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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L448

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00940

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245310**
2.STATE VENDOR OR MEDICAID NO.
(L2) **810313500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE-NE II 04/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/20/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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: anne.kleppe@state.mn.us

Enclosure

cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00940	A. Building B. Wing	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 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** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **03/28/2014**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **03/28/2014**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **03/28/2014**
ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **03/28/2014**	ID Prefix **23010** Reg. # **MN Rule 4658.4635 A** LSC	Correction Completed **03/28/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	04/09/2014	32982	03/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245310	A. Building B. Wing	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** Reg. # **483.25(l)** LSC	Correction Completed **03/28/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/28/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/28/2014**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **03/28/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/28/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	04/09/2014	32982	03/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/30/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L448

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00940

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245310**
2.STATE VENDOR OR MEDICAID NO.
(L2) **810313500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE-NE II 04/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/20/2014
(L33)

DETERMINATION APPROVAL

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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,

Anne Kleppe

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: anne.kleppe@state.mn.us

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245310	A. Building B. Wing	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** Reg. # **483.25(l)** LSC	Correction Completed **03/28/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **03/28/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/28/2014**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **03/28/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/28/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	04/09/2014	32982	03/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2014			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00940	A. Building B. Wing	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 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** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **03/28/2014**	ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **03/28/2014**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1** LSC	Correction Completed **03/28/2014**
ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **03/28/2014**	ID Prefix **23010** Reg. # **MN Rule 4658.4635 A** LSC	Correction Completed **03/28/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	04/09/2014	32982	03/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/30/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L448

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00940

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245310**
2.STATE VENDOR OR MEDICAID NO.
(L2) **810313500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/30/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 02/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/18/2014 CO. L448

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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:

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

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

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

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,

Anne Kleppe

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	01/30/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329 D** The facility failed to ensure a gradual dose reduction was completed for one of five residents reviewed for unnecessary medication, (R33). There was no documentation of a rational for no GDR attempt. **How will we correct for issue cited?** Nurse practitioner will document reasons why gradual dose reduction is not indicated for this resident. **What measures or systemic changes will be made to ensure that the deficient practice will not recur?** Documentation guidance for GDR was created. All licensed nurses will document the positive and negative side effects for two weeks during any GDR. Target behavior signs and symptoms were audited to ensure they are appropriate to medication.	

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

Administrator/CEO 2/27/14

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.

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

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F 329	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was completed or justification why a GDR was not attempted for Zyprexa (an anti-psychotic medication), Depakote (an anti-seizure medication that can be used for Bi-polar disorder), and Prozac (an antidepressant medication) for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include: Zyprexa/Prozac use: R33 was interviewed and observed on 1/27/14, at 6:20 p.m. R33 refused to participate in the Resident Council interview. R33 was observed and interviewed on 1/30/14, at 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 his current medications and would not allow them to be changed. A nursing progress note dated 7/26/10, noted the Zyprexa was started because R33 became tearful when discussing current mental status. R33 had been prescribed Zyprexa 5 milligrams (mg) at bedtime and Prozac 40 mg every morning upon re-admission to the facility on 4/27/11, per the Physician Orders. The medication was ordered for depression and altered mental status.	F 329	**How will we monitor its performance to make sure that solutions are sustained?** Pharmacy consultant monitors monthly and will continue to advise on GDRs. **Date when corrective action will be completed.** This will be completed by Monday, March 10, 2014. The Director of Nursing is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 2 A progress note on 5/17/12, indicated a recommendation for a GDR on Zyprexa was declined at that time. The progress note lacked evidence of the rationale for why an attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. The quarterly Minimum Data Set (MDS) dated 3/14/13, identified R33 as needing assistance with cares and was non-ambulatory. The MDS also noted R33 displayed no hallucinations, no delusions, no behaviors directed toward self or others, no rejection of cares. R33's mood section noted R33 had identified concerns with concentrating on reading the newspaper or watching the television. On 7/10/13, the consultant pharmacist left a repeated recommendation (from 3/25/13) for a gradual dose reduction of Zyprexa. Which was declined by the physician 8/30/13, with a written note as follows "need to monitor patient and get to know him, new to us, patient states gets manic without the medication." Again the medical record lacked evidence of the rationale for why an attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. 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. A 60 Day Geriatric Services progress note dated 12/9/13, indicated behaviors "no change in recent medications or behaviors" and listed "Bipolar diagnosis: Depakote/Zyprexa/fluoxetine (Prozac) and continue follow up." The 60 Day Geriatric	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 3 Services NP progress note dated 1/24/14, did not address the antipsychotic medications. The MDS dated 12/12/13, indicated R33 was cognitively intact with minimal depression, no hallucinations, no delusions, no behaviors directed toward self or others, no rejection of cares. R33 required extensive assistance with assist of two people for bed mobility, transfers, bathing, dressing and toilet use, and R33 no longer ambulated. The care plan dated 12/12/13, indicated, "Psychotropic medication use. Potential for untoward effects of decreased activities of daily living, isolation falls, changes in mood, behavior, and cognition on Zyprexa and Depakote (consults with psych as needed for ongoing evaluation of psychotropic medication. Abnormal Involuntary Movement Scale (AIMS) every 5 months and as needed. Monitor vital signs weekly and as necessary and report abnormalities, monitor for weight changes and dehydration, monitor and report changes in mood, condition and behavior. Alteration in mood state related bipolar disorder as evidenced by a history of episodes of repetitive anxious and or health complaints (should let social service) and nursing know of scheduled outside psychiatric appointments, offer in house psychiatry, medications as ordered. Monitor for side effects, inform of possible effects of refusing medications." The care plan was requested but not provided by the facility. A review of the nursing assessments indicated: the Abnormal Involuntary Movement Scale (AIMS) assessment dated 12/13/13, and completed by the licensed practical nurse (LPN) noted some minimal extremity movements while	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 4 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, but lacked specific target behaviors to monitor for R33. R33's Target behavior 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 in a shift did the resident refused care, treatments, 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=toilet, 6=reposition, 7= adjust room temp, 8=back rub, 9=warm/cold pack, 10=music, 11-quiet environment, 12=aromatherapy, 13= lotion, 14= walk/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 the Zyprexa/Prozac use and lacked identified specific and individualized behaviors for R33. Also the medical record lacked evidence of justification for why a gradual dose reduction had notbeen attempted for R33. Depakote use: On 9/2/13, Depakote 125 mg every morning and 250 mg every evening were ordered for R33. The medication was ordered for bipolar disorder with manic episodes.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 5 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:	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 6 -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. ... 6. Attempt a GDR decrease or discontinuation of psychotropic medication after no more than 3 months unless clinically contraindicated. GDR must be attempted for 2 separate quarters with at least one month between attempts.) GDR must be attempted annually thereafter or as the resident's clinical condition warrants. 7. Sedative/Hypnotics will be reviewed quarterly for gradual dose reduction. GDR must be attempted quarterly unless clinically contraindicated. NURSING 1. Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence of functional decline. 2. Will monitor for the presence of target behaviors on a daily basis charting by exception (i.e., charting only when the behavior are	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	01/30/2014

