Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 3, 2025

Administrator
Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112

RE: CCN: 245310
Cycle Start Date: May 15, 2025

Dear Administrator:

On May 15, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

If an acceptable ePoC 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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 August 15, 2025 (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).

In addition, if substantial compliance with the regulations is not verified by November 15, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Administrator
Benedictine Health Center Innsbruck
1101 Black Oak Drive
New Brighton, MN 55112

Re: State Nursing Home Licensing Orders
Event ID: LT2H11

Dear Administrator:

The above facility was surveyed on May 12, 2025 through May 15, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	C 05/15/2025

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
E 000	Initial Comments On 5/12/25-5/15/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 5/12/25-5/15/25 , a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53109446C (MN00107254), H53104530C (MN00112940) AND The following complaints were reviewed: H53104289C (MN00109774) with a defiincies cited at F550 and F677. AND The following complaints were reviewed: H53104290C (MN00106629) Deficient practice was identified related to incidental finding at F583	F 000		

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

Electronically Signed | 06/12/2025

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

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F 000	Continued From page 1 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all	F 550		6/30/25

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F 550	Continued From page 2 residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain dignity for 1 of 1 resident (R62) reviewed for dignity. R62's discharge Minimum Data Set (MDS) dated 3/28/25, indicated intact cognition and diagnoses of quadriplegia, traumatic rupture of cervical intervertebral disc (C5-6), spinal stenosis, and neurogenic bladder. It further indicated R62 required substantial assistance with toileting, was always incontinent of urine, and received a diuretic on routine basis. R62's care plan dated 4/25/25, indicated the potential for alteration of bowel and bladder related to a diagnosis of a neurogenic bladder and included an intervention of R62 requiring 2 person assistance to use the toilet upon rising in the morning, before and after each meal,	F 550	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R62 is to be treated with dignity and respect. R62 is occasionally continent of	

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F 550	Continued From page 3 bedtime, on night rounds, and as needed. R62 also required assistance with all toileting tasks and used brief/pads for incontinence protection indicating he was not able to reliably notify staff of his need to be toileted. During interview on 5/12/25 at 5:25 p.m. R62 stated he had to wait 20-45 minutes (on average)almost every time he needed to use the urinal. Since his spinal cord injury, he doesn't have much notice when having to urinate and often ends up urinating in his brief. When that happens he then had to wait long periods of time sitting in his urine or feces. R62 also stated he had reported this to RN-E and the DON but nothing ever happened to fix the problem stating "It's a culture here to not help each other out. I put my call light on and wait for staff to respond. When they don't respond, I go out into the hallway (in my wheelchair) to get help and I am often told by staff they're not my aide and then continue to play on their phone." During observation on 5/14/25 at 7:04 a.m., the following events occurred: -7:15 a.m. R62 put his call light on. -7:28 a.m. NA-E answered call light for another resident who's room was in close proximity to R62's room (exited the room at 7:34 a.m.) but failed to answer R62's call light when she was finished assisting the other resident. -7:35 a.m. NA-F was walking down the hall towards R62's room with the vital signs (VS) machine. NA-F entered the room and asked R62 what he needed because his call light was on. He stated he had to urinate but he already urinated in his brief because he couldn't hold it. NA-G stated that was okay, proceeded to take his blood pressure, then left the room stating "I will come	F 550	bowel and bladder per the bowel and bladder assessment dated 4/27 and is toileted per resident's plan of care. Staff involved were counseled and re-educated on resident rights and the importance of timely incontinence care. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of call light response times was conducted for 5/12/25 through 5/16/25 – results of that audit showed an average response time of 8 minutes, 12 seconds. No other resident complaints have been received related to call light response times. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nursing associates were re-educated on the Resident Rights & Notification of Resident Rights policy. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee will audit the timeliness of 2 resident's care, including incontinence care, weekly for a period of 6 weeks to ensure the care being provided with dignity and is according to the resident's individual plan of care. The audit results will be reviewed by the Quality Council to	

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F 550	Continued From page 4 back later and get you up when she's (unknown) done." -7:45 a.m. NA-F assisted another resident with a shower. -8:01 a.m. registered nurse (RN)-D entered R62's room with medications, blood sugar monitor, and stethoscope. RN-D asked his name, date of birth, took his VS, tested his blood sugar, administered his medications, and gave him a nebulizer treatment. RN-D did not change R62's brief. -8:30 a.m. RN-D exited R62's room. -8:34 a.m. R62 stated RN-D did not change him while she was in his room and that he put his call light on at 7:15 a.m. when he first had to go to the bathroom. -8:40 a.m. R62 put on his call light again. -8:42 a.m. NA-F answered R62's call light and R62 stated he was still waiting for his brief to be changed. NA-F changed his brief (which was visibly full of urine) and removed the pad underneath him which was also visibly wet. During interview on 5/14/25 at 9:15 a.m. NA-F verified R62 told her he had urinated in his brief when she answered his call light at 7:35 a.m. NA-F stated was waiting for the nurse to go in and do what she needed to do but she should have changed him right away before the next call light went on. During interview on 5/14/25 at 9:30 a.m. RN-D stated anyone can answer call lights but it was usually the NA's who answer them. They try to answer call lights within 15 minutes and if a resident stated they need to be changed, staff should try to do that immediately or as soon as possible and changing a brief would take precedence over giving a resident a shower. RN-D further stated NA's are assigned to a group	F 550	determine if further action is needed.	

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F 550	Continued From page 5 of residents but the other NA's are expected to answer the call lights and help each other out. If the nurse needs to administer medications or perform cares, etc. they can wait if a resident needed to be changed. RN-D verified she did not change R62 when she was in his room because she was unaware he needed to be changed. There was no reason he needed to wait to be changed until after she was done working with him. During interview on 5/14/25 at 2:00 p.m. NA-D stated NA's are assigned to a certain group of residents and "we stick with our residents, unless someone is really busy, but everyone can help." NA-D further stated they try to answer call lights within 15 minutes and changing a residents brief should be done before giving a resident shower. An hour was too long for a resident to wait to have their brief changed and stated 10 minutes should be the longest they should have to wait unless they were really busy. During an follow up interview on 5/15/25 at 11:16 a.m., R62 stated if he hadn't fallen, he would still be able to do all all the things the staff do for him by himself and it took awhile for him to get used to staff having to help him and when he has to sit in his own urine or feces he feels "useless and worthless." When it takes 45 minutes to an hour for staff to come, It makes him think staff don't want to help him and it's embarrassing and degrading. During interview on 5/15/24 at 10:56 a.m., the director of nursing (DON) stated he did not think an hour was too long for a resident to have to sit in a wet brief and there wouldn't be any negative outcomes as a result (specifically skin	F 550		

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F 550	Continued From page 6 breakdown). The DON further stated changing a residents brief didn't necessarily take precedence over giving another resident a shower and would depend on the situation. He was unable to provide an approximate amount/range of time he would expect a residents call light to be answered or a residents brief to be changed (once they put their call light on.) A facility policy reagrding dignity was requested but not received.	F 550		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records.	F 583		6/30/25

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F 583	Continued From page 7 (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure personal privacy during activities of daily living (ADLs) was provided for 1 of 2 residents (R9) reviewed for privacy. Findings include: R9's significant change Minimum Data Set (MDS) dated 4/11/25, indicated severe cognitive impairment, did not reject cares, used a wheelchair, and required substantial assist with toileting hygiene, and partial to moderate assist with dressing. R9's optional state assessment (OSA) dated 4/11/25, indicated R9 required assist with bed mobility, transfers, and toileting. R9's Facesheet undated, indicated the following diagnoses: rheumatoid arthritis, Myelodysplastic syndrome, weakness, history of falling, and Alzheimer's disease. R9's care plan dated 4/14/25, indicated R9 had an alteration in ADLs and required assist of one with dressing, and grooming. R9's care plan dated 4/14/25, indicated R9 had	F 583	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Privacy curtain was returned from being laundered and rehung in R9’s room while surveyors were onsite. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Inspections of all shared rooms were conducted to ensure privacy curtains were in place.	

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 583	Continued From page 8 an alteration in mobility and required assist of one with transfers and ambulating. R9's care plan dated 4/14/25, indicated R9 had an alteration in toileting and interventions included to assist with toileting upon rising before and after meals, at bedtime, on night rounds and as needed. R9'S care sheet undated, indicated R9 required assist of one with toileting. During observation on 5/13/25 at 8:57 a.m., nursing assistant (NA)-H entered R9's room and asked if she was ready to get up. At 9:01 a.m., NA-H asked resident if she wanted to go into the bathroom and stated they bring R9 to the bathroom and complete cares in the bathroom. At 9:03 a.m., NA-H assisted R9 to the bathroom and R9 stood up in the bathroom using the sink and sat on the toilet. At 9:03 a.m., registered nurse (RN)-F entered R9's room. At 9:08 a.m., NA-H donned R9's hip protector and pants. R9's wheelchair was outside the bathroom door and R9's room mate was in bed sleeping across from the opened bathroom door. There was no privacy curtain located on the track on the ceiling to provide privacy between the bathroom and R9's roommate. At 9:17 a.m., R9 was assisted by NA-H to stand up and R9's pants were down, the bathroom door was opened, and R9's roommate was in bed. NA-H wiped R9's bottom with the door open and pulled up R9's incontinent brief, hip protector and pants as R9 held on to the sink. During interview on 5/13/25 at 9:24 a.m., NA-H verified there was no privacy curtain and stated there used to be a curtain because there were	F 583	3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Staff were provided re-education on Resident Rights and Notification of Resident Rights, with emphasis on ADLs and room configurations. Environmental Services staff will ensure a replacement privacy curtain is hung in place of the one being removed for laundering. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee to conduct audits on 2 shared rooms weekly for a period of 6 weeks to ensure privacy curtains are hung in place as appropriate. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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F 583	Continued From page 9 hooks on the track and further stated it would be important to have for privacy and stated the bathroom was crowded and R9 liked to sit on the toilet in the a.m. During interview on 5/13/25 at 10:02 a.m., RN-F verified there was no privacy curtain between the bathroom in R9's room and R9's roommate and stated she thought it was taken off to be washed and stated there could be a reason for why the curtain wasn't on the track and further stated it was important for privacy and added even though a resident had dementia, you still provide them with privacy. During interview on 5/13/25 at 3:42 p.m., the director of nursing (DON) viewed R9's room and stated one of the staff members informed the DON the curtains went down to the laundry and stated he expected staff provide privacy if a resident was in the bathroom with the door wide open with another resident in the room. A form, Combined Federal and State Bill of Rights, dated 6/18/19, indicated the resident has a right to personal privacy. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.	F 583		
F 605 SS=D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any	F 605		6/30/25

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F 605	Continued From page 10 physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to ensure resident specific target behavior monitoring for antipsychotic use and further failed to ensure a gradual dose reduction (GDR) of an antipsychotic for 1 of 4 residents reviewed (R9) for antipsychotic use. Findings include: R9's annual Minimum Data Set (MDS) dated 12/19/23, indicated R9 did not take an	F 605	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	

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F 605	Continued From page 11 antipsychotic. R9's quarterly MDS dated 3/19/24, indicated R9 routinely took an antipsychotic and a GDR had not been attempted and the physician had not documented a GDR was clinically contraindicated. Further, did not have physical, verbal, or other behavioral symptoms, did not reject care, and did not wander. R9's quarterly MDS dated 6/19/24, indicated R9 routinely took an antipsychotic and a gradual dose reduction (GDR) had not been attempted. Further, the MDS indicated a GDR (gradual dose reduction) had not been documented by a physician as clinically contraindicated. Further, R9 did not have physical, verbal, or other behavioral symptoms, did not reject care, and did not wander. R9's quarterly MDS dated 9/15/24, indicated R9 routinely took an antipsychotic and a GDR had not been attempted and was documented by a physician as clinically contraindicated on 8/1/24. Further R9 did not have physical, verbal, or other behaviors, did not reject care, and did not wander. R9's annual MDS dated 12/11/24, indicated R9 routinely took an antipsychotic, and a GDR had not been attempted and was documented by a physician as clinically contraindicated on 8/1/24. Further, R9 did not have physical, verbal, or other behaviors, did not reject care, and did not wander and R9's behavior status, wandering and rejection of care status remained the same compared to prior assessments. R9's quarterly MDS dated 3/10/25, indicated R9	F 605	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The Psychotropic medication regimen for R9 was reviewed. Documentation of target behaviors was updated and integrated into MAR/TAR and care plan. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents on prescribed psychotropic medication regimens were reviewed to ensure that target behaviors are documented on the MAR/TAR and in the care plan. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Re-education on Chemical and Physical Restraints policy was provided to Nurse Managers with emphasis on the identifying and documenting of target behaviors with specificity. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee will audit 2 charts weekly for a period of 6 weeks to ensure antipsychotic use is clinically justified, target behaviors are clearly defined and	

