- was under the pan- pork and it should a at 9:12 a.m. meats	2 a.m. a tour of the kitchen was ietary aide (DA)-A the following alk in freezer noted an tained a large piece of meat beled, or dated. The meat five in diameter by 20 inches h. DA-A stated, "It is pork, I s in here. It should be aluminum pan approximately nches deep contained an oduct; the cover for the pan . DA-A explained, "It is ground also be covered." DA-A verified stored in the freezer should d, dated, and labeled.	3			
	and continued the	etary manager (DM) arrived tour. The DM observed the red pork and stated, "The mea	t			

	NT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00940	B. WING	B. WING		30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT	FRINNSBRUCK	ACK OAK DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21015	Continued From pa	age 4	21015			
		ed like that and it wasn't there e labeled, covered, and then				
	On 1/30/14, at 9:15 a.m. during the environmental tour of the kitchen with the DM the following additional concerns were observed:		đ			
	stated, "We can on	d calcium buildup. The DM ly scrub it" and because of the they could not keep the ng up in the sink.				
		lack grimy film on the top e outer surfaces of the toasters	3			
	The ceiling vent ab area had peeling a	ove the cook stove/counter nd chipping paint.				
	cook stove were m "Maintenance is su am not sure how lo	r control knobs from the gas issing. The DM stated, pposed to be getting some. I ng they have known or when use the other knobs to control have knobs."	I			
	stove had a thick b	oven next to the gas cook lack debris build up. The les also had a grimy build up.				
	and the mixer stan	mixer had a brown film on top d had chipped paint which the t a cleanable surface.				
	Cleaning Procedur	Y Equipment Operations and es policy indicated, "All wy standard operation and es for equipment."				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00940	B. WING	B. WING		01/30/2014	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
BENEDI	CTINE HEALTH CENT		ACK OAK DRI\ RIGHTON, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
21015	Continued From pa	age 5	21015				
	identified, "Shelves and spills should be occurWalls, ceilin chipped and/or pee washed, rinsed and ensure the safety of On 1/30/14, at 9:43 equipment was not storage was reques SUGGESTED MET dietary manager co policies and educat of the kitchen area cleaning and repair department could be schedules could be to assure dietary ta	ngs and vents must be free of eling paintEquipment is d sanitized after each use to	Ð				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one					
21535	MN Rule4658.1315 Drug Usage; Gene	5 Subp.1 ABCD Unnecessary ral	21535				
	must be free from a unnecessary drug i A. in excessive therapy; B. for excessive C. without ade D. in the prese	al. A resident's drug regimen unnecessary drugs. An is any drug when used: e dose, including duplicate drug re duration; quate indications for its use; o ence of adverse consequences dose should be reduced or	r				

Minnesota Departm STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00940	B. WING	B. WING		30/2014
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDI	CTINE HEALTH CENT		ACK OAK DRI\ IGHTON, MN 🗄			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	part 4658.1310, th with provisions in th Code of Federal Re 483.25 (1) found in Operations Manual Long-Term Care Fa Department of Hea Health Care Finand This standard is ind available through th system and the Sta subject to frequent This MN Requirem by: Based on observat	Irug regimen review required in e nursing home must comply he Interpretive Guidelines for egulations, title 42, section Appendix P of the State I, Guidance to Surveyors for acilities, published by the lith and Human Services, cing Administration, April 1992. corporated by reference. It is he Minitex interlibrary loan ate Law Library. It is not change. ent is not met as evidenced ion, interview and document failed to ensure a gradual dose				
	why a GDR was no anti-psychotic medi anti-seizure medica Bi-polar disorder), a medication) for 1 of for unnecessary me Findings include:					
	6:20 p.m. R33 refus Resident Council in R33 was observed 11:30 a.m. R33 initi then allowed the initi use. R33 stated he	ed and observed on 1/27/14, at sed to participate in the				