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

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F 329	Continued From page 7 present)... The facility lacked a system for behavior monitoring that identified behaviors, and the non-pharmacological interventions that were or were not successful, to develop patterns or trends of behaviors that supported decisions for treatment or GDR.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that food was prepared in a sanitary environment for 93 of 94 residents who were served food from the kitchen. Findings include: On 1/27/14, at 4:30 p.m. DA-B was preparing to serve food in the transitional care unit. DA-B dropped a pen on the floor and picked it up and without cleaning his hands continued to place the thermometer in foods and record the temperatures of foods on the steam table. During the process the cook touched his face and	F 371		

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F 371	Continued From page 9 water in the facility, they could not keep the calcium from building up in the sink. Two toasters had black grimy film on the top metal slots, and the outer surfaces of the toasters had a brown film. The ceiling vent above the cook stove/counter area had peeling and chipping paint. Three of the burner control knobs from the gas cook stove were missing. The DM stated, "Maintenance is supposed to be getting some. I am not sure how long they have known or when they will come. We use the other knobs to control burners that do not have knobs." The upright baking oven next to the gas cook stove had a thick black debris build up. The exterior oven handles also had a grimy build up. The large stand up mixer had a brown film on top and the mixer stand had chipped paint which the DM verified was not a cleanable surface. The undated facility Equipment Operations and Cleaning Procedures policy indicated, "All employees will follow standard operation and cleaning procedures for equipment." The undated facility Cleaning Guidelines policy identified, "Shelves and other surfaces: splashes and spills should be wiped off as they occur...Walls, ceilings and vents must be free of chipped and/or peeling paint...Equipment is washed, rinsed and sanitized after each use to ensure the safety of the food served." On 1/30/14, at 9:43 a.m. the DM verified the	F 371	We purchased new toasters. Maintenance cleaned and painted ceiling vent. New knobs for stove were purchased and installed. The side of the upright oven was cleaned with a new oven cleaner purchased from Ecolab. The mixer stand was sanded and painted by Maintenance. **What measures or systemic changes will be made to ensure that the deficient practice will not recur?** All staff will be in-serviced on hand washing, glove use and proper food storage. New cleaning schedules were made and a new monitoring checklist for food safety sanitation. **How will we monitor its performance to make sure that solutions are sustained?**	