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F 605	Continued From page 12 routinely took an antipsychotic, and a GDR had not been attempted and was documented by a physician as clinically contraindicated on 8/1/24. Further, R9 did not have physical, verbal, or other behavior symptoms, did not reject cares, and did not wander. R9's significant change Minimum Data Set (MDS) dated 4/11/25, indicated severe cognitive impairment, did not reject cares, did not hallucinate or have delusions, or physical, verbal, or other behavioral symptoms, did not wander and R9's behavior remained the same compared to prior assessment. Further, R9 routinely took an antipsychotic and a GDR had not been attempted and was documented by a physician as clinically contraindicated on 8/1/24. R9's Resident Census form dated 5/15/25, indicated R9 moved to the Villa (a locked unit) on 1/28/25, from another unit at the facility. Further, the form indicated R9's payer changed to hospice on 4/4/25. R9's care area assessment (CAA) dated 4/14/25, for psychotropic use indicated R9 received Seroquel (an antipsychotic) for psychosis with delusions and Zoloft for her diagnoses of depression and started on hospice care on 4/4/25. R9's care plan dated 4/14/25, indicated R9 was on the falling star program and was at risk for falling. Interventions included providing essential oils, ensure R9 wore her glasses, provide reminders not to ambulate or transfer without assist, keep the call light in reach. R9's care plan dated 4/14/25, indicated R9	F 605	documented; and gradual dose reductions (GDR) are attempted as appropriate or contraindications are documented. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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F 605	Continued From page 13 wandered looking for her husband or car to go home and interventions indicated to approach from the front and walk in step before redirecting, will have a wander guard to ensure safety, when wandering provide comfort measures for basic needs. R9's care plan dated 4/14/25, indicated R9 was at risk for complications from psychotropic use related to receiving Zoloft for depression, Seroquel for a psychotic disorder with delusions and interventions indicated to monitor target behaviors, observe for changes in mood and behavior, observe for side effects, proper dosing and continued need, and pharmacy consultant review. The care plan lacked information what R9's target behaviors were. R9's care plan dated 5/12/25, indicated R9 was at high risk for falling due to dementia and an overall decline. Interventions included fall prevention and reduction precautions per facility protocol, monitor side effects of medication: cardiac medication as ordered, narcotic pain medication as ordered. R9's Orders form indicated the following orders: Starting on 2/28/24, and discontinued on 5/15/25, target behavior interventions for Seroquel, code 1 for refusing to leave her room, code a 2 for self-isolation, special instructions indicated code 1 for redirection, 2 for 1:1, 3 for activity, 4 for offer food/fluid, 5 for toilet, 6 for reposition, 7 for adjusting room temperature, 8 for a back rub, 9 for a warm pack, 10 for music, and 11 for a quiet environment, 12 for lotion, 13 for aromatherapy, 14 for walking, 15 for reading, 16 for pet therapy, and 17 for rest. The target behaviors lacked	F 605		

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F 605	Continued From page 14 information R9 looked for family including her husband, children, or sister. 2/28/24, Monitor for potential side effects of antipsychotic medication such as an increase in sedation, drowsiness, dry mouth, blurred vision, constipation, urinary retention, tachycardia, muscle weakness, agitation, headaches, skin rash, excess weight gain, insomnia, dizziness, and nausea. Document (-) for no side effects and (+) for side effect present every shift. 3/20/24, Seroquel (quetiapine) tablet, 25 milligrams (mg) daily at 4:00 p.m. 1/29/25, Zoloft (an antidepressant) 125 mg orally every a.m. 5/15/25, target behavior interventions for antipsychotic, code 1 for hallucinations, code a 2 for looking for car keys to go to work, code a 3 for wanting to go home, code a 4 for looking for family, husband, children, or sister. Special instructions indicated code a 1 for redirection, 2 for 1 to 1, 3 for activity, 4 for offering food and fluids, 5 for toileting, 6 for repositioning, 7 for adjusting the room temperature, 8 for a back rub, 9 for a warm or cold pack, 10 for music, 11 for quiet environment, 12 for lotion, 13 for aromatherapy, 14 for walking , 15 for reading, 16 for pet therapy, 17 for resting twice a day. R9's medication administration record (MAR) and treatment administration record (TAR) dated 1/1/25, to 1/31/25, indicated R9 received Seroquel 25 mg at 4:00 p.m., for a psychotic disorder with delusions due to a known physiological condition. R9's TAR indicated target behavior interventions for Seroquel included to code 1 for refusing to leave her room and code a 2 for self-isolation. The form indicated zeros and dashes from 1/1/25, to 1/31/25, for the 7:00 a.m., to 3:00 p.m. shift for the number of behaviors.	F 605		

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F 605	Continued From page 15 The 3:00 p.m., to 11:00 p.m., shift indicated four documented behavior episodes coded as a 1 for refusing to leave her room on 1/3/25, 1/13/25, 1/17/25, and 1/27/25. The 11:00 p.m., to 7:00 a.m., shift indicated one documented behavior on 1/21/25, coded as a 1, refusing to leave the room. The form lacked target behaviors of looking for her husband, children, or sister, wanting to go home, or looking for car keys to go to work. R9's MAR and TAR dated 2/1/25, to 2/28/25, indicated R9 received Seroquel 25 mg at 4:00 p.m. R9's TAR indicated target behavior interventions for Seroquel included to code 1 for refusing to leave her room and code a 2 for self-isolation. R9 had three behaviors coded as a "2", on the day shift, one behavior coded as a "1" on the evening shift, and one behavior coded as a "1" on the night shift. The form lacked target behaviors of looking for her husband, children, or sister, wanting to go home, or looking for car keys to go to work. R9's MAR and TAR dated 3/1/25, to 3/31/25, indicated R9 received Seroquel 25 mg at 4:00 p.m. R9's TAR indicated target behavior interventions for Seroquel included to code 1 for refusing to leave her room and code a 2 for self-isolation. R9 had zeros and dashes documented on the day shift, evening shift, and had two behaviors coded as a "1" on the night shift. The form lacked target behaviors of looking for her husband, children, or sister, wanting to go home, or looking for car keys to go to work. R9's MAR and TAR dated 4/1/25, to 4/30/25, indicated R9 received 25 mg at 4:00 p.m. R9's TAR indicated target behavior interventions for Seroquel included to code 1 for refusing to leave	F 605		

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F 605	Continued From page 16 her room and code a 2 for self-isolation. R9 had zeros and dashes for the day shift, evening shift, and had one behavior coded as a 1 on the night shift. The form lacked target behaviors of looking for her husband, children, or sister, wanting to go home, or looking for car keys to go to work. R9's MAR and TAR dated 5/1/25, to 5/15/25, indicated R9 received 25 mg at 4:00 p.m. R9's TAR indicated target behavior interventions for Seroquel included to code 1 for refusing to leave her room and code a 2 for self-isolation. R9 had zeros and dashes for the day shift, evening shift, and the night shift. R9's MAR and TAR dated 5/1/25, indicated new target behavior interventions for an antipsychotic, dated 5/15/25, that included code 1 for hallucinations, code 2 for looking for car keys to go to work, code a 3 for wanting to go home, code a four for looking for family (husband, children or sister). The day shift on 5/15/25, was coded as a zero for the number of behaviors. R9's consulting pharmacist recommendation to the physician dated 7/26/24, indicated R9 was discussed at IDT (interdisciplinary team) meeting and staff reported R9 had distress and agitation in the afternoon, mostly based on looking for her husband or other family and had some exit seeking and recommended increasing R9's Zoloft to 100 mg in the hope it would calm her and ease distress and then begin tapering off the Seroquel. The physician documented on 8/1/24, they disagreed with the pharmacist recommendation and indicated sundowning was a common behavior in R9's age group and recommended monitoring because R9 was in an environment she was not used to.	F 605		

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F 605	Continued From page 17 R9's consulting pharmacist recommendation to the physician dated 1/25/25, indicated R9 continued to perseverate on her husband and was distressed at times and was on Seroquel 25 mg daily which was not likely effective at that dose but was difficult to discontinue considering her distress and further, R9's dose of Zoloft was not optimized at 100 mg daily. The pharmacist recommended increasing the Zoloft up to 125 mg daily in the hope of alleviating R9's anxiety and distress thus allowing them to discontinue the high-risk antipsychotic. The physician agreed on 1/29/25, with the recommendation. The record was reviewed and lacked evidence a GDR for the Seroquel was attempted following the recommendation. R9's consulting pharmacist recommendation reports were reviewed for November 2024, December 2024, February 2025, March 2025, and April 2025 and lacked information a GDR was attempted. R9's Associated Clinic of Psychology (ACP) note dated 4/24/24, indicated staff did not identify any behavior changes, thought processes were scattered, but denied any distress in her life, and was in good spirits, compliant with medications and cares, and was well adjusted to the facility. R9's physician's progress note dated 4/2/25, indicated R9 had Alzheimer's disease and R9's daughter reported R9 had increased confusion and anxiety in the evening, calling R9's daughter multiple times and having delusions such as having job interviews. Further, the note indicated, R9's Zoloft was increased, but was not effective. Additionally, R9 was on Zoloft 100 mg daily and the dose was increased on 8/21/24, due to	F 605		

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F 605	Continued From page 18 ongoing evening anxiety behaviors, delusions, and wandering and was also on Seroquel 25 mg daily, and according to report, R9 was stable. R9's Behavior Management Follow Up form dated 12/9/24, indicated R9's targeted behavior was "going to other residents [sic] room and up and down". Further, the document indicated behavioral symptoms were exhibited in the evening and occurred daily, was easily altered. Non-pharmacological interventions included "calm her down" and measures included redirection and aromatherapy. The form indicated these interventions were effective following use of aromatherapy. Further, pharmacological interventions of Seroquel 25 mg were usually effective, and dose reductions had been attempted. An evaluation of R9's behavior symptoms indicated there was no change as compared to 90 days ago or last assessment and further indicated to continue the current plan of care. R9's Behavior Management Follow Up form dated 3/7/25, indicated a targeted behavior of wandering, but the form was not further completed to indicate when symptoms were exhibited, how frequent, whether behaviors were able to be altered. No other targeted behaviors were identified on the form. Further, no pharmacological and non-pharmacological interventions were identified and the form lacked information an evaluation of whether behaviors improved, declined, or stayed the same. R9's Behavior Management Follow Up form dated 4/8/25, indicated "N/A" under a heading, "Describe Resident's Specific Targeted Behavior". The form was not further completed to indicate	F 605		

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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 605	Continued From page 19 when symptoms were exhibited, how frequent, and whether behaviors could be altered. Further, no pharmacological and non-pharmacological interventions were identified or outcomes of interventions. A heading, "Evaluation" lacked information R9's behavioral symptoms improved, declined, or stayed the same. A heading, "Care Planning" indicated the facility would continue with the current plan of care. R9's Point of Care History form, dated 11/1/24, to 11/30/24, indicated R9 had verbal expressions of distress two times out of 90 opportunities and the behavior was easily altered. R9's Point of Care History form, dated 12/1/24 to 12/31/24, indicated R9 had verbal expressions of distress 1 time out of 93 opportunities that included negative statements and was not easily altered. R9's Point of Care History form, dated 1/1/25, to 1/31/25, indicated R9 had verbal expressions of distress 5 times out of 95 opportunities and behaviors were easily altered. R9's Point of Care History form, dated 2/1/25, to 2/28/25, indicated R9 had verbal expressions of distress including repetitive questions, 16 times out of 93 opportunities and behaviors were easily altered. R9's Point of Care History form, dated 3/1/25, to 3/31/25, indicated R9 had verbal expressions of distress 6 times out of 95 opportunities. R9 had a behavior of stating something terrible was going to happen on 3/20/25, and 3/22/25, was not easily altered, and all other behaviors were easily altered.	F 605		