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00940				01/30/2014	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			50/2014	
BENEDI	CTINE HEALTH CENT	TER INNSBRUCK 1101 BL	ACK OAK DRIV	/E			
		NEW BF	RIGHTON, MN S	55112 PROVIDER'S PLAN OF		(NE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
21535	Continued From pa	age 7	21535				
	A nursing progress note dated 7/26/10, noted the Zyprexa was started because R33 became tearful when discussing current mental status.						
	(mg) at bedtime an upon re-admission the Physician Orde	scribed Zyprexa 5 milligrams of Prozac 40 mg every morning to the facility on 4/27/11, per ers. The medication was sion and altered mental status	-				
	recommendation for declined at that time evidence of the rational to dose reduction at t	5/17/12, indicated a br a GDR on Zyprexa was le. The progress note lacked ionale for why an attempted hat time would be likely to 's function or increase r.					
	3/14/13, identified I with cares and was also noted R33 dis delusions, no beha others, no rejection noted R33 had iden	num Data Set (MDS) dated R33 as needing assistance s non-ambulatory. The MDS played no hallucinations, no viors directed toward self or n of cares. R33's mood section ntified concerns with eading the newspaper or sion.	1				
	repeated recomme gradual dose reduc declined by the phy note as follows "ne to know him, new t without the medica lacked evidence of attempted dose red	nsultant pharmacist left a endation (from 3/25/13) for a ction of Zyprexa. Which was ysician 8/30/13, with a written ed to monitor patient and get o us, patient states gets manic tion." Again the medical record the rationale for why an duction at that time would be resident's function or increase	E E				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00940	B. WING	B. WING		30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
BENEDIC	CTINE HEALTH CENT		ACK OAK DRIN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 8	21535		- ,	
	A nurse practitioner (NP) progress note had been scanned into the chart on 8/19/13, but lacked a progress note for the Zypreza/Prozac.					
	12/9/13, indicated medications or beh diagnosis: Depako and continue follow Services NP progra	Services progress note dated behaviors "no change in recent naviors" and listed "Bipolar te/Zyprexa/fluoxetine (Prozac) v up." The 60 Day Geriatric ess note dated 1/24/14, did not ychotic medications.				
	cognitively intact w hallucinations, no o directed toward se cares. R33 require assist of two peopl	2/12/13, indicated R33 was ith minimal depression, no delusions, no behaviors If or others, no rejection of d extensive assistance with e for bed mobility, transfers, and toilet use, and R33 no				
	"Psychotropic med untoward effects o living, isolation falls and cognition on Z with psych as need psychotropic medie Movement Scale (needed. Monitor vi necessary and rep	ed 12/12/13, indicated, lication use. Potential for f decreased activities of daily s, changes in mood, behavior, yprexa and Depakote (consults ded for ongoing evaluation of cation. Abnormal Involuntary AIMS) every 5 months and as tal signs weekly and as ort abnormalities, monitor for	\$			
	report changes in r Alteration in mood as evidenced by a anxious and or hea social service) and outside psychiatric	Id dehydration, monitor and mood, condition and behavior. state related bipolar disorder history of episodes of repetitive alth complaints (should let I nursing know of scheduled appointments, offer in house tions as ordered. Monitor for	e			