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F 371	Continued From page 8 rubbed a finger under his nose. Without performing washing his hands, DA-B donned gloves, added utensils to the steam table, and served food to the residents on the unit. After the observations DA-B reported he was unaware touched his face and verified he should have washed his hands prior to donning gloves and serving the meal. A policy was requested for glove use in food service, but was not provided. On 1/30/14, at 9:02 a.m. a tour of the kitchen was conducted with a dietary aide (DA)-A the following was noted: The walk in freezer noted an aluminum pan contained a large piece of meat was not covered labeled, or dated. The meat was approximately five in diameter by 20 inches (") and 20" in length. DA-A stated, "It is pork, I don't know why it is in here. It should be covered." Another aluminum pan approximately 12" by 12" and 8" inches deep contained an uncovered food product; the cover for the pan was under the pan. DA-A explained, "It is ground pork and it should also be covered." DA-A verified at 9:12 a.m. meats stored in the freezer should have been covered, dated, and labeled. At 9:12 a.m. the dietary manager (DM) arrived and continued the tour. The DM observed the inappropriately stored pork and stated, "The meat should not be stored like that and it wasn't there last night. It is to be labeled, covered, and then stored." 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: The rinsing sink had calcium buildup. The DM stated, "We can only scrub it" and because of the	F 371	F371 F The facility failed to ensure that food was served in a sanitary manner in one of three dining rooms (TCU) reviewed for dining. The facility failed to ensure expired foods were removed from the refrigerator. The facility failed to ensure a clean food preparation area in the main kitchen. **How will we correct for issue cited?** Spoke with DA-B about touching his face and not washing his hands before putting on his gloves. He did not realize he had touched his face but said he did wash his hands before putting on the gloves. The DM was not asked to supply a glove use policy but it is available. DA-B was the cook that stored the roast pork and ground pork in the freezer without covering, labeling and dating. He was given disciplinary action. DM was not asked to supply a food storage policy but it is available.	

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F 371	Continued From page 10 equipment was not clean. A policy for food storage was requested, but was not provided.	F 371	This tool will be completed weekly by the DM or appropriate delegate.	
F 428 SS=D	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, at 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, at 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 his current medications and would not allow them	F 428	**Date when corrective action will be completed.** This will be completed by Monday, March 10, 2014. The dietary manager is responsible. F428 D Drug Regimen review **How will we correct for issue cited?** The pharmacy consultant did identify drug regimen irregularities in her monthly visits. The resident stated he would not allow changes to his drug regimen.	

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F 428	Continued From page 11 to be changed. R33 displayed no ill behaviors during the interview. A nursing progress note dated 7/26/10, noted the Zyprexa was started because R33 became tearful when discussing current mental status. R33 had been prescribed Zyprexa 5 milligrams (mg) at bedtime and Prozac 40 mg every morning upon re-admission to the facility on 4/27/11, per the Physician Orders. The medication was ordered for depression and altered mental status. The quarterly Minimum Data Set (MDS) dated 3/14/13, identified R33 as needing assistance with cares and was non-ambulatory. The MDS also noted R33 displayed no hallucinations, no delusions, no behaviors directed toward self or others, no rejection of cares. R33's mood section noted R33 had identified concerns with concentrating on reading the newspaper or watching the television. The pharmacy drug regimen was reviewed from 3/25/13, going forward and the following was identified: - On 3/25/13, a consultant pharmacy recommendation was completed and indicated R33 had been on Prozac 40 mg since 5/1/10, and recommended a GDR. The physician response was dated 8/30/13 (five months after the recommendation was made), and declined the recommendation, since the patient was new to the practice and R33 stated he had been on 60 mg. The declination stated "will not change multiple psych med at one time. Will take down 1 med at a time." The pharmacist did not report the irregularity of the target behaviors for R33 as R33 was on Zyprexa and not Thorazine and R33 did	F 428	**What measures or systemic changes will be made to ensure that the deficient practice will not recur?** Documentation guidance for GDR was created. All licensed nurses will document the positive and negative side effects for two weeks during any GDR. Target behavior signs and symptoms were audited to ensure they are appropriate to the current medication. **How will we monitor its performance to make sure that solutions are sustained?** Pharmacy consultant monitors monthly and will continue to make recommendations as appropriate. **Date when corrective action will be completed.** March 10. Director of Nursing responsible.	

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F 428	Continued From page 12 not have specific target behaviors identified for the Zyprexa. - On 7/10/13, the consultant pharmacist left a repeated recommendation (from 3/25/13) for a gradual dose reduction of Zyprexa. Which was declined by the physician 8/30/13, with a written note as follows "need to monitor patient and get to know him, new to us, patient states gets manic without the medication." Again the pharmacist did not report the irregularity of the target behaviors for R33 as R33 was on Zyprexa and not Thorazine, R33 was non-ambulatory, and R33 did not have specific target behaviors identified for the Zyprexa. A 60 Day Geriatric Services progress note dated 12/9/13, indicated behaviors "no change in recent medications or behaviors" and listed "Bipolar diagnosis: Depakote/Zyprexa/fluoxetine (Prozac) and continue follow up." The 60 Day Geriatric Services NP progress note dated 1/24/14, did not address the antipsychotic medications. The Minimum Data Set (MDS) dated 12/12/13, indicated R33 was cognitively intact with minimal depression, no hallucinations, no delusions, no behaviors directed toward self or others, no rejection of cares during the look back period. R33 required extensive assistance with assist of two people for bed mobility, transfers, bathing, dressing and toilet use, and R33 no longer ambulated. The care plan dated 12/12/13, indicated, "Psychotropic medication use. Potential for untoward effects of decreased activities of daily living, isolation falls, changes in mood, behavior, and cognition on Zyprexa and Depakote (consults with psych as needed for ongoing evaluation of	F 428		