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F 605	Continued From page 20 R9's Point of Care History form, dated 4/1/25, to 4/30/25, indicated R9 had verbal expressions of distress 16 times out of 98 opportunities and behaviors were easily altered. R9's Point of Care History form, dated 5/1/25, to 5/15/25, indicated R9 had verbal expressions of distress 9 times out of 49 opportunities and behaviors were easily altered. R9's progress note dated 3/22/24 at 6:03 p.m., indicated R9 went to other floors looking for her husband. R9's progress note dated 4/15/24 at 11:25 p.m., indicated R9 was confused and had hallucinations, was looking for her driver's license, needing to pick up her husband, looking for her mother and went down the elevator and tried to get out the main door. R9's progress note dated 6/8/24 at 7:23 p.m., indicated R9 was looking for her husband and wanted to go see him and headed towards the elevator multiple times trying to locate her husband and was redirected multiple times without effect. R9's progress note dated 12/19/24 at 2:12 p.m., indicated R9 was confused and was wandering in other rooms at the beginning of the shift. R9's progress note dated 1/28/25, indicated R9 moved to the Villa community (locked unit) of the facility from the Oakview unit. R9's progress note dated 4/11/25, indicated R9 asked about R9's sisters who are all deceased	F 605		

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F 605	Continued From page 21 and was surprised at the information. R9's progress note dated 4/23/25, indicated R9 was in a secure memory care unit and hospice IDT met to discuss the need for wander guard placement and determined the wander guard would be removed with agreement with IDT because R9's wandering decreased significantly since signing onto hospice. R9's progress note dated 4/28/25, indicated R9 was combative during cares and did not want to get up. R9's social worker (SW) documented two progress notes from 1/1/24, through 5/13/25. The SW progress note on 2/4/25 at 10:03 a.m., indicated the IDT reviewed interventions from a fall on 1/1/25. Further, R9's SW progress note on 4/17/25, indicated R9's wandering decreased significantly since signing onto hospice and R9's wander guard would be removed. During observation on 5/12/25 at 1:58 p.m., R9 was in bed and a bruise was noted on the right side of R9's face. During observation on 5/13/25 at 8:11 a.m., R9 was in bed snoring softly. During interview on 5/13/25 at 9:24 a.m., nursing assistant (NA)-H stated she was the usual NA in the Villa. Further, NA-H stated R9 refused cares one time approximately two weeks ago, but otherwise did not refuse cares and asked the nurse to administer pain medications and added R9 did not fight or resist. During observation on 5/13/25 at 2:02 p.m., R9	F 605		

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F 605	Continued From page 22 was in the dining room talking with a staff person and appeared content socializing. During interview on 5/14/25 at 2:09 p.m., the pharmacist consultant (PC) stated gradual dose reductions (GDRs) were completed twice in the first year and then one time after that and wanted to taper R9's Seroquel and was on Zoloft 125 mg. R9 was perseverating on her husband and stated there had not been a GDR request on the Seroquel because he wanted to increase the Zoloft before decreasing the Seroquel and added a GDR was not done if a resident had distress. Further, PC stated the social worker would have notes regarding resident's behaviors and stated he had monthly meetings with the facility and speaks with nursing staff on how a patient is doing and receives his information through the meetings and not the medical record. Further, PC stated R9's behavior of perseverating on her husband should be a part of R9's targeted behaviors. During interview on 5/15/24 at 10:45 a.m., nursing assistant (NA)-H stated R9 did not have behaviors and stated every now and then R9 talks about her husband but stated it did not cause her any distress. Further NA-H stated R9 might state she is looking for her husband and NA-H will tell R9 her husband is at work and R9 was easily redirected. During interview on 5/15/25 at 10:48 a.m., registered nurse (RN)-F stated R9's behavior was moving up and down and wanting to go out but has not done that for a few months and stated R9's family visited frequently. R9 was focused on looking for her husband but behavior improved after moving to the Villa. RN-F stated R9 was	F 605		

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F 605	Continued From page 23 easy to redirect and was not a combative person and did not ruminate since coming to the Villa. RN-F stated R9 moved to the locked unit on 1/28/25. When asked what R9's target behaviors were, RN-F stated R9's behaviors were asking for keys and looking for her husband. RN-F viewed R9's orders for target behaviors that were dated 5/15/25, and stated target behaviors for the antipsychotic were hallucinations, looking for car keys, wanting to go home, and looking for family and husband. During interview on 5/15/25 at 1:35 p.m., the director of nursing (DON) stated documentation for targeted behaviors was in the treatment administration record. The DON viewed R9's record for target behaviors that included refusal to leave the room and self-isolation from 2/28/24, and was discontinued on 5/15/25. The DON further stated targeted behaviors had been updated on 5/15/25, and stated they go over events every day and the targeted behaviors should have recent information and that was probably why the targeted behaviors were updated. The DON viewed the targeted behaviors from 5/15/25, that included looking for car keys, wanting to go home and looking for family and her husband and stated R9 was on hospice and was on the other unit prior to enrolling in hospice and was not aware R9 had a behavior of looking for her husband and further stated the pharmacist did not communicate that concern to anyone at the facility. The DON further stated the pharmacist communicates with the DON by going through resident's records and they also had behavior meetings where GDRs are discussed. A policy, Psychotropic Medication Use, dated	F 605		

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F 605	Continued From page 24 9/7/23, indicated psychotropic medications are used when ordered by medical providers after medical, physical, functional, psychological, emotional psychiatric, social and environmental causes of behavioral expressions have been identified and addressed. Psychotropic medications are given upon a medical provider order. The nursing associates collaborate with the medical provider to ensure the lowest possible dosage is given for the shortest period of time and are subject to gradual dose reductions and re-review. When resident exhibits expressions or indications of distress that interfere with daily living, the licensed nurse and or members of the IDT identify target behaviors, discuss and implement non-pharmacological interventions (i.e. aromatherapy, therapy doll, music, comforting touch, comforting foods, etc. When psychotropic medications are ordered, the IDT identifies target behaviors, medication side effects to be monitored and implements a resident centered care plan with both non-pharmacological and pharmacological interventions. GDRs begin within the first year in which a resident is admitted with or is newly prescribed a scheduled psychotropic medication. GDR is attempted in two separate quarters (with at least one month between the attempts), unless clinically contraindicated and documented by the medical provider. Contraindications may include the continued use is in accordance with relevant current standards of practice and the medical provider has documented the clinical rationale for why any attempted dose reduction would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying psychiatric disorder; or the resident's target symptoms returned or worsened after the most recent attempt at a GDR within the facility	F 605		

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F 605	Continued From page 25 and the medical provider has documented the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. The IDT team monitors the resident condition and target behaviors for efficacy of the medications and any clinically significant adverse consequences. Documentation will reflect implementation of the above.	F 605		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide timely incontinence care for 1 of 1 resident (R62) reviewed for activities of daily living (ADL). Findings include: R62's discharge Minimum Data Set (MDS) dated 3/28/25, indicated intact cognition and diagnoses of quadriplegia, traumatic rupture of cervical intervertebral disc (C5-6), spinal stenosis, and neurogenic bladder. It further indicated R62 required substantial assistance with toileting, was always incontinent of urine, and received a diuretic on routine basis. R62's care plan dated 4/25/25, indicated the potential for alteration of bowel and bladder	F 677	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Staff involved were counseled on the	6/30/25

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F 677	Continued From page 26 related to a diagnosis of a neurogenic bladder and included an intervention of R62 requiring 2-person assistance to use the toilet upon rising in the morning, before and after each meal, bedtime, on night rounds, and as needed. R62 also required assistance with all toileting tasks and used brief/pads for incontinence protection indicating he was not able to reliably notify staff of his need to be toileted. During interview on 5/12/25 at 5:25 p.m. R62 stated he had to wait 20-45 minutes (on average)almost every time he needed to use the urinal. Since his spinal cord injury, he doesn't have much notice when having to urinate and often ends up urinating in his brief. When that happens he then had to wait long periods of time sitting in his urine or feces. R62 also stated he had reported this to RN-E and the DON but nothing ever happened to fix the problem stating "It's a culture here to not help each other out. I put my call light on and wait for staff to respond. When they don't respond, I go out into the hallway (in my wheelchair) to get help and I am often told by staff they're not my aide and then continue to play on their phone." During observation on 5/14/25 at 7:04 a.m., the following events occurred: -7:15 a.m. R62 put his call light on. -7:28 a.m. NA-E answered call light for another resident whose room was in close proximity to R62's room (exited the room at 7:34 a.m.) but failed to answer R62's call light when she was finished assisting the other resident. -7:35 a.m. NA-F was walking down the hall towards R62's room with the vital signs (VS) machine. NA-F entered the room and asked R62 what he needed because his call light was on. He	F 677	failure to respond timely to R62's toileting and incontinence needs and also re-educated on the resident plan of care. R62's care plan was reviewed and revised to have R62 receive immediate assistance in the morning from the nightshift staff. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. A comprehensive audit of all residents needing toileting assistance and/or are incontinent was completed. Residents with similar care needs were assessed to ensure they are receiving ADL services according to their care plans. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Nursing associates were re-educated on the Resident Rights & Notification of Resident Rights policy with emphasis on sections regarding resident dignity and plan of care. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee will audit incontinence care for 2 residents weekly for a period of 6 weeks. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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F 677	Continued From page 27 stated he had to urinate but he already urinated in his brief because he couldn't hold it. NA-G stated that was okay, proceeded to take his blood pressure, then left the room stating "I will come back later and get you up when she's (unknown) done." -7:45 a.m. NA-F assisted another resident with a shower. -8:01 a.m. registered nurse (RN)-D entered R62's room with medications, blood sugar monitor, and stethoscope. RN-D asked his name, date of birth, took his VS, tested his blood sugar, administered his medications, and gave him a nebulizer treatment. RN-D did not change R62's brief. -8:30 a.m. RN-D exited R62's room. -8:34 a.m. R62 stated RN-D did not change him while she was in his room and that he put his call light on at 7:15 a.m. when he first had to go to the bathroom. -8:40 a.m. R62 put on his call light again. -8:42 a.m. NA-F answered R62's call light and R62 stated he was still waiting for his brief to be changed. NA-F changed his brief (which was visibly full of urine) and removed the pad underneath him which was also visibly wet. During interview on 5/14/25 at 9:15 a.m. NA-F verified R62 told her he had urinated in his brief when she answered his call light at 7:35 a.m. NA-F stated was waiting for the nurse to go in and do what she needed to do but should have changed him right away before the next call light went on. During interview on 5/14/25 at 9:30 a.m. RN-D stated anyone can answer call lights but it was usually the NA's who answer them. They try to answer call lights within 15 minutes and if a resident stated they need to be changed, staff	F 677		

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F 677	Continued From page 28 should try to do that immediately or as soon as possible and changing a brief would take precedence over giving a resident a shower. RN-D further stated NA's are assigned to a group of residents but the other NA's are expected to answer the call lights and help each other out. If the nurse needs to administer medications or perform cares, etc. they can wait if a resident needed to be changed. RN-D verified she did not change R62 when she was in his room because she was unaware he needed to be changed. There was no reason he needed to wait to be changed until after she was done working with him. During interview on 5/14/25 at 2:00 p.m. NA-D stated NA's are assigned to a certain group of residents and "we stick with our residents, unless someone is really busy, but everyone can help." NA-D further stated they try to answer call lights within 15 minutes and changing a residents brief should be done before giving a resident shower. An hour was too long for a resident to wait to have their brief changed and stated 10 minutes should be the longest they should have to wait unless they were really busy. During interview on 5/15/24 at 10:56 a.m., the director of nursing (DON) stated he did not think an hour was too long for a resident to have to sit in a wet brief and there wouldn't be any negative outcomes as a result (specifically skin breakdown). The DON further stated changing a resident's brief didn't necessarily take precedence over giving another resident a shower and would depend on the situation. He was unable to provide an approximate amount/range of time he would expect a resident's call light to be answered or a resident's brief to be changed	F 677		

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F 677	Continued From page 29 (once they put their call light on.) A facility policy reagrding ADL's was requested but not received.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate monitoring was in place for 1 of 1 residents (R60) who sustained an injury during a transfer reviewed for safe resident handling. In addition, the facility failed to ensure tube feeding (TF) was administered and maintained per provider orders. Findings include: R60's quarterly Minimum Data Set (MDS) dated 3/10/25, indicated she had intact cognition and required partial-to-moderate assistance for bed mobility but was dependent on staff for transfers. The MDS identified diagnoses of a cerebrovascular accident or CVA (a stroke, or an episode of insufficient blood supply to the brain caused by either a blood clot or abnormal bleeding), and hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis) and aphasia	F 684	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The staff conducted neurovascular assessments, including circulation, movement and sensation (CMS) checks	6/30/25