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00940	B. WING	B. WING		30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT		CK OAK DRINGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC ¹	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	lge 9	21535			
		of possible effects of refusing care plan was requested but facility.				
	the Abnormal Involution (AIMS) assessment completed by the line noted some minimation doing the AIMS. The	sing assessments indicated: untary Movement Scale t dated 12/13/13, and censed practical nurse (LPN) al extremity movements while e assessment indicated the use to monitor quarterly and fects.				
	revealed Zyprexa (evening for bipolar target behaviors to R33's Target behav listed for Prozac ar antipsychotic) as fo	vior signs and symptoms were ad Thorazine (a sedating				
	refused care or sel Thorazine- How ma resident refused ca therapy and include **special instruction					
	temp, 8=back rub, 11-quiet environme lotion, 14= walk/am therapy, 17=rest.	6=reposition, 7= adjust room 9=warm/cold pack, 10=music, nt, 12=aromatherapy, 13= ibulation, 15=reading, 16=pet				
	R33 did not receive ambulated. R33's r of specific target be Zyprexa/Prozac us	e and lacked identified specific				
anacasta D	medical record lack	behaviors for R33. Also the ked evidence of justification for e reduction had been				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00940	B. WING		01/	30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT		ACK OAK DRIN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 10	21535			
	attempted for R33.					
	250 mg every even	te 125 mg every morning and ing were ordered for R33. The dered for bipolar disorder with	•			
	the Psychotropic M multiple behavior a diagnosis of bipola a decrease in the d R33 was more aler Resident had no be	essment (CAA) dated 9/13/13 ledication Use indicated: on ltering medications due to r disease. The CAA also noted lose of Depakote and stated t based on nursing notes. ehavioral outbursts, and was to n an as needed basis.				
	revealed the Depal	dication orders on 1/30/14, kote for bipolar disorder lackec aviors to monitor for R33.	1			
	(RN)-B stated R33 of his chair when h every two hours, ar	5 a.m. registered nurse did not always like to get out e was supposed to off load nd when R33 refused it would the matrix (electronic medical				
	assistant (CNA)-C	' p.m. certified nursing stated sometimes (R33) in the afternoon, and if R33 be documented.				
	pharmacist stated to recommendation 3, her copy did not has documented. The re dose reduction was	a.m. the consultant that she had made the /25/13, and again 7/10/13, but we the physician responses recommendation for a gradual s sent to the previous provider Cyprexa, Prozac and Depakote				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		ESURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00940	B. WING		01/	30/2014
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			00/2014
		1101 BL				
BENEDI	CTINE HEALTH CENT	ER INNSBRUCK	IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	ige 11	21535			
ree to to TI Pr -F ps win ap -T st ps te cc ris th ps te cc ris th ps te cc ris th ps te cc ris th ps te cc ris th ps te cc ris th c cc ris th cc ris th c c ris th c c ris th c c ris th c c ris th c c ris th c c ris th c c ris th c c ris th c c ris th c ris th c c ris th c c c c c c c c c c c c c c c c c c	but a new provider took over in August 2013 and responded with that note (new to us, need to get to know him), even though R33 was well known to the facility. The Psychotropic Medication Policy and Procedure, undated indicated: -Physicians and mid-level providers will use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. -The facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications i the long term care facility to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits. 1. Orders for psychotropic medication only for the treatment of specific medical and or psychiatric conditions or when the medication 2. Documents rationale and diagnosis for use and identifies target symptoms 4. Evaluates with the input from the interdisciplinary team, effects and side effects of psychoactive medication within one month of initiating, increasing, or decreasing dose and during routine visits					
			, r			
	discontinuation of p no more than 3 mo contraindicated. GI separate quarters v between attempts.) annually thereafter condition warrants. 7. Sedative/Hyp	DR decrease or osychotropic medication after nths unless clinically DR must be attempted for 2 with at least one month GDR must be attempted or as the resident's clinical				
nesota D		al dose reduction. GDR must erly unless clinically				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00940	B. WING	B. WING		30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT		ACK OAK DRI\ IGHTON, MN 🗄			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21535	Continued From pa	age 12	21535			
	any adverse effect somnolence of fun 2. Will monitor behaviors on a dail		3			
	monitoring that ide pharmacological in not successful, to o	a system for behavior ntified behaviors, and the non- terventions that were or were develop patterns or trends of ported decisions for treatment				
	The DON could rev educate staff to wo pharmacist to ensu- medications have a behaviors identified	THOD OF CORRECTION: view and revise policies and rk with the consultant appropriate indications, and tracked, appropriate interventions, and clear menting behaviors.				
	educate staff to en reviewing medicati	view and revise polices and sure that licensed staff are on orders in collaboration with rmacist to prevent duplication				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one	,			
21665	MN Rule 4658.140	0 Physical Environment	21665			
	functional, comfort environment, allow	ust provide a safe, clean, able, and homelike physical ing the resident to use is to the extent possible.				