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F 428	Continued From page 13 psychotropic medication. Abnormal Involuntary Movement Scale (AIMS) every 5 months and as needed. Monitor vital signs weekly and as necessary and report abnormalities, monitor for weight changes and dehydration, monitor and report changes in mood, condition and behavior. Alteration in mood state related bipolar disorder as evidenced by a history of episodes of repetitive anxious and or health complaints (should let social service) and nursing know of scheduled outside psychiatric appointments, offer in house psychiatry, medications as ordered. Monitor for side effects, inform of possible effects of refusing medications." The care plan was requested but not provided by the facility. A review of the medication orders on 1/30/14, revealed Zyprexa (olanzapine) 5 mg every evening for bipolar disorder, but lacked specific target behaviors to monitor for R33. R33's Target behavior 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 in a shift did the resident refused care, treatments, 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=toilet, 6=reposition, 7= adjust room temp, 8=back rub, 9=warm/cold pack, 10=music, 11-quiet environment, 12=aromatherapy, 13= lotion, 14= walk/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 the	F 428		

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F 428	Continued From page 14 Zyprexa/Prozac use and lacked identified specific behaviors for R33. Also the medical record lacked evidence of justification for why a gradual dose reduction not had been attempted for R33. Depakote use: On 9/2/13, Depakote 125 mg every morning and 250 mg every evening were ordered for R33. The medication was ordered for bipolar disorder with manic episodes. 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 the bipolar disorder lacked specific target behaviors to staff monitor the efficacy of the Depakote 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. The Psychotropic Medication Policy and Procedure indicated:	F 428		

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F 428	Continued From page 15 -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 in 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. ... 6. Attempt a GDR decrease or discontinuation of psychotropic medication after no more than 3 months unless clinically contraindicated. GDR must be attempted for 2 separate quarters with at least one month between attempts.) GDR must be attempted annually thereafter or as the resident's clinical condition warrants. 7. Sedative/Hypnotics will be reviewed quarterly for gradual dose reduction. GDR must be attempted quarterly unless clinically contraindicated. NURSING 1. Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence of functional decline. 2. Will monitor for the presence of target behaviors on a daily basis charting by exception (i.e., charting only when the behavior are	F 428		

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F 428	Continued From page 16 present)... The facility lacked a system for behavior monitoring that identified behaviors, and the non-pharmacological interventions that were or were not successful, to develop patterns or trends of behaviors that supported decisions for treatment or GDR.	F 428		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a non-functioning call light for 1 of 1 resident (R132) reviewed who had a non-functioning call light. Findings include: When observed on 1/28/14, at 9:34 a.m. the call light for R132 in room 220 was checked and not working. Nursing assistant (NA)-B confirmed the call light was not functioning and called the maintenance department at 9:35 a.m. on 1/28/14, to request an immediate repair. When interviewed on 1/28/14, at 2:05 p.m. maintenance employee (ME)-B, confirmed the call light in room 220 was not functioning and in need of repair. ME-B said the call light cord was	F 463	**F463 D** The facility failed to identify a non-functioning call light for one of 35 residents reviewed, R132. **How will we correct for issue cited?** The call light in question was functioning: the button on the call light was working but the cord was not. When maintenance staff tried to fix the cord, the box broke and had to be replaced. The call light was fixed immediately. Our current system covered all call lights in 10 weeks. The surveyor commented that there were not many calls from this unit due to cognitive limitations and the ES director concurred; the administrator was not present.	

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F 463	Continued From page 17 not the problem but that he needed to replace the entire call light box in the room. When interviewed on 1/30/14, at 10:15 a.m. during the environmental tour, the director of environmental service, (DES) and the administrator indicated R132 was not capable of 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. The facility document titled, Daily Schedule Checklist dated 1/23/14, indicated call lights were randomly checked in four rooms that day. Rooms 127, 149, 206, and 241 had been found to have properly functioning call lights. The checklist for the call light audits had four empty spaces to write randomly selected rooms for auditing. There was not system in place to ensure all of the rooms were audited for functioning call lights. On 1/31/14, the facility faxed additional documentation the Daily Schedule Checklist 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 463	**What measures or systemic changes will be made to ensure that the deficient practice will not recur?** Call lights are checked every 10 weeks in a room audit, call lights that are not functioning are recorded in the maintenance book on each neighborhood and checked by maintenance staff daily, and the Arial call light system alerts staff when the call light is not working. We will revise the room audit and check call lights in all bedrooms and bathrooms monthly. **How will we monitor its performance to make sure that solutions are sustained?** The revised room audit form will be reviewed to monitor trends in call light functioning. **Date when corrective action will be completed.** New system will be started on March 10. Director of Environmental Services is responsible.	
F 465	483.70(h)	F 465		

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F 465 SS=E	Continued From page 18 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, 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 feet 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	F 465	F465 E The facility failed to maintain a sanitary environment for 3 of 4 units observed, Oak View, Garden Terrace and the Villa. **How will we correct for issue cited?** On Garden Terrace, a different night stand was placed in the room and the room furniture was 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 the same day and the tape and signs removed. We have removed the old caulking and re-caulked the restrooms on the list and also found others in similar shape and did the same to them.	