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F 684	Continued From page 30 (a language disorder caused by injury to the brain). R60's Care Area Assessment (CAA) dated 6/16/24, for Activities of Daily Living (ADLs) triggered related to her needing assistance with cares and mobility related to her CVA with left-sided hemiparesis. The CAA indicated she required 2 staff assist with bed mobility and transfers and directed staff to "proceed to the plan of care". R60's treatment administration record (TAR) dated 4/2025 reflected the following orders: - "NWB L arm every shift," dated 4/25/25 (where "NWB" denoted "non-weight bearing"). - "Ok for ice pack on L shoulder Q1 hr" as needed, dated 4/25/25 (where "L" denoted "left" and "Q1 hr" denoted "every 1 hour"). - "Sling L arm - on day off in bed x 2 weeks" for left humerus fracture, dated 4/25/25 - 5/9/25. Her TAR dated 4/25 was reviewed 5/14/25 and lacked documentation of neurovascular assessments of her left upper extremity. Neurovascular assessments would include an evaluation of the color, temperature, capillary refill or circulation, palpable pulse, edema or swelling, sensation, motor function or strength, and pain to her left upper extremity compared to both her baseline and her right upper extremity. R60's TAR dated 5/25 reflected the following orders: - "ensure L) arm in sling at all times every shift,"	F 684	during each shift and after every sling application for R60. Nursing staff received re-education on proper pain assessment following patient transfers and on the importance of elevating the limb as ordered. All tube feeding supplies, including formula bags, tubing, cylinders and syringes, were replaced and labeled correctly as of 5/15/25. Patient R37's nutrition and hydration status were monitored. No infections or adverse outcomes were noted. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. A comprehensive audit of all residents requiring transfer assistance, mobility support, feeding tubes or enteral feeding orders was conducted to identify and address any gaps in care. No other residents were found to have undocumented neurovascular checks or improper tube feeding setups. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Re-education was provided to nursing staff including RNs, LPNs and CNAs on neurovascular assessment standards (CMS checks). Re-education was provided to licensed nursing staff on the Infection Prevention & Control Manual as it pertains to G-tube care protocols.	

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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 684	Continued From page 31 dated 5/12/25. - "NWB L arm every shift," dated 4/25/25. - "Ok for ice pack on L shoulder Q1 hr" as needed, dated 4/25/25. - "Sling L arm - on day off in bed x 2 weeks" for left humerus fracture, dated 4/25/25 - 5/9/25. The TAR dated 5/25 was reviewed 5/15/25 and lacked documentation of neurovascular monitoring. A provider progress note dated 4/29/25 indicated she was seen for follow-up sustaining an injury from a "transfer via hoyer". The progress note referenced the x-ray dated 4/24/25, which showed the proximal humerus fracture, and indicated R60 was having "unrelieved pain" and "did not appear comfortable". The progress note identified under the "Assessment/Plan:" header the plan was to consult orthopedics, "OK to ice", non-weight bearing status to left upper extremity, wear a sling "24/7" and have a follow-up x-ray in 4 weeks. R60's electronic health record (EHR) was reviewed 5/14/25 and lacked documentation of neurovascular monitoring of her left upper extremity. During observation and interview on 5/12/25 at 4:54 p.m., R60 was lying in her bed without a sling on her left arm. She stated while she was getting into bed, "I heard a big crack, it hurt." R60 stated she was "okay" to have the sling off while in bed but needed to have staff assist her with putting it on when out of bed. She stated not a lot	F 684	Education was also provided using the Tube Feeding Standing Order Set including daily change and labeling requirements of bags, tubing, syringes and cylinders. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The DON/designee will conduct weekly audits on 2 residents per week requiring neurovascular documentation, sling compliance and/or tube feeding system changes for a period of 6 weeks. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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F 684	Continued From page 32 of staff knew how to put the sling on. She stated she broke her left shoulder, which was the side affected by her stroke. She stated she felt staff were doing a "pretty good job" at managing her pain, however, were not offering her ice packs anymore, which was something she would like to have for pain management. During observation on 5/13/25 at 9:24 a.m., R60 was up in her wheelchair and requested to lay down. She pushed her call light at 9:25 a.m. and at 9:29 a.m., registered nurse (RN)-E and nursing assistant (NA)-Q entered her room to answer her call light. After performing hand hygiene, donning gloves and providing for privacy, NA-Q retrieved the lift sling from the back of the door and asked her to lean forward and began tucking the sling behind and down her back. NA-Q pulled the sling straps under her legs, first under her right hip and through the front of her right leg and then NA-Q repeated the steps on the left side. NA-Q walked across the room and pulled the ceiling mechanical lift from one side of the room over to above R60 and used the remote to lower the lift. RN-E asked her to hold onto her left hand and guided her to her affected left hand in the sling. NA-Q crisscrossed the sling straps in the front and hooked the sling straps up to the mechanical lift before using the remote to lift her up from the wheelchair. The bottom hem of the sling was above her sacral level; however, her head was above the top hem and there was no slipping observed during the transfer. Together, RN-E and NA-Q pushed her over top of her bed and NA-Q used the remote to lower her onto the bed. R60 made an "ouch" noise during the transfer and NA-Q asked her if she was okay, and she answered, "yeah". RN-E and NA-Q assisted her to turn to the side to tuck the sling, and then to sit	F 684		

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F 684	Continued From page 33 forward. Together, they removed the sling out from behind her. RN-E stated she had a stroke and only had "one working arm and hand" and had always transferred with a mechanical body lift. NA-Q provided the call light within her reach, lowered the bed and gave her a stuffed animal. There was no offer to elevate her left arm on a pillow and no assessment of her pain prior to staff exiting the room, however, R60 did not report her pain to staff. During observation and interview on 5/14/25 at 11:49, R60 was wearing her sling and stated she had not been offered ice for her shoulder. R60 stated she had numbness and tingling in her left hand and fingers that was not her baseline. The color in her left fingers was normal per her race and she indicated the strength in her moveable index finger felt "the same" as before the fracture. R60 stated staff had not asked her about the sensation or strength in her left hand or arm, and family member (FM)-J endorsed this. FM-J stated they visited R60 often and had not heard staff asking about sensation, movement, temperature or strength to her affected arm. During interview on 5/14/25 at 12:08 p.m., nurse practitioner (NP)-H reviewed previous documentation and stated she had a proximal left humerus fracture and recent follow-up imaging showed the fracture was "more prominent", which NP-H explained meant there was no evidence of healing on the x-ray. NP-H stated the x-ray results "probably means the matrix hasn't formed yet and it's still a fracture." NP-H further explained the matrix formed after a fracture began to heal and formed a callus, and the follow-up x-ray did not show such a callus. NP-H indicated she was "non-compliant with her sling" and stated when	F 684		

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F 684	Continued From page 34 she was wearing the sling, "she's moving it around a lot", referring to her left upper extremity. NP-H indicated her follow-up x-ray was sent to geriatric orthopedics and physical therapy (PT) and occupation therapy (OT) for further evaluation. NP-H hoped PT/OT could evaluate her for a better fitting wheelchair that would promote better positioning for her arm to "help elevate it" and maintained ice and elevation remained appropriate interventions for her fracture. During interview on 5/14/25 at 2:26 p.m., registered nurse (RN)-E expected staff to monitor for pain and swelling and stated initially, R60 was using ice for pain management but "now when we ask she says no, she does not want ice." RN-E expected staff to elevate her affected arm on a pillow and to perform a neurovascular assessment (circulation, movement, sensation or CMS) and indicated the assessment should be documented in progress notes. RN-E reviewed her progress notes and was unable to locate such documentation. RN-E reviewed her treatment orders and indicated there was an order to assess previously but stated, "it fell off, it looks like. It was on there from before, so they were documenting that from before, but it fell of." RN-E confirmed there was no current documentation or order in place and stated there should be. During interview on 5/15/25 at 11:54 a.m., the director of nursing (DON) stated assessing for neurovascular changes (CMS changes) after a fracture was a standard of practice and expected staff to perform the assessment when applying R60's sling per orders. The DON reviewed her orders and identified the order to ensure her sling was on at all times or "24/7". When asked what	F 684		

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F 684	Continued From page 35 part of the order directed staff to assess her neurovascular status or for CMS changes, the DON stated the order did not state specifically to monitor, however, identified progress notes in which staff documented swelling in her shoulder and discomfort. When asked about documentation of sensation, temperature, pulses, color, and strength, the DON indicated staff should be charting by exception. A request was made for documentation of staff's assessment of her neurovascular status or CMS after the fracture, however this information was not received. During interview on 5/15/25 at 12:45 p.m., licensed practical nurse (LPN)-B stated NAs put R60's sling on in the morning, "but I can put it on, too". LPN-B stated, "there's an order in there I mark off every day if its on or not." LPN-B stated for a resident who sustained a fracture, "I look for signs of swelling at the site of fracture, signs of infection, like redness and warmth, and I assess for pain." LPN-B stated they could compare it to the other side to see how it looked and would document that if noted. During interview on 5/15/25 at 12:50 p.m., NA-M stated NAs normally applied her sling in the morning and confirmed applying that morning stating, "I heard they were having trouble with her sling this morning, so I helped with it." A policy pertaining to monitoring and/or assessing post-accident or fracture was requested but not available and not received.	F 684		

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F 684	Continued From page 36 Feeding Tube R37's quarterly Minimum Data Set (MDS) dated 4/8/25, indicated R37 was cognitively intact, was dependent on staff for all activities of daily living (ADLs), and required a FT for nutrition. R37's diagnoses included dysphagia (difficulty swallowing) and nutritional deficiency, R37's care plan dated 5/13/24, indicated R37 had swallowing difficulty related to severe esophageal dysphagia and required nutrition provided using a feeding tube through a G-tube. R37's care plan instructed staff to check residual every four hours, flush G-tube with water before and after medications, maintain FT materials, not allow formula to hang longer than eight hours at room temperature, and change set up daily. R37's provider orders included the following: -Diet: NPO (nothing by mouth) except small sips of water-4/17/25 -Diet: tube feeding 45cc per hour for 22 hours Novasource renal-5/13/25 -Ensure formula bag for enteral feed has time and date on bag. Discard formula and replace every 24 hours-10/29/22 -Hold tube feeding between 5:00 a.m. and 7:00 a.m.-4/4/25 -Change bag, tubing, and syringe daily-1/12/23 -Flush G-tube with 30cc water before and after each medication-2/3/22 During observation on 5/12/25 at 12:29 p.m., R37 in bed with TF running with a pump. There was one bag of formula and one bag of water flush. A graduated cylinder containing a syringe sat on the dresser with other supplies. The cylinder was dated 5/4 at 0430 (4:30 a.m.).	F 684		

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F 684	Continued From page 37 During observation on 5/13/25 at 8:14 a.m., R37 was lying in bed. Cylinder with syringe on dresser dated 5/12/25. No TF or water bag hanging on pole and pump turned off. During observation on 5/13/25 at 9:46 a.m., R37 was sleeping in bed. Still no TF being administered. During observation and interview on 5/13/25 at 10:13 a.m., registered nurse (RN)-A into R37's room to administer medications. R37 stated, "It's time to hook me up to my food, isn't it?" meds. RN-A administered medications using the syringe and cylinder date 5/12/25 and then hung a new bag of tube feeding formula, tubing and water flush. RN-A labeled both bags with date and time. RN-A stated the date on the cylinder reflected when the cylinder and the syringe were last changed, in this case 5/12/25. RN-A could not state how often they needed to be changed and stated, "I will have to check on that" and left the room. R37 stated her TF had been turned off and disconnected at about 5:00 a.m. and should have been restarted by now. During interview on 5/13/25 at 10:36 a.m., RN-A stated the cylinder and syringe were supposed to be changed daily and proceeded to date a new cylinder and placed in R37's room. During observation of 5/14/25 at 7:18 a.m., a full bag of TF hanging with water flush bag but pump not on and tubing not attached to R37. Neither TF bag nor water bag dated. Cylinder with syringe sitting on dresser dated 5/13.	F 684		