ta Department of He	alth			TONM	APPROVED
IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				E SURVEY PLETED
or connection	IDENTITION TON NOMBER.	A. BUILDING: _		001	
	00940	B. WING	B. WING		30/2014
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CTINE HEALTH CENT					
SUMMARY STA				CORRECTION	(X5)
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	COMPLETE
Continued From pa	age 13	21665			
by: Based on observat review, the facility f homelike environm well as the kitchen,	ion, interview and document ailed to maintain a sanitary ent for three of four units, as potentially affecting all				
Findings include:					
identified during the	e environmental tour on				
drawer that had a s across the surfaces Room 166-A the in scraped and expos	six and a four-inch scratch s. terior of the room door was sed the wood underneath the				
station had numero extending from the up the door frames 2) Room 242-A had missing the outer p at the base of the p tape around the co wall directing staff t not pushing bed up 3) Room 254-A the plunger which was half way hanging of	bus splintered areas bilaterally floor of the frame to three fee a. d an electric cord for the bed plastic seal measuring one inch plug. There was clear plastic rd. There was a sign on the to "Avoid electrical mishaps by against the wall." bathroom held a large black positioned by the door and ut of a plastic bag.	1			
	PROVIDER OR SUPPLIER CTINE HEALTH CENT SUMMARY STA (EACH DEFICIENCI REGULATORY OR L Continued From pa This MN Requirem by: Based on observat review, the facility f homelike environm well as the kitchen, residents residing i Findings include: The following envir identified during the 1/30/14, at 10:00 a Garden Terrace: Room 158-B had a drawer that had a s across the surfaces Room 166-A the im scraped and expos entire width of the o Oakview: 1) The main door fr station had numero extending from the up the door frames 2) Room 242-A had missing the outer p at the base of the p tape around the co wall directing staff f not pushing bed up 3) Room 254-A the plunger which was half way hanging o 4) Room 258-A a ra	OF CORRECTION IDENTIFICATION NUMBER: 00940 00940 PROVIDER OR SUPPLIER STREET A CTINE HEALTH CENTER INNSBRUCK 1101 BL. NEW BR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a sanitary homelike environment for three of four units, as well as the kitchen, potentially affecting all residents residing in the facility. Findings include: The following environmental issues were identified during the environmental tour on 1/30/14, at 10:00 a.m. Garden Terrace: Room 158-B had a night stand and clothes drawer that had a six and a four-inch scratch across the surfaces. Room 166-A the interior of the room door was scraped and exposed the wood underneath the entire width of the door and two inches wide. Oakview: 1) The main door frames across from the nurses' station had numerous splintered areas bilaterally extending from the floor of the frame to three feel up the door frames. 2) Room 242-A had an electric cord for the bed missing the outer plastic seal measuring one inch at the base of the plug. There was clear plastic tape around the cord. There was a sign on the	IT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING:	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION OPECORRECTION IDENTIFICATION NUMBER B. WING 00940 B. WING PROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) ID PRECINCE To DEFICIENCIES ID (EACH COERCENT) PREFIX Continued From page 13 21665 This MIN Requirement is not met as evidenced by: Description Based on observation, interview and document review, the facility failed to maintain a sanitary homelike environment for three of four units, as well as the kitchen, potentially affecting all residents residing in the facility. Findings include: The following environmental issues were identified during the environmental tour on 1/30/14, at 10:00 a.m. Garden Terrace: Room 186-A the interior of the room door was scraped and exposed the wood underneath the entire width of the door and two inches wide. Oakview: 1) The main door frames across from the nurses' station had numerous splintered areas bilaterally extending from the floor of the frame to three feet up the door frames. 2) Room 242-A had an electric cord for the bed missing the outer plastic beal measuring one inch at the base of the plug. There was a sign on the wall directing staff to "Avoid	tal Department of Health or propercession (xi) PROVIDERSUPPLENCUA IDENTIFICATION NUMBER: (xi) MUTIFILE CONSTRUCTION A BUILDING: (xi) DATA COM arrow of the propercession (xi) PROVIDER OR SUPPLIER OD940 STREET ADDRESS, CITY, STATE, ZIP CODE 01////////////////////////////////////

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00940	B. WING	B. WING		30/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BENEDIO	CTINE HEALTH CENT		ACK OAK DRIN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From pa	age 14	21665			
	long vertical scrape In addition, the resi scratched measurin 6) Room 241-A and	dent's clothes cupboard was				
	the tiles around the stall was black with tiles. 2) The brick fireplat sharp edges. 3) Room 201-A a w	a shower grout surrounding entire bottom of the shower pinkish black spots on the ce in the dining room had wheelchair was soiled and al hardware and seating				
	service (DES), and (DOM), were prese tour, The DOM exp findings were on a The DES stated du expectation that sta	director of environmental the director of maintenance ent during the environmental plained that some of the list of items needing attention. ring the tour that it was her aff notify her right away of any es that needed attention.				
	dated 11/01, indica services was respo repair of plant, grou facility had a progra maintenance and "	perations/Services policy ted the facility plant operations onsible for the upkeep and unds, and equipment. The am of preventative routine inspections are tain a safe and comfortable				
	indicated routine au twenty randomly se	hecklist dated 1/23/14, udits were completed on elected rooms and these room eeded repairs and were	s			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00940	B. WING	B. WING		30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT		ACK OAK DRIN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
21665	Continued From pa	age 15	21665			
	deemed "OK."					
	checklist for house	udit dated 1/14/16, included a keeping staff to check anything oted during resident room	9			
		a.m. during the environmenta with the DM the following s were observed:	ı			
	grouted areas of the clean in the dishwa the vegetable freez located by the cook counters, at the floor edges of the floors	black debris buildup in the tiles and the tiles were not tashing area, storage area by er, food preparation areas king and food preparation or drains, and at the outer adjunct to the walls. ath the stove and upright oven pris.				
	2) The walls were I black marks and d	argely covered with brown and ust.				
	3) The garbage dis yellowish-brown bu	posal had a thick ildup on all the drain pipes.				
		ontainers in the kitchen were ood debris on outsides.				
	Cleaning Procedur	y Equipment Operations and es policy indicated, "All ow standard operation and es for equipment."				
	identified: "Shelves and other	y Cleaning Guidelines policy surfaces: splashes and spills				
	should be wiped of Kitchen floor maint epartment of Health	f as they occur. enance will be done after each	1			