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F 465	Continued From page 19 wall directing staff to "Avoid electrical mishaps by not pushing bed up against the wall." 3) Room 254-A the bathroom held a large black plunger which was positioned by the door and half way hanging out of a plastic bag. 4) Room 258-A a radiator with a seven inch long paint scrape at wheel level. 5) Room 244-A a bathroom wall had a six inch long vertical scrape to left of the sink. In addition, the resident's clothes cupboard was scratched measuring five inches. 6) Room 241-A and room 236-A the bathroom toilet caulking was black and crumbling. The Villa: 1) The personal spa shower grout surrounding the tiles around the entire bottom of the shower stall was black with pinkish black spots on the tiles. 2) The brick fireplace in the dining room had sharp edges. 3) Room 201-A a wheelchair was soiled and stained on the metal hardware and seating portion of the chair. The administrator, director of environmental service (DES), and the director of maintenance (DOM), were present during the environmental tour, The DOM explained that some of the findings were on a list of items needing attention. The DES stated during the tour that it was her expectation that staff notify her right away of any housekeeping issues that needed attention. The facility Plant Operations/Services policy dated 11/01, indicated the facility plant operations services was responsible for the upkeep and repair of plant, grounds, and equipment. The facility had a program of preventative	F 465	On the Villa, we have ordered replacement base for the shower 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 wheelchairs are washed at least once per month. Resident rooms mentioned are repaired. Kitchen - The grout used for the kitchen floor is a dark color. The floor has been cleaned and will be scrubbed with a specialized floor scrubber. The walls, the pipes and equipment were washed. The trash containers were replaced. **What measures or systemic changes will be made to ensure that the deficient practice will not recur?**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING _____ B. WING _____	01/30/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 20 maintenance and "routine inspections are completed to maintain a safe and comfortable environment." A Daily Schedule Checklist dated 1/23/14, indicated routine audits were completed on twenty randomly selected rooms and these rooms were checked for needed repairs and were deemed "OK." A Housekeeping Audit dated 1/14/16, included a checklist for housekeeping staff to check anything in need of repair noted during resident room cleaning. 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: 1) The floors had a black debris buildup in the grouted areas of the tiles and the tiles were not clean in the dishwashing area, storage area by the vegetable freezer, food preparation areas located by the cooking and food preparation counters, at the floor drains, and at the outer edges of the floors adjunct to the walls. The floor underneath the stove and upright oven had thick black debris. 2) The walls were largely covered with brown and black marks and dust. 3) The garbage disposal had a thick yellowish-brown buildup on all the drain pipes. 4) All of the trash containers in the kitchen were unclean and had food debris on outsides. The undated facility Equipment Operations and	F 465	We identified additional doors that are scratched, ordered more material and will replace when materials arrive. All plungers have been removed from private bathrooms and access to a plunger is in the common bathroom where the plunger is in a plunger stand. New cleaning schedules were made and a new monitoring checklist for food safety sanitation. The room check audit (monthly) will include checking bed plug ins, general repairs, and environmental review. **How will we monitor its performance to make sure that solutions are sustained?** This tool will be completed weekly by the DM or appropriate delegate. The revised room audit form will be reviewed to monitor trends in call light functioning. **Date when corrective action will be completed.** This will be completed by Monday, March 10, 2014. The dietary manager and environmental services director are responsible.	

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	245310	A. BUILDING _____ B. WING _____	01/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 465	Continued From page 21 Cleaning Procedures policy indicated, "All employees will follow standard operation and cleaning procedures for equipment." The undated facility Cleaning Guidelines policy identified: "Shelves and other surfaces: splashes and spills should be wiped off as they occur. Kitchen floor maintenance will be done after each 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." On 1/30/14, at 9:43 a.m. the DM verified that the floors, walls and equipment were not clean.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING **02 - NEW BLDG** B. WING _____	**01/28/2014**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Health Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Benedictine Health Center at Innsbruck is a 2-story building with no basement. The building was built at 3 different times. The original building was constructed in 1965 and was determined to be of Type II (222) construction. In 1991 an addition was constructed to the north and was determined to be of Type I(222) construction. In 2005 the Transitional Care Unit (TCU) was added to the north that was determined to be of Type V(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building one was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19 and the TCU building was surveyed in accordance with LSC Chapter 18. Both buildings have a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in each resident room that is monitored for fire department notification. the facility has a capacity of 105 census at the time of this survey was 96.	K 000		

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING **02 - NEW BLDG** B. WING _____	**01/28/2014**

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

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K 000	Continued From page 1 A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1965 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2014**

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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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.