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F 684	Continued From page 38 During observation on 5/15/25 at 8:10 a.m., cylinder with syringe labeled 5/13, water bag now labeled 5/14/25- 8:00 a.m. TF bag not dated. During observation and interview on 5/15/25 at 8:25 a.m., licensed practical nurse (LPN)- A stated the TF bag and tubing should be changed out every 24 hours and was on the treatment administration record (TAR) for the evening shift to complete. LPN-A stated evening shift will leave the bag up since there was still TF formula left in it, in which case nights or days would change it. LPN-A stated if the formal runs out and the bag had not reached 24 hours, they will just add more TF formula to the hanging bag. LPN-A stated she added the label to the water bag yesterday at 8:00 a.m., but could not confirm when the bags or tubing had been changed prior to that time since they were not dated. LPN-A stated the entire set up including the bags, tubing, cylinder and syringe should be changed every 24 hours and should be labeled with the date and time of change. LPN-A confirmed the cylinder with syringe was dated 5/13 and should have been changed yesterday (5/14/25). LPN-A stated she would change out the whole set up this morning and label everything appropriately. During interview on 5/15/25 at 10:09 a.m., RN-B stated staff should change TF materials including bag, tubing and syringe every 24 hours and all should be labeled to indicate the date and time of change. RN-B stated the TF materials change was scheduled for evening shift, but not always done on that shift, which made it very important to indicate the date and time of change. RN-B stated TF materials should not be used for longer than 24 hours due to the increased risk of bacterial growth and possible infection.	F 684		

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F 684	Continued From page 39 During interview on 5/15/25 at 10:40 a.m., director of nursing (DON) stated expectation for staff to administer and maintain TF per provider orders. DON referred to facility policy and stated TF materials should be changed out every 24 hours and labeled with date and time when changed. DON stated TF materials used greater than recommended time could lead to bacterial growth and could cause infection. Facility policy Gastrostomy "G" Tube Use, undated, indicated syringe and administration set should be changed every 24 hours. The policy further indicated, "On the formula label document initials, date and time the formula was hung/administered."	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe resident handling for 2 of 2 residents reviewed for accidents (R47, R60). Furthermore, the facility failed to reassess and, if needed, develop new interventions to reduce the risk of injury during resident handling for 1 of 1 residents (R60) who sustained an injury during a transfer at the facility.	F 689	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies.	6/30/25

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F 689	Continued From page 40 In addition, the facility failed to ensure fall interventions were implemented for 1 of 1 resident (R9) reviewed for falls. Findings include: R47 R47's quarterly Minimum Data Set (MDS) dated 4/8/25, indicated he had intact cognition, required partial-to-moderate staff physical assistance for bed mobility and was dependent on staff for transfers. The MDS reported diagnoses of a cerebrovascular accident or CVA (a stroke, or an episode of insufficient blood supply to the brain caused by either a blood clot or abnormal bleeding), and hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis) and aphasia (a language disorder caused by injury to the brain). R47's Care Area Assessment (CAA) dated 1/13/25 for Activities of Daily Living (ADLs) was triggered related to needing assistance with "cares and mobility due to CVA" and left-sided hemiplegia, in addition to other co-morbidities. The CAA indicated he required extensive assist of 2 with "bed mobility, transfers (EZstand), and toileting" and directed staff to "proceed to the care plan for risk". A safe lifting and movement assessment dated 4/8/25, indicated R47 was able to bear weight as tolerated to is upper and lower extremities but was unable to stand safely for 8 seconds without any assistive devices. The assessment identified his hemiplegia and pain as physical limitations to a safe transfer and recommended "two person transfer with Stand Assist Lift". The assessment	F 689	The plan of correction is prepared and/or executed in accordance with federal and state law requirements. 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R60 was assessed by nursing and therapy after the reported incident. Pain management plan was updated including scheduled and PRN analgesics. A post-incident safe lifting and mobility reassessment was conducted on 4/23/25 by unit nurse manager. Correct sling size and application technique were also reviewed and validated by the unit nurse manager. Transferring techniques for R47 were observed and corrected in real-time. A competency validation on safe repositioning was completed for all involved CNAs. Care plan for R9 was audited to ensure all fall interventions were in place. Staff members involved were re-educated on R9’s fall prevention strategies, including but not limited to ensuring resident is seated in an anti-roll back wheelchair. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Care plans were reviewed for all residents dependent on staff for transfers or mobility and updated as necessary. The implementation of fall prevention interventions for all residents identified as	

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F 689	Continued From page 41 indicated the lift manufacturer recommendations for correct harness size and his care plan was reviewed. R47's care plan last revised 2/26/25 identified his alteration in mobility related to his need for assistance with mobility due to CVA and left-sided hemiplegia, among his other co-morbidities. The care plan directed staff "assist 2 with transfers (EZs Stand). The care plan also identified he was susceptible for abuse related to residing in a skilled nursing facility (SNF) and directed staff to provide a safe environment for him and follow his plan of care to ensure for safety. An undated nursing assistant (NA) care sheet identified R47 required assist of 2 with an "EZ Lift". During a continuous observation on 5/13/25 between 11:19 a.m. and 11:41 a.m., R47 was in his wheelchair and was in a laid-back position. NA-B pulled R47's wheelchair from a table and NA-D locked the brakes on the wheelchair. NA-D used their foot to push the pedal on his wheelchair that said "TILT" and the wheelchair reclined backwards. NA-B and NA-I stood in front of R47 facing him and each of the NAs put one of their arms under one of his arms until they were under his shoulder joint on either side. The NAs counted to three and together they lifted him in an upwards and backwards motion so his buttocks was off of the wheelchair seat and he was boosted up in his wheelchair. NA-B asked, "are you alright?" and NA-D unlocked the brakes on the wheelchair, used their foot to press the "TILT" pedal and the wheelchair was moved forward in an upright position. NA-D pushed his wheelchair back to the table.	F 689	“Falling Star” or as a high fall risk was reviewed and verified for accuracy. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All nursing staff received re-education on post-incident documentation and reassessment requirements. Re-education was also provided on Safe Patient Handling and Falls Prevention and Reduction policy. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. DON/designee will conduct 2 resident audits weekly on post incident documentation involving fractures for a period of 6 weeks. Will audit 2 residents weekly with repositioning orders for a period of 6 weeks. Will audit 2 residents weekly with fall interventions for a period of 6 weeks. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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F 689	Continued From page 42 At 11:40 a.m., R47's was in his wheelchair in a semi-reclined/laid-back position. At 11:41 a.m., he was in his wheelchair outside of the elevator doors and waiting for the elevator. The NAs reclined his wheelchair using the "TILT" pedal and locked the brakes on the wheelchair. NA-B and NA-I stood facing him and each of the NAs put one of their arms under one of his arms until they were under his shoulder joint. Next, the NAs each put their other arm under one of his legs, each positioning their hand above his knee joint in the middle of his upper leg on his thigh. The NAs together lifted him in an upwards and backwards motion in the wheelchair and R47 groaned out as the NAs performed the maneuver. When the NAs finished, he was sitting upright in his wheelchair. During interview on 5/13/25 at 11:45 a.m., NA-D confirmed the observation stated he "always sides down in his chair" and indicated staff used the observed positioning maneuver "or sometimes we pull the waist of his pants" to pull him up. NA-D stated he had weakness on his left side and said staff "grab very gently and then we pull him". NA-D stated staff used the "TILT" pedal on his wheelchair to recline him because it allowed staff to pull him back easier in his chair as well as helped keep pressure off his backside. NA-D stated he required 2 staff assistance for his transfers and had to be repositioned "like, every 10-15 minutes" because he would slide down "that way" in his wheelchair. NA-D explained to position him, staff would lay the chair all way back, support his head with pillows if he was in his room, use their arms to support his weak side "because his weak side does not go up, so we have to support that side and we position him that way". NA-D stated it was important to be mindful	F 689		

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 _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 43 of his weak side during positioning because his weak side was painful and if staff were not cautious, "he will scream". NA-D demonstrated his weak side's restricted range of motion (ROM) and stated he would scream if staff were not careful. Per interview on 5/13/25 at 3:18 p.m. with the director of physical therapy (PT)-I, the recommended approach to reposition a resident in a wheelchair would be to use a gait belt and pull their hips back against the edge of the chair. PT-I stated if the resident had a "tilt and space" wheelchair, staff could tilt the wheelchair back and "let gravity take effect" to assist with the repositioning. When asked if it would be appropriate to reposition a resident as observed by pulling a resident upwards and backwards by their underarms, PT-I stated depending on the resident's body physical characteristics, like body shape, height and weight; if staff had good support from the legs, "you could boost someone like that, but it shouldn't be the primary method. I would recommend trying to get a gait belt under and behind the resident so they can get support from the trunk area instead of under the arms. PT-I indicated the observed method of positioning R47 should be reserved a last resort for boosting/positioning. PT-I stated there are "a lot of nerves" under a person's shoulder and indicated there could be potential for injury. Per interview on 5/14/25 at 7:25 a.m., registered nurse (RN)-E stated staff should not position or boost a resident by their arms as observed because of the risk of bodily harm to the resident or themselves. RN-E stated all staff underwent safe lifting education and if management observed such positioning or boosting, were	F 689		

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F 689	Continued From page 44 expected to provided education on the spot and provide re-education to the involved staff, which would "go in their file". RN-E expected staff to position a resident with their hips or the appropriate lift as identified on their care plan as opposed to under their arms. RN-E indicated NA-B and NA-D would be educated regarding appropriate positioning techniques. Per interview on 5/15/25 at 12:34 p.m., the director of nursing (DON) stated staff were trained on more appropriate ways to position a resident. R60 Findings include: R60's quarterly Minimum Data Set (MDS) dated 3/10/25, indicated she had intact cognition and required partial-to-moderate assistance for bed mobility but was dependent on staff for transfers. The MDS identified diagnoses of a cerebrovascular accident or CVA (a stroke, or an episode of insufficient blood supply to the brain caused by either a blood clot or abnormal bleeding), and hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis) and aphasia (a language disorder caused by injury to the brain). R60's Care Area Assessment (CAA) dated 6/16/24, for Activities of Daily Living (ADLs) triggered related to her needing assistance with cares and mobility related to her CVA with left-sided hemiparesis. The CAA indicated she required 2 staff assist with bed mobility and transfers and directed staff to "proceed to the plan of care".	F 689		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 689	Continued From page 45 A safe lifting and movement assessment dated 3/5/25, indicated R60 was unable to bear weight in her upper and lower extremities and was not able to stand safely for 8 seconds without holding onto an assistive device. The assessment identified her hemiparesis as a physical limitation to safe transfers and recommended "two person transfer with full lift". The assessment also indicated lift manufacturer recommendation were reviewed to ensure for correct sling size and her care plan was reviewed. R60's care plan last revised 3/11/25, identified her alteration in mobility related to her needing assistance with mobility due to her CVA and left-sided hemiparesis, among her other co-morbidities. The care plan direct staff to transfer her using the "ceiling lift" and 2-person assistance. The care plan also identified she had a fracture to her left humerus (the long bone going from the shoulder to the elbow in the upper arm) "due to and not limited to pathological bone changes, which was identified by a provider on an x-ray," dated 5/12/25. A North Star mobile X-ray patient report dated 4/24/25, indicated the x-ray results or findings were "a proximal humeral fracture is identified just beneath the humeral head. Inferior medial displacement of the distal fracture fragment is noted." A "proximal humeral fracture" is a fracture or break in the upper arm bone near the shoulder joint. A progress note dated 4/22/25 indicated it was "recorded as Late Entry on 4/24/25 5:29 p.m." and reported "resident complain of pain writer assess resident note resident was lying on her	F 689		

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F 689	Continued From page 46	F 689		

side, writer reposition resident vitals are stable, administer two Tylenol 500mg as staff continue to monitor."

A progress note dated 4/23/25 at 10:59 a.m., indicated the writer was updated on R60's "painful shoulder" and during an assessment, the left shoulder was "swollen, warm and tender to touch" and had limited mobility due to pain. The progress note indicated she denied falling and utilized assistance of 2 with a mechanical lift for transfers. The progress note identified she received Tylenol for pain which was effective. The progress note reported her NP was updated.

An additional progress note dated 4/23/25 at 1:45 p.m., indicated R60 complained of pain when staff were assisting her with dressing and "she was unable to move her left arm". The progress note indicated Tylenol was administered and an ice pack was applied to her left shoulder, her NP and family were updated.