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			E SURVEY PLETED
		00940			01/	01/30/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT		ACK OAK DRIV			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21665	Continued From page 16		21665			
	meal. Spills need to be mopped up immediately. Sweep the floor, pushing the debris forward. Use a dustpan to remove debris as it accumulates. Walls, ceilings and vents must be free of chipped and/or peeling paint. Walls and ceilings should be washed thoroughly at least twice a year. Heavily soiled surfaces must be cleaned more frequently and as required. Garbage containers and lids, wash the outside of the container."		,			
		a.m. the DM verified that the quipment were not clean.				
	DM could review a maintenance staff building disrepair. Director of nursing	THOD OF CORRECTION: The nd revise the policies, educate and identify trends of repeated The DM could work with the (DON) to ensure staff are ental issues appropriately.				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				
23010	MN Rule 4658.463 Construction	5 A Nurse Call System; New	23010			
	communication sys from the resident a required by this par system, if electrica connected to the e Nurse calls and em of being inactivated central annunciator	n must be equipped with a stem designed to receive calls and nursing service areas rt. The communication Ily powered, must be mergency power supply. hergency calls must be capable d only at the points of origin. A r must be provided where the rom the nurses' station.				
	A A nurse call	must be provided for each				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 01/30/2014	
		00940				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
BENEDIC	CTINE HEALTH CENT		ACK OAK DRIN IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
23010	Continued From page 17		23010			
	communication der they are within read from a resident mu station, activate a l bedroom, and activ medication room, r room, soiled utility multi-corridor nursi must be provided a This MN Requirem by: Based on observat review, the facility f non-functioning ca	Il cords, buttons, or other vices must be placed where ch of each resident. A call ist register at the nurses' ight outside the resident vate a duty signal in the nourishment area, clean utility room, and sterilizing room. In ing units, visible signal lights at corridor intersections.				
	Findings include:					
	light for R132 in ro- working. Nursing a call light was not fu	n 1/28/14, at 9:34 a.m. the call om 220 was checked and not ssistant (NA)-B confirmed the unctioning and called the rtment at 9:35 a.m. on 1/28/14 ediate repair.	,			
	maintenance empl call light in room 22 need of repair. ME	on 1/28/14, at 2:05 p.m. oyee (ME)-B, confirmed the 20 was not functioning and in -B said the call light cord was It that he needed to replace the in the room.				
	during the environr environmental serv	on 1/30/14, at 10:15 a.m. mental tour, the director of <i>r</i> ice, (DES) and the ated R132 was not capable of				

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
	00940		B. WING		01/	30/2014
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
BENEDI	CTINE HEALTH CENT		ACK OAK DRIV IGHTON, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
23010	Continued From pa	age 18	23010			
	using the call light. When interviewed on 1/30/14, at 10:16 a.m. the director of maintenance explained that call lights are checked randomly.					
	The facility policy titled, Plant Operations/Services, dated 11/2001, pages five and six indicated there was a program of preventative maintenance and routine inspections are completed to maintain a safe and comfortable environment. Routine inspection of environmental safety devices was to include resident call system and alternative plan if call system was nonfunctional.					
	Checklist dated 1/2 randomly checked 127, 149, 206, and properly functioning the call light audits write randomly sele was not system in p	ent titled, Daily Schedule (3/14, indicated call lights were in four rooms that day. Rooms 241 had been found to have g call lights. The checklist for had four empty spaces to ected rooms for auditing. There blace to ensure all of the d for functioning call lights.				
	documentation the dated 12/2/13, india 119, 159, 220, and	ility faxed additional Daily Schedule Checklist cated call lights in rooms 121, 258 were checked and "ok". hts: "220 missing light bulb				
	DM could review w ascertain if addition non-functional call could review and re the Director of nurs	THOD OF CORRECTION: The ith the manufacturer to hal ways of identifying lights are possible. The DM evise the policies and work with sing (DON) to ensure staff are ioning equipment and call				

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00940		(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED 01/30/2014		
	TINE HEALTH CENT	TER INNSBRUCK 1101 BLA	CK OAK DRIV	E		
		NEW BRIG	GHTON, MN 5		0000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
23010	Continued From page 19		23010			
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				