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

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	245310	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/28/2014**

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K 000	Continued From page 1 A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1965 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

and the Time Period For Correction.

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

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

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

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

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,

Anne Kleppe

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00940	A. BUILDING: _____ B. WING _____	01/30/2014

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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 27, 28, 29,and 30, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	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.	

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2 000	Continued From page 1	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed.	21000		

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21000	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure that food was prepared in a sanitary environment for 93 of 94 residents who were served food from the kitchen. Findings include: On 1/27/14, at 4:30 p.m. DA-B was preparing to serve food in the transitional care unit. DA-B dropped a pen on the floor and picked it up and without cleaning his hands continued to place the thermometer in foods and record the temperatures of foods on the steam table. During the process the cook touched his face and rubbed a finger under his nose. Without performing washing his hands, DA-B donned gloves, added utensils to the steam table, and served food to the residents on the unit. After the observations DA-B reported he was unaware touched his face and verified he should have washed his hands prior to donning gloves and serving the meal. A policy was requested for glove use in food service, but was not provided. SUGGESTED METHOD OF CORRECTION: The Dietary Manager could review and revise the policies and educate dietary staff to ensure appropriate hand hygiene is performed before donning gloves. The DM and DON could standardize the policy for refrigerator cleaning, educate nursing and dietary staff to ensure staff were monitoring/cleaning refrigerators with potentially hazardous foods. The DON could revise the admission information to clearly state how long food will be retained in a refrigerator when it is not in manufacturers packaging. TIME PERIOD FOR CORRECTION: Twenty-one	21000		

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21000	Continued From page 3 (21) days.	21000		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that food was prepared in a sanitary environment for 93 of 94 residents who were served food from the kitchen. Findings include: On 1/30/14, at 9:02 a.m. a tour of the kitchen was conducted with a dietary aide (DA)-A the following was noted: The walk in freezer noted an aluminum pan contained a large piece of meat was not covered labeled, or dated. The meat was approximately five in diameter by 20 inches (") and 20" in length. DA-A stated, "It is pork, I don't know why it is in here. It should be covered." Another aluminum pan approximately 12" by 12" and 8" inches deep contained an uncovered food product; the cover for the pan was under the pan. DA-A explained, "It is ground pork and it should also be covered." DA-A verified at 9:12 a.m. meats stored in the freezer should have been covered, dated, and labeled. At 9:12 a.m. the dietary manager (DM) arrived and continued the tour. The DM observed the inappropriately stored pork and stated, "The meat	21015		

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21015	Continued From page 4 should not be stored like that and it wasn't there last night. It is to be labeled, covered, and then stored." 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: The rinsing sink had calcium buildup. The DM stated, "We can only scrub it" and because of the water in the facility, they could not keep the calcium from building up in the sink. Two toasters had black grimy film on the top metal slots, and the outer surfaces of the toasters had a brown film. The ceiling vent above the cook stove/counter area had peeling and chipping paint. Three of the burner control knobs from the gas cook stove were missing. The DM stated, "Maintenance is supposed to be getting some. I am not sure how long they have known or when they will come. We use the other knobs to control burners that do not have knobs." The upright baking oven next to the gas cook stove had a thick black debris build up. The exterior oven handles also had a grimy build up. The large stand up mixer had a brown film on top and the mixer stand had chipped paint which the DM verified was not a cleanable surface. The undated facility Equipment Operations and Cleaning Procedures policy indicated, "All employees will follow standard operation and cleaning procedures for equipment."	21015		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21015	Continued From page 5 The undated facility Cleaning Guidelines policy identified, "Shelves and other surfaces: splashes and spills should be wiped off as they occur...Walls, ceilings and vents must be free of chipped and/or peeling paint...Equipment is washed, rinsed and sanitized after each use to ensure the safety of the food served." On 1/30/14, at 9:43 a.m. the DM verified the equipment was not clean. A policy for food storage was requested, but was not provided. SUGGESTED METHOD OF CORRECTION: The dietary manager could review and revise dietary policies and educate staff on the proper cleaning of the kitchen area, additionally, coordination of cleaning and repairs with the maintenance department could be implemented. Cleaning schedules could be assigned and reviewed daily to assure dietary tasks are being completed to assure a safe and sanitary dietary food prep environment TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.	21535		

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21535	Continued From page 6 In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was completed or justification why a GDR was not attempted for Zyprexa (an anti-psychotic medication), Depakote (an anti-seizure medication that can be used for Bi-polar disorder), and Prozac (an antidepressant medication) for 1 of 5 residents (R33) reviewed for unnecessary medications. Findings include: Zyprexa/Prozac use: R33 was interviewed and observed on 1/27/14, at 6:20 p.m. R33 refused to participate in the Resident Council interview. R33 was observed and interviewed on 1/30/14, at 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 his current medications and would not allow them to be changed.	21535		