A progress note dated 4/26/25 indicated the interdisciplinary team (IDT) reviewed an incident "that occurred on 4/22/25 around [sic] while staff assisted with cares." The progress note indicated staff were interviewed on 4/22/25 and "while two staff members assisted the resident from her wheelchair into bed using a ceiling lift" R60 heard a "crack" sound she stated came from her left shoulder. The progress note indicated a nursing assistant (NA) notified the nurse "promptly" of her "complaint" and a nurse assessed her and "found that the resident experienced pain associated with the popping sound during the transfer". The progress note indicated the nurse "administered 1000 mg of Tylenol." The progress note continued, "on April 23, 2025, the resident

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

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F 689	Continued From page 47 continued to report pain in her left shoulder during morning care assistance provided by nursing assistants." R60's nurse practitioner (NP) was updated regarding her reports of pain and limited range of motion (ROM) to her left upper extremity and ordered an x-ray and pain management plan including "acetaminophen 1000 mg three times daily, tramadol 25 mg as needed every four hours, and the application of ice packs." The progress note indicated she took "omeprazole, a proton pump inhibitor that increases the risk of bone fractures." The progress note stated staff would continue to monitor her condition and update the provider as needed but lacked documentation of further assessment of R60's safe lifting and movement to determine if new interventions were necessary to reduce the risk of future injury during transfers. R60's electronic health record (EHR) was reviewed on 5/15/25 and lacked documentation of post-incident safe lifting and movement assessment. During observation and interview on 5/12/25 at 4:54 p.m., R60 was lying in her bed without a sling on her left arm. She stated while she was getting into bed, "I heard a big crack, it hurt." R60 stated she was "okay" to have the sling off while in bed but needed to have staff assist her with putting it on when out of bed. She stated not a lot of staff knew how to put the sling on. She stated she broke her left shoulder, which was the side affected by her stroke. She stated she felt staff were doing a "pretty good job" at managing her pain, however, were not offering her ice packs anymore, which was something she would like to have for pain management.	F 689		

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F 689	Continued From page 48 During observation on 5/13/25 at 9:24 a.m., R60 was up in her wheelchair and requested to lay down. She pushed her call light at 9:25 a.m. and at 9:29 a.m., registered nurse (RN)-E and nursing assistant (NA)-Q entered her room to answer her call light. After performing hand hygiene, donning gloves and providing for privacy, NA-Q retrieved the lift sling from the back of the door and asked her to lean forward and began tucking the sling behind and down her back. NA-Q pulled the sling straps under her legs, first under her right hip and through the front of her right leg and then NA-Q repeated the steps on the left side. NA-Q walked across the room and pulled the ceiling mechanical lift from one side of the room over to above R60 and used the remote to lower the lift. RN-E asked her to hold onto her left hand and guided her to her affected left hand in the sling. NA-Q crisscrossed the sling straps in the front and hooked the sling straps up to the mechanical lift before using the remote to lift her up from the wheelchair. The bottom hem of the sling was above her sacral level; however, her head was above the top hem and there was no slipping observed during the transfer. Together, RN-E and NA-Q pushed her over top of her bed and NA-Q used the remote to lower her onto the bed. NA-Q asked her if she was okay and she answered, "yeah". RN-E and NA-Q assisted her to turn to the side to tuck the sling, and then to sit forward. Together, they removed the sling out from behind her. RN-E stated she had a stroke and only had "one working arm and hand" and had always transferred with a mechanical body lift. NA-Q provided the call light within her reach, lowered the bed and gave her a stuffed animal. During observation and interview on 5/14/25 at 11:49, R60 was wearing her sling and family	F 689		

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F 689	Continued From page 49 member (FM)-J stated being told she had a fracture that wouldn't require surgery but could not recall if the facility had reported how the fracture occurred. FM-J stated, "I was not told how this happened, only that the injury occurred." FM-J stated preference for wanting to know what happened to have caused to injury. FM-J stated, "the day it happened, I wasn't here when it happened, I was here beforehand, and after she told me about the pain." FM-J indicated the "nursing supervisors" was notified the following day and "decided R60 needed a doctor to look her over and he decided she need an x-ray and ice pack." FM-J denied concern with the facility's management of her pain. FM-J and R60 would not recall which nurse or NA were working when she sustained the injury. FM-J indicated he was not present for many transfers but stated "they tell me and I have witnessed on a few occasions them using the ceiling lift." During interview on 5/14/25 at 12:08 p.m., NP-H reviewed previous documentation and stated R60 was "transferring and she heard a pop." NP-H stated she had a proximal left humerus fracture recent follow-up imaging showed the fracture was "more prominent", which NP-H explained meant there was no evidence of healing on the x-ray. NP-H stated the x-ray results "probably means the matrix hasn't formed yet and it's still a fracture." NP-H further explained the matrix formed after a fracture began to heal and formed a callus, and the follow-up x-ray did not show such a callus. When asked if taking omeprazole could be a contributing factor to her fracture as identified in the IDT progress note dated 4/24/25, NP-H confirmed it could be, however stated it would be "kind of a weak argument, but maybe". NP-H expected staff involved in the incident to	F 689		

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F 689	Continued From page 50 have been "interrogated". NP-H stated, "I would be curious about the body mechanics; how was she transferred; was it with the lift?" NP-H indicated her follow-up x-ray was sent to geriatric orthopedics and physical therapy (PT) and occupation therapy (OT) for further evaluation. During interview on 5/14/25 at 12:28 p.m., NA-O stated staff could locate a resident's transfer status on the NA care sheet. NA-O stated staff should read their assignment sheet "first thing" to determine if a resident's care has changed. NA-O stated they also received shift report with pertinent resident care information and staff could ask questions during report if they were unsure. During initial interview on 5/14/25 at 2:06 p.m., NA-B indicated she was not working on the day of R60's incident and could not recall any details from the incident. NA-B stated R60 had been at the facility for a long time and at times, would refuse cares, like a shower or getting up in the morning. NA-B stated she did not have physical or verbal behaviors related to her refusal of cares and stated, "she will tell you what she wants." During interview on 5/14/25 at 2:26 p.m., RN-E recalled R60 complaining of shoulder pain when "I came in the morning". RN-E assessed and interviewed her to determine what happened and FM-J stated, 'they were transferring you and you said you heard something pop'. RN-E indicated reporting the incident "immediately" to the supervisor and initiating an investigation. RN-E stated the NA said when they heard the pop, the nurse was notified. When the nurse went to assess her, FM-J was there and R60 complained of pain and was given Tylenol. RN-E stated on-the-spot education was provided to the NAs	F 689		

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F 689	Continued From page 51 involved regarding how to choose the appropriate sling size, how to know if staff were using the correct sling size and who to report to if staff felt a transfer was not safe. RN-E stated, "we went together, and I asked them to show me how to check the sling size," and indicated the NAs performed a teach-back of an appropriate transfer of R60. RN-E stated the NAs involved were interviewed right away after the incident was reported and education was provided over the phone initially. RN-E stated staff were expected to follow the plan of care for transfers and safe resident handling and indicated staff received safe patient handling education yearly. During interview on 5/15/25 at 8:41 a.m., the director of physical therapy (PT)-I stated ceiling lift transfers should always be performed with two people. PT-I explained the proper ceiling lift transfer technique to assist a resident from a chair to the bed was to get the sling under them and ensure it was centered. Next, staff should get the two leg pieces under the resident's legs and cross them over each other (in a crisscross fashion). Next, PT-I stated the sling's loops should be hooked up to the lift according to the color associated with the resident's preferred position (for example, a particular color loop was associated with a more upright position while the other color was associated with a more reclined position). PT-I continued to explain once sling was centered, the leg straps were hooked up, the upper body loops should be hooked up and one person could operate the lift while the other person maneuvered the resident's body to ensure for their safety, being mindful of their limbs. PT-I stated contributing factors to a resident's risk for injury, like a shoulder fracture, during a ceiling lift transfer, could include if a resident had brittle	F 689		

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F 689	Continued From page 52 bones or other diagnoses, the resident's position in the sling, and inappropriate sling size. PT-I stated, "I don't see a way that could happen if the proper procedure was followed." During follow-up interview on 5/15/25 at 8:41 a.m., NA-B confirmed working with R60 during the incident and stated when RN-E interviewed staff about the incident, "I told her the next day when RN-E asked that it was two people in to do that." NA-B reported two staff transferred her with the ceiling lift per her care plan and denied hearing a "popping" or "cracking" sound as R60 reported hearing. NA-B stated, "when we transferred on the ceiling lift, we were there with 2 and we put her to bed, the wheelchair was close to the bed, but it was two people that did that." During interview on 5/15/25 at 9:38 a.m., licensed practical nurse (LPN)-C was unsure what day she assessed R60 after the injury but recalled she had swelling in her shoulder and "I gave her some Tylenol, I think I applied some ice." LPN-C asked her if she could lift her arm, and she stated she could not because it hurt. LPN-C stated the information was passed along to the next shift. During interview, NA-M was sitting nearby and indicated it was the following day because it was "my morning shift." During interview on 5/15/25 at 9:40 a.m., NA-M confirmed being R60's assigned NA on the day LPN-C was recounting during interview and indicated it was the day following the initial incident. NA-M stated, "I went to get LPN-C because when I touched her arm she said ouch, so I covered her back up and immediately went to get the nurse." NA-M stated "nobody on night shift" reported anything about her having pain.	F 689		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 689	Continued From page 53 NA-M stated R60 did not have physical behaviors and stated she "says 'no' if she don't [sic] want something, but she doesn't get aggressive with cares." NA-M stated if a resident was care planned to use a mechanical lift for a transfer, "we should be doing that to keep the resident safe." During interview on 5/15/25 at 11:54 a.m., the director of nursing (DON) recounted, "We asked the patient if the transfer was rough, she said 'no.' ... I checked the sling size to confirm it was the right size. It was medium, which she uses, and it was the right size of the sling." The DON continued and stated the NAs were brought in and shown "the right way to put the sling on," and were provided on-the-spot education about the incident, but it was not considered disciplinary action. The DON reported staff also received annual safe resident handling education. The DON indicated staff performed an investigation into R60's accident but was unable to identify or provide documentation of an identified root cause analysis of the incident. The DON stated staff assessed sling size appropriateness using the lift manufacturer's guidelines and stated the facility did not have their own assessment tool. The DON indicated R60's sling was "visually" inspected after the accident to determine it was the appropriate sling size. The DON stated RN-E had "handwritten" documentation of the sling assessments and safe lifting and movement assessment post-accident but was unable to provide such documentation when requested. A facility education form dated 4/23/25 was reviewed on 5/15/25 at 2:06 p.m. and indicated NA-B and NA-D received education regarding the ceiling lift and safe resident transfers after R60's	F 689		

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

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F 689	Continued From page 54 accident. A request was made for the ceiling lift's manufacturer's instruction manual and/or sling guidelines but was not received. Per undated facility policy titled Safe Lifting and Movement of Residents copyright 2024, all communities used appropriate techniques and devices to lift and move residents in order to protect the safety and well-being of associates and residents, and to promote quality care. The policy indicated safe lifting and movement of residents was part of an overall Safe Patient Handling program and indicated associates would be observed for competency in using mechanical lifts and observed periodically for adherence to polices and procedures regarding use of equipment and safe lifting techniques. R9's significant change Minimum Data Set (MDS) dated 4/11/25, indicated severe cognitive impairment, did not reject cares, used a wheelchair, and required substantial assist with toileting hygiene, and partial to moderate assist with dressing. Further, R9's vision was adequate with glasses. R9's care area assessment (CAA) dated 4/14/25, indicated R9 triggered for falls due to needing assist with cares, mobility, toileting due to multiple diagnoses and received Seroquel for psychotic disorder with delusions, and Zoloft for depression. R9's optional state assessment (OSA) dated 4/11/25, indicated R9 required assist with bed mobility, transfers, and toileting.	F 689		

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 _____	C 05/15/2025

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F 689	Continued From page 55 R9's Facesheet undated, indicated the following diagnoses: rheumatoid arthritis, Myelodysplastic syndrome, weakness, history of falling, and Alzheimer's disease. R9's Active Orders form indicated the following orders: 3/20/24, Seroquel (an antipsychotic) 25 milligram (MG) tablet orally daily at 4:00 p.m. 1/2/25, hip protector on at all times every shift. 1/29/25, Zoloft (an antidepressant) 125 mg orally every a.m. 4/4/25, Admit to Allina Hospice with a primary diagnosis of vascular dementia. R9's medication administration record (MAR) and treatment administration record (TAR) dated April 2025, indicated starting 2/5/25, and ending 4/22/25, R9 required night staff to check on the resident, prepare her, and bring her to the dining room for monitoring before the end of their shift to prevent falls. R9's care plan dated 4/14/25, indicated R9 had good vision and required assistance with her glasses as needed, additionally R9 had an intervention to assist with vision exams as needed. R9's care plan dated 4/14/25, indicated R9 had an alteration in activities of daily living (ADLs) due to needing assist with cares and required assist of one with bathing, dressing grooming. Additionally, R9 required her call light be within reach. R9's care plan dated 4/14/25, indicated R9 had an alteration in mobility and required one assist with transfers, her wheelchair, and ambulation.	F 689		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 689	Continued From page 56 R9's care plan dated 4/14/25, indicated R9 was on the Falling Star program, and was at risk for falls due to needing assist with cares, mobility, toileting, and had a history of frequent falls due to multiple diagnoses. R9's goal was to remain free from falls with injury and had the following interventions: essential oils as needed, night staff check on the resident, prepare her, and bring her to the dining room for monitoring before the end of the shift, anti-roll backs on wheelchair, ensure R9 wore her glasses and that they were clean and in good repair, keep call light in reach at all times, keep the bed in the lowest position to allow feet to be flat on the floor with the brakes locked, give verbal reminders not to ambulate or transfer without assist, wears hip protector at all times to minimize injury, provide proper, well maintained footwear, provide an environment free of clutter, keep personal items and frequently used items within reach, and toilet per plan of care. R9's care plan dated 4/14/25, indicated R9 required assist with toileting upon rising, before and after meals, at bedtime, on night rounds, and as needed. R9's care plan dated 5/12/25, indicated R9 was at high risk for falling due to dementia and overall decline and interventions included fall prevention reduction precautions per facility protocol, monitor side effects of medication: cardiac medication as ordered. Narcotic pain medication as ordered. Monitor for side effects such as dizziness, lethargy, increased confusion, decreased respirations and report to the provider, and toilet per the urinary bowel section of the care plan. R9's Villa Team Report sheet dated 4/22/25, and	F 689		

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F 689	Continued From page 57	F 689		

provided by registered nurse (RN)-F on 5/12/25 at 12:08 p.m., indicated R9 was a falling star, ensure resident is in bed in the early hours, hip protector at all times, and night staff to check on the resident, prepare her, and bring her to the dining room for monitoring before the end of their shift.

R9's Team 1 Villa Assignments sheet, undated, indicated R9 was at high risk for falling, was a falling star, required assist of one for dressing, grooming, toileting, and staff were to offer to toilet every three hours and as needed and the night staff were to check and toilet patient before their shift ended and bring R9 to the dining room for monitoring. Further, the form indicated R9 always needed her call light and personal items in reach with the bed in the low position, gripper socks on when in bed, hip protector at all times, and could not be left unattended on the toilet or in the room unless sleeping. Further, the form indicated R9 required anti-roll backs on the wheelchair, and staff needed to monitor the bruise on R9's right forehead.

R9's Event Report dated 2/4/25 at 9:37 a.m., indicated R9 was in her room when she fell trying to go to the bathroom. Further, R9 took 9 or more medications including antidepressants, antihypertensives, and antipsychotics and had fallen previously on 1/1/25. Additionally, R9 was on the floor behind the door and was last seen at 7:10 a.m. R9's interdisciplinary team (IDT) reviewed the fall on 2/5/25, and determined the night staff would check on the resident, prepare her, and bring her to the dining room for monitoring before the end of their shift, as she was an early riser and preventative measures to avoid fall injuries would continue, such as utilizing

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F 689	Continued From page 58 hip protectors. R9's Event Report dated 2/18/25, indicated R9 fell in her room. R9 was in her wheelchair in the hallway prior to the fall and R9 stated the entrance of the door slipped her and she fell. Under a heading, "Possible Contributing Factors" indicated R9 had confusion. Under a heading, "Drug Review-Does resident use any of the following types of medications?" indicated check boxes for various medications including antidepressants, analgesics, and antipsychotics. Additionally, there was a check box for "None of above". The information was undocumented. Under a heading, "Notes", indicated R9 was in the hall and wheeling her wheelchair around her room prior to the fall. R9 was on the floor and the wheelchair was far away from the resident. R9 was transferred to her wheelchair and brought to the dining room to prevent another fall and on 2/19/25 at 12:29 a.m., was escorted to the hospital. Further, the IDT reviewed R9's fall and determined to prevent injuries from frequent falls, R9 wore a hip protector additionally, plans were in place to install an anti-roll back device on R9's wheelchair. Further, the Event Report indicated IDT met on 3/4/25, and evaluated the effectiveness of interventions related to R9's fall on 2/18/25 and determined therapy was not appropriate and would implement hip protectors and install an anti-rollback device on R9's wheelchair. R9's Event Report dated 5/11/25, indicated R9 fell from her wheelchair in the dining room at 7:04 p.m., and sustained a bump on her right forehead. IDT reviewed R9's fall on 5/12/25, and indicated R9 was in the dining room using her wheelchair when another resident came up from	F 689		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 59 behind and pushed R9's wheelchair causing R9 to fall and interventions implemented included providing the other resident with a stroller and a doll when showing a tendency to push other residents. R9's Post Fall report dated 3/10/24, indicated R9 fell going to the bathroom to brush her teeth and was re-educated on using her call button for help. R9's Post Fall report dated 1/2/25, indicated R9 fell backward in her room and under a heading, "EVALUATION" indicated, "Call light not use". Further, measures taken to prevent further falls included frequent checks and assist R9 with toileting per the care plan. R9's Post Fall report dated 2/5/25, indicated R9 was in bed prior to falling, took antidepressants and antihypertensives, and last fell on "1/7/202". Further, R9 was at risk for falls due to dementia, and not getting resident up early when she is up, and staff would get resident up when she is up and toilet R9 to prevent falling. R9's Post Fall report dated 2/19/25, indicated R9 was sitting on the floor when staff members entered the room and was previously in her wheelchair, complained of chest pain and was sent to the ED for further evaluation. R9's Post Fall report dated 5/12/25, indicated R9 had a witnessed fall in the dining room from her wheelchair, did not take 9 or more medications, took antidepressants, and narcotics. Under a heading, "EVALUATION" was left undocumented and under a subheading, "Describe measures to be taken to prevent further falls" was left undocumented.	F 689		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 689	Continued From page 60 During observation on 5/12/25 at 1:58 p.m., R9 was in bed and her call light was on the floor under the bed on the side closest to the door. R9's wheelchair was unlocked and approximately two to three feet from the foot of the bed next to the room divider curtain and parallel to the foot of the bed. R9 had a bruise on the right side of her face. During interview on 5/12/25 at 3:13 p.m., family member (FM)-K stated there was another resident on the floor and did not know if the resident was pushing R9 or went to push R9 and scared her, but R9 fell out of her wheelchair and hit her head on the table. FM-K stated the facility updated her and further, did not indicate if there were any new interventions to prevent falls. FM-K stated when R9 lays down, staff provide a call light and clip it so R9 can see it, but didn't know if R9 understood what it was. Further, FM-K stated FM-K stated R9 lost her glasses three weeks ago and has been without glasses since. FM-K further stated she told SW-A on 5/9/25, he had to do something because R9's glasses still had not been found. During observation on 5/13/25 at 8:11 a.m., R9's door was closed. During observation on 5/13/25 at 8:12 a.m., R9 was in bed and her wheelchair was located by her closet and next to a garbage can and unlocked. R9's call light was on the floor under her bed and on the side closest to the door and there was a clip on the call light cord. R9's glasses were not located on the nightstand. During interview and observation on 5/13/25 at	F 689		

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F 689	Continued From page 61 8:35 a.m., nursing assistant (NA)-H entered R9's room and checked on both residents and was going to leave the room and stated she got the residents up when they were awake and further stated they were both not early persons. NA-H stated R9 sometimes woke up early and stated R9 used her call light. NA-H verified R9's call light was on the floor and picked the call light up and clipped it to R9's sheet. During interview and observation on 5/13/25 between 8:57 a.m., and 9:17 a.m., NA-H went into R9's room and asked if she was ready to get up and offered clothing. At 8:59 a.m., NA-H left the room and stated she would be right back. R9 did not have glasses on. At 9:01 a.m., NA-H asked R9 to go to the bathroom and donned R9's shoes, but did not tie the laces. At 9:01 a.m., NA-H applied a gait belt and at 9:02 a.m., NA-H assisted to stand R9 and pivot transfer her to the wheelchair. R9's shoelaces were dragging on the floor. NA-H did not apply any glasses. At 9:03 a.m., NA-H assisted R9 to stand in the bathroom using the sink and registered nurse (RN)-F entered the room. R9 sat down on the toilet and her shoes were still untied. At 9:06 a.m., NA-H verified R9's shoes were untied and stated she would tie the shoes. At 9:08 a.m., NA-H donned R9's pants and hip protector and at 9:19 a.m., assisted resident to sit down again in her wheelchair. R9 did not have glasses on. During interview and observation on 5/13/25 at 9:24 a.m., R9 did not have anti tips or rollbacks on her wheelchair. NA-H stated R9 refused cares one time a couple of weeks ago because she did not want to get up. NA-H stated she looked to the care sheet to know what cares a resident required and pulled out a care sheet that	F 689		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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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F 689	Continued From page 62 indicated the night shift was to check and toilet patient before the shift ended and bring R9 to the dining room for monitoring and stated the night shift ended at 7:00 a.m. Further, NA-H stated if a resident refused, they documented and let the nurse know and verified R9's care sheet indicated nights were supposed to get R9 up. NA-H stated R9 was a falling star and staff had to keep an eye on the falling star person and added there was a time when R9 would wake up early and then they brought her to the dining room to keep an eye on her for safety and stated she guessed R9 was sleeping and that was why they didn't get R9 up. NA-H stated they don't close the door 100% for safety. NA-H stated she could not provide a copy of her care sheet. During interview on 5/13/25 at 9:35 a.m., RN-F stated the aides used care sheets and further, care plans were updated and then they printed new care sheets. RN-F stated a blue star indicated a patient fell a few times and call it a falling star. During interview on 5/13/25 at 9:47 a.m., RN-F stated the care plan should be followed and if care deviated from the care plan they would have to document the deviation. RN-F stated R9's glasses have been missing and stated they looked in the laundry and couldn't find them and the social worker (SW)-A was aware. RN-F stated R9 should have her call light in bed and stated once in a while she used it and R9 probably shook the bed. RN-F verified R9's care plan indicated night staff were to check on R9, prepare her and bring her to the dining room for monitoring before the end of their shift and stated if R9 was awake then nights would get R9 up. RN-F verified R9 did not have antiroll backs on	F 689		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 63	F 689		

her wheelchair and verified R9's care plan indicated R9 required antiroll backs. Further, RN-F stated they normally kept doors ajar to check on residents.

During interview on 5/13/25 at approximately 1:50 p.m., social worker (SW)-A stated he was aware R9 was missing her glasses and had been missing a couple of weeks and would check to see if R9 was signed up for HealthDrive and verified R9 had signed up for HealthDrive on 3/3/23.

During observation on 5/13/25 at 2:02 p.m., R9 was in the dining room and did not have glasses on and did not have the antiroll backs on the wheelchair.

During interview on 5/13/25 at 2:45 p.m., NA-P stated he worked on 5/11/25, and witnessed R9 was sitting in her wheelchair and used her feet to move the chair and was trying to get past the threshold when another resident came from behind to push R9 forward in her chair and stated R9 fell out of her chair. NA-P stated they had strollers for the other resident so the other resident wouldn't push residents.

During interview on 5:13/25 at 3:30 p.m., the director of nursing (DON) stated he expected staff follow the care plan and if interventions were no longer relevant expected interventions be discontinued. Further the DON stated interventions implemented should reflect on the care plan and nursing assistant assignment sheet and stated R9 had anti roll backs on her wheelchair in February because R9 tried to stand and the chair moved backward and stated the intervention for R9's chair was in place unless

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 689	Continued From page 64 they washed the chair, or if hospice changed R9's chair. The DON stated the SW-A was working on the concern of R9's missing glasses. At 3:42 p.m., the DON checked R9's wheelchair and verified she did not have anti roll backs. A policy, Integrated Fall Management, undated, indicated fall risk assessment, identification and implementation of appropriate interventions as necessary to maintain resident safety, prevent falls, and reduce further injury from falls. Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment. The IDT reviews the fall and care plan changes and may, if needed, implement additional interventions. Documentation of the above items is completed.	F 689		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow up on reported grievances in a timely manner for 1 of 2 residents (R9) reviewed for grievances. Findings include: See also F689 related to falls. R9's significant change Minimum Data Set (MDS) dated 4/11/25, indicated severe cognitive	F 745	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	6/30/25

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 745	Continued From page 65 impairment, did not reject cares, used a wheelchair, and required substantial assist with toileting hygiene, and partial to moderate assist with dressing. Further, R9's vision was adequate with glasses. R9's optional state assessment (OSA) dated 4/11/25, indicated R9 required assist with bed mobility, transfers, and toileting. R9's Facesheet undated, indicated the following diagnoses: rheumatoid arthritis, Myelodysplastic syndrome, weakness, history of falling, and Alzheimer's disease. R9's care plan dated 4/14/25, indicated R9 had an alteration in ADLs and required assist of one with dressing, and grooming. R9's care plan dated 4/14/25, indicated R9 had an alteration in mobility and required assist of one with transfers and ambulating. R9's care plan dated 4/14/25, indicated R9 had vision, and interventions indicated to assist with glasses as needed, and provide vision exams as needed. R9's care plan dated 4/14/25, indicated R9 was on the facility Falling Star program and was at risk for falling due to multiple diagnoses. R9's goal was to be free from falls with injury and interventions included ensuring R9 wore her glasses and that they were clean and in good repair. R9's care sheet undated, lacked information R9 wore glasses.	F 745	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident R9 was seen by Health Drive Eye Care Group on 06/03/2025. Replacement prescription eyeglasses were recommended at this time and ordered by family. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Facility audit was completed of all residents listed as requiring prescription eyeglasses for full time use to verify they had access to them. No other prescription eyeglasses were identified as missing by residents. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. Re-education was provided to nursing and social services staff pertaining to the Missing Items policy and the Concerns/Grievances policy. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. 20% of the facility's residents listed as requiring prescription eyeglasses for full	

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

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F 745	Continued From page 66 R9's HealthDrive Eye Care Group note dated 2/28/25, indicated R9's daughter reported R9 had a bad fall the week prior and was in the hospital. Further, R9 required full time use of glasses for distance and reading. R9's progress notes were reviewed from 3/10/25, to 5/15/25, and lacked documentation on any efforts the facility made to locate R9's glasses or that R9 was missing her glasses. A form, Customer Concerns Database, dated 2/13/25, through 5/13/25, was provided by the facility that included a list of residents in various units with various concern types including missing items. The form was reviewed and lacked information R9 was missing any items. A form, Lost Items Log dated 2025, was provided by the facility on 5/13/25 at 10:54 a.m., that indicated a list of residents with missing clothing items and the dates reported along with various notes whether items were found or if staff searched for the missing items. The form was reviewed and lacked information R9 was missing any items. A form, Combined Federal and State Bill of Rights, dated 6/18/19, indicated the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, and other concerns regarding their LTC (long-term care) facility stay. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance	F 745	time use will be audited each week for a total of 5 weeks. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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 _____	C 05/15/2025

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F 745	Continued From page 67 with this paragraph. The facility must make information on how to file a grievance or complaint available to the resident. The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights. The grievance policy must include, notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally or in writing, the contact information of the grievance official with whom a grievance can be filed, a reasonable expected time frame for completing the review of the grievance, the right to obtain a written decision regarding his or her grievance, and the contact information of independent entities with whom grievances may be filed including the state agency, quality improvement organization, State survey agency, and the State Long Term Care Ombudsman program. Further, the policy must identify the grievance official, as necessary take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, ensure all written grievance decisions including the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued, and maintain evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision. A form, Grievance Notice, dated 11/2022, indicated residents had a right to file grievances	F 745		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 745	Continued From page 68 orally or in writing, and the right to file grievances anonymously. Further, the form indicated social worker (SW)-A was the community's grievance officer responsible for receiving grievances. Additionally, the form indicated the grievance officer generally acknowledges receipt of grievances within one business day and generally completes review of the grievance within five business days. The form provided a list of independent agencies with whom grievances may be filed including the Minnesota Department of Health (MDH), Livanta LLC (Medicare Beneficiary and Family Centered Care Quality Improvement Organization), and the Minnesota office of Ombudsman for Long-Term Care. An undocumented Customer Concern form provided by SW-A on 5/13/25 at approximately 1:50 p.m., indicated a facility feedback investigation form that included an area for documenting the resident's name, the person voicing the concern and their phone number, a description of the concern with a request to include all details, including dates, times and description, the date and time of the event, the expected outcome, and the staff person who received the concern. During interview on 5/12/25 at 3:13 p.m., family member (FM)-K stated R9 used to go into other resident's rooms and lie down and would take off her glasses. FM-K stated R9 lost her glasses three weeks ago and has been without glasses since. FM-K further stated she told SW-A on 5/9/25, he had to do something because R9's glasses still had not been found. During observation on 5/13/25 at 8:12 a.m., R9 was in bed snoring softly and did not have	F 745		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 745	Continued From page 69 glasses on her nightstand. During interview and observation on 5/13/25 between 8:57 a.m., and 9:19 a.m., nursing assistant (NA)-H entered R9's room and asked if she was ready to get up. R9 did not have her glasses on. At 9:01 a.m., NA-H donned R9's shoes, but did not tie the laces and at 9:02 a.m., NA-H assisted to stand R9 to pivot transfer into her wheelchair. R9's shoelaces were dragging on the floor during the transfer. NA-H did not apply any glasses. At 9:19 a.m., NA-H completed assisting R9 in the bathroom and R9 did not have her glasses on. During interview on 5/13/25 at 9:35 a.m., registered nurse (RN)-F stated they updated care plans and printed care sheets for the aides to know what cares a resident required and stated R9 required assist with all cares and further stated R9 had a blue star that indicated she fell a few times and was called a falling star. During interview on 5/13/25 at 9:47 a.m., RN-F stated staff were supposed to report missing items to SW-A and they look for the items by checking rooms and looking in the laundry and document the missing item. RN-F stated R9 was missing her glasses, and they could not locate them and stated R9's daughter was aware R9's glasses were missing and further stated SW-A was also aware of the missing glasses. RN-F viewed R9's care plan and stated it would be important for R9 to have her glasses because she was a falling star and was important to prevent falls. During interview on 5/13/25, at approximately 1:50 p.m., SW-A stated if nursing or the front	F 745		

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F 745	Continued From page 70 desk was aware of a missing item, they provide a missing item form to the resident or family, and SW-A will put the forms in a customer concerns data base and stated he did not have any concerns in the data base at this time. SW-A viewed the data base and verified nothing was documented in the database and mentioned another two residents with glasses missing and a resident with missing hearing aides and stated the residents he mentioned already had plans in place and stated staff notify him of missing items and will go through the resident's room, the med cart and common spaces and then would get entered in the data base once identified as missing and they conducted a walk through a few days later. SW-A stated he was aware R9 was missing her glasses and stated he could add it in the data base and was working with the family to try to locate her glasses. SW-A further stated it had been a while and would confirm R9 was on the list for HealthDrive and stated HealthDrive sends the facility a list of residents to see and stated he would check to see if R9 was signed up for the actual service. SW-A viewed R9's chart and verified R9 signed up for the HealthDrive service as of 3/3/23, but not because her glasses were missing, and further stated R9's glasses had been missing for a couple of weeks and stated it was his fault for not putting the information in there. SW-A stated R9 needed her glasses and verified the Concern log, was their grievance log and the purpose for completing the form was to ensure concerns were followed up on and to let residents know they are addressing concerns and added it was like a physical reminder. SW-A stated Concern forms were located by the elevators and the front desk and provided a concern form and verified he had not completed a form for R9.	F 745		

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F 745	Continued From page 71 During interview on 5/13/25 at 3:42 p.m., the director of nursing (DON) stated grievances should be documented immediately and expected staff follow up immediately. During interview on 5/15/25 at 12:34 p.m., the administrator, (A)-C stated she had been at the facility about four weeks and stated if something could not be resolved in the moment, it was considered a grievance and further stated lost glasses didn't consist of a concern, but stated she expected a reasonable timeframe would be within a week to let someone know the status of a missing item and further stated SW-A was working on R9's missing glasses. During interview on 5/15/25 at 2:10 p.m., A-C stated she revisited with SW-A and confirmed the family was aware of the missing eye glasses for a while and when asked about the expectation for following up with the family on the status A-C stated SW-A chatted with family on 5/14/25, and let them know they were going to have the optometrist come in and provide R9 an eye exam. A policy, Concerns, Grievances, dated 6/29/22, indicated the purpose was to create an environment where resident and customer concerns were solicited and readily resolved. Further, a resident/customer/resident representative has the right to voice grievances and concerns without discrimination or reprisal and without fear of discrimination or reprisal. The term "voice concerns" is not limited to a formal, written grievance process, but may include a resident's verbalized concerns to staff. The community view customer concerns as a primary method to learn of and meet customer	F 745		

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F 745	Continued From page 72	F 745		

expectations. In keeping with this belief, staff is trained to obtain and respond to resident/resident representative customer concerns. The community assures that after receiving a concern, there is a prompt response by the associates to acknowledge the receipt of the concern, investigate, seek a resolution, and keep the resident appropriately apprised of progress toward resolution. When a resident, resident representative, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards the form to the social services department/Grievance Officer/designee. Completed forms are processed in a timely manner. The SW checks the confidential container daily, removes the completed forms, logs the concern, and routes the copy to the staff responsible to acknowledge, investigate, and resolve the concern. The SW assigns the concern to an associate accountable for the work area and the staff person responsible acknowledges receipt of the concern with the resident/resident representative/customer within 24 hours or the next working day, in the event of a holiday or weekend and documents acknowledgement. The staff person responsible investigates, resolves the issue, and responds back to the customer within five business days and documents action. If more time is needed for a resolution, the customer is updated on the status until resolution. Documentation in the medical record, when applicable, reflects the concern, plan for addressing, and follow-up of the resolution. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement

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F 745	Continued From page 73 as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.	F 745		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the daily cleaning schedule was followed in the kitchen. During observation on 5/12/25 at 12:05 p.m., the kitchen floor was visibly soiled with dirt, there were multiple footprints, food spills, it was sticky, and there were copious amounts of food particles pushed down into the grout of the floor.	F 812	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and	6/30/25

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F 812	Continued From page 74 During observation and interview on 5/14/25 at 10:37 a.m., the kitchen floor was visibly soiled with dirt, there were multiple footprints, food spills, it was sticky, and there were copious amounts of food particles pushed down into the grout of the floor. The director of dining services (DDS) verified the floor was dirty and stated kitchen staff were responsible for mopping the floor daily. During interview on 5/14/25 at 11:04 a.m., dietary aide (DA)-A stated the dishwasher was responsible for mopping the kitchen floor every day and verified the floor was dirty stating "It had been a while" since it had been cleaned. During interview on 5/15/25 at 10:47 a.m., the administrator stated the kitchen staff were contracted employees, it was their responsibility to clean the kitchen, and she expected them to be following their cleaning schedule and their policies. The cleaning schedule for the kitchen titled "Back of the House Cleaning Log" for the month of May 2025, indicated the kitchen floor should be swept and mopped daily. It further indicated the last time the floor had been swept and/or mopped was on 5/10/25. A facility policy regarding the cleaning schedule for the kitchen was requested and received, however did not address cleaning of the floor or frequency.	F 812	state law requirements. 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Kitchen floor was cleaned thoroughly on 5/16/25. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. Kitchen floor was cleaned thoroughly on 5/16/25. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All contracted culinary services employees were trained on the Daily Floor Cleaning procedures required for each area of the Main Kitchen including How to Sweep Floors and Sanitizing Wash & Walk. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. Audits will be conducted 2 times weekly for a period of 6 weeks to ensure the ongoing compliance with daily floor cleaning procedures. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880		6/30/25

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 _____	C 05/15/2025

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F 880	Continued From page 76 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene practices for 2 of 2 residents (R62, R59) observed during personal cares. In addition, the facility failed to ensure appropriate room assignment for 6 of 10 residents (R26,R23,R136,R74,R12,R11) reviewed for transmission based precautions (TBP). Also, the facility failed to ensure consistent and appropriate personal protective equipment (PPE) use for 5 of 10 residents (R11,R12,R73,R76, R59) reviewed	F 880	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	

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 _____	C 05/15/2025

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F 880	Continued From page 77 for TBP and staff handling soiled laundry. Findings include: Room Assignment From CDC website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes | LTCFs | CDC "Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. The resident is given dedicated equipment (e.g., stethoscope and blood pressure cuff) and is placed in a private room. When private rooms are not available, some residents (e.g., residents with the same pathogen) may be roomed together. Residents on Contact Precautions are recommended to be restricted to their rooms except for medically necessary care