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21535	Continued From page 7 A nursing progress note dated 7/26/10, noted the Zyprexa was started because R33 became tearful when discussing current mental status. R33 had been prescribed Zyprexa 5 milligrams (mg) at bedtime and Prozac 40 mg every morning upon re-admission to the facility on 4/27/11, per the Physician Orders. The medication was ordered for depression and altered mental status. A progress note on 5/17/12, indicated a recommendation for a GDR on Zyprexa was declined at that time. The progress note lacked evidence of the rationale for why an attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. The quarterly Minimum Data Set (MDS) dated 3/14/13, identified R33 as needing assistance with cares and was non-ambulatory. The MDS also noted R33 displayed no hallucinations, no delusions, no behaviors directed toward self or others, no rejection of cares. R33's mood section noted R33 had identified concerns with concentrating on reading the newspaper or watching the television. On 7/10/13, the consultant pharmacist left a repeated recommendation (from 3/25/13) for a gradual dose reduction of Zyprexa. Which was declined by the physician 8/30/13, with a written note as follows "need to monitor patient and get to know him, new to us, patient states gets manic without the medication." Again the medical record lacked evidence of the rationale for why an attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior.	21535		

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21535	Continued From page 8 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. A 60 Day Geriatric Services progress note dated 12/9/13, indicated behaviors "no change in recent medications or behaviors" and listed "Bipolar diagnosis: Depakote/Zyprexa/fluoxetine (Prozac) and continue follow up." The 60 Day Geriatric Services NP progress note dated 1/24/14, did not address the antipsychotic medications. The MDS dated 12/12/13, indicated R33 was cognitively intact with minimal depression, no hallucinations, no delusions, no behaviors directed toward self or others, no rejection of cares. R33 required extensive assistance with assist of two people for bed mobility, transfers, bathing, dressing and toilet use, and R33 no longer ambulated. The care plan dated 12/12/13, indicated, "Psychotropic medication use. Potential for untoward effects of decreased activities of daily living, isolation falls, changes in mood, behavior, and cognition on Zyprexa and Depakote (consults with psych as needed for ongoing evaluation of psychotropic medication. Abnormal Involuntary Movement Scale (AIMS) every 5 months and as needed. Monitor vital signs weekly and as necessary and report abnormalities, monitor for weight changes and dehydration, monitor and report changes in mood, condition and behavior. Alteration in mood state related bipolar disorder as evidenced by a history of episodes of repetitive anxious and or health complaints (should let social service) and nursing know of scheduled outside psychiatric appointments, offer in house psychiatry, medications as ordered. Monitor for	21535		

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21535	Continued From page 9	21535		

side effects, inform of possible effects of refusing medications." The care plan was requested but not provided by the facility.

A review of the nursing assessments indicated: the Abnormal Involuntary Movement Scale (AIMS) assessment dated 12/13/13, and completed by the licensed practical nurse (LPN) noted some minimal extremity movements while 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, but lacked specific target behaviors to monitor for R33.
R33's Target behavior 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 in a shift did the resident refused care, treatments, 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=toilet, 6=reposition, 7= adjust room temp, 8=back rub, 9=warm/cold pack, 10=music, 11-quiet environment, 12=aromatherapy, 13= lotion, 14= walk/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 the Zyprexa/Prozac use and lacked identified specific and individualized behaviors for R33. Also the medical record lacked evidence of justification for why a gradual dose reduction had been

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21535	Continued From page 10 attempted for R33. Depakote use: On 9/2/13, Depakote 125 mg every morning and 250 mg every evening were ordered for R33. The medication was ordered for bipolar disorder with manic episodes. 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,	21535		

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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. ...

6. Attempt a GDR decrease or discontinuation of psychotropic medication after no more than 3 months unless clinically contraindicated. GDR must be attempted for 2 separate quarters with at least one month between attempts.) GDR must be attempted annually thereafter or as the resident's clinical condition warrants.

7. Sedative/Hypnotics will be reviewed quarterly for gradual dose reduction. GDR must be attempted quarterly unless clinically contraindicated.

NURSING

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21535	Continued From page 12 1. Monitors psychotropic drug use daily noting any adverse effects such as increased somnolence of functional decline. 2. Will monitor for the presence of target behaviors on a daily basis charting by exception (i.e., charting only when the behavior are present)... The facility lacked a system for behavior monitoring that identified behaviors, and the non-pharmacological interventions that were or were not successful, to develop patterns or trends of behaviors that supported decisions for treatment or GDR. SUGGESTED METHOD OF CORRECTION: The DON could review and revise policies and educate staff to work with the consultant pharmacist to ensure that all antipsychotic medications have appropriate indications, behaviors identified and tracked, appropriate nonpharmological interventions, and clear directions for documenting behaviors. The DON could review and revise polices and educate staff to ensure that licensed staff are reviewing medication orders in collaboration with the consultant pharmacist to prevent duplication of medications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		

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21665	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 feet 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 wall directing staff to "Avoid electrical mishaps by not pushing bed up against the wall." 3) Room 254-A the bathroom held a large black plunger which was positioned by the door and half way hanging out of a plastic bag. 4) Room 258-A a radiator with a seven inch long paint scrape at wheel level.	21665		

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21665	Continued From page 14 5) Room 244-A a bathroom wall had a six inch long vertical scrape to left of the sink. In addition, the resident's clothes cupboard was scratched measuring five inches. 6) Room 241-A and room 236-A the bathroom toilet caulking was black and crumbling. The Villa: 1) The personal spa shower grout surrounding the tiles around the entire bottom of the shower stall was black with pinkish black spots on the tiles. 2) The brick fireplace in the dining room had sharp edges. 3) Room 201-A a wheelchair was soiled and stained on the metal hardware and seating portion of the chair. The administrator, director of environmental service (DES), and the director of maintenance (DOM), were present during the environmental tour, The DOM explained that some of the findings were on a list of items needing attention. The DES stated during the tour that it was her expectation that staff notify her right away of any housekeeping issues that needed attention. The facility Plant Operations/Services policy dated 11/01, indicated the facility plant operations services was responsible for the upkeep and repair of plant, grounds, and equipment. The facility had a program of preventative maintenance and "routine inspections are completed to maintain a safe and comfortable environment." A Daily Schedule Checklist dated 1/23/14, indicated routine audits were completed on twenty randomly selected rooms and these rooms were checked for needed repairs and were	21665		

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21665	Continued From page 15 deemed "OK." A Housekeeping Audit dated 1/14/16, included a checklist for housekeeping staff to check anything in need of repair noted during resident room cleaning. 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: 1) The floors had a black debris buildup in the grouted areas of the tiles and the tiles were not clean in the dishwashing area, storage area by the vegetable freezer, food preparation areas located by the cooking and food preparation counters, at the floor drains, and at the outer edges of the floors adjunct to the walls. The floor underneath the stove and upright oven had thick black debris. 2) The walls were largely covered with brown and black marks and dust. 3) The garbage disposal had a thick yellowish-brown buildup on all the drain pipes. 4) All of the trash containers in the kitchen were unclean and had food debris on outsides. The undated facility Equipment Operations and Cleaning Procedures policy indicated, "All employees will follow standard operation and cleaning procedures for equipment." The undated facility Cleaning Guidelines policy identified: "Shelves and other surfaces: splashes and spills should be wiped off as they occur. Kitchen floor maintenance will be done after each	21665		

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21665	Continued From page 16 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." On 1/30/14, at 9:43 a.m. the DM verified that the floors, walls and equipment were not clean. SUGGESTED METHOD OF CORRECTION: The DM could review and revise the policies, educate maintenance staff and identify trends of repeated building disrepair. The DM could work with the Director of nursing (DON) to ensure staff are reporting environmental issues appropriately. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
23010	MN Rule 4658.4635 A Nurse Call System; New Construction The nurses' station must be equipped with a communication system designed to receive calls from the resident and nursing service areas required by this part. The communication system, if electrically powered, must be connected to the emergency power supply. Nurse calls and emergency calls must be capable of being inactivated only at the points of origin. A central annunciator must be provided where the door is not visible from the nurses' station. A. A nurse call must be provided for each	23010		

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23010	Continued From page 17 resident's bed. Call cords, buttons, or other communication devices must be placed where they are within reach of each resident. A call from a resident must register at the nurses' station, activate a light outside the resident bedroom, and activate a duty signal in the medication room, nourishment area, clean utility room, soiled utility room, and sterilizing room. In multi-corridor nursing units, visible signal lights must be provided at corridor intersections. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify a non-functioning call light for 1 of 1 resident (R132) reviewed who had a non-functioning call light. Findings include: When observed on 1/28/14, at 9:34 a.m. the call light for R132 in room 220 was checked and not working. Nursing assistant (NA)-B confirmed the call light was not functioning and called the maintenance department at 9:35 a.m. on 1/28/14, to request an immediate repair. When interviewed on 1/28/14, at 2:05 p.m. maintenance employee (ME)-B, confirmed the call light in room 220 was not functioning and in need of repair. ME-B said the call light cord was not the problem but that he needed to replace the entire call light box in the room. When interviewed on 1/30/14, at 10:15 a.m. during the environmental tour, the director of environmental service, (DES) and the administrator indicated R132 was not capable of	23010		

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23010	Continued From page 18 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. The facility document titled, Daily Schedule Checklist dated 1/23/14, indicated call lights were randomly checked in four rooms that day. Rooms 127, 149, 206, and 241 had been found to have properly functioning call lights. The checklist for the call light audits had four empty spaces to write randomly selected rooms for auditing. There was not system in place to ensure all of the rooms were audited for functioning call lights. On 1/31/14, the facility faxed additional documentation the Daily Schedule Checklist 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." SUGGESTED METHOD OF CORRECTION: The DM could review with the manufacturer to ascertain if additional ways of identifying non-functional call lights are possible. The DM could review and revise the policies and work with the Director of nursing (DON) to ensure staff are reporting non-functioning equipment and call lights.	23010		

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	00940	A. BUILDING: _____ B. WING _____	01/30/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
23010	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	23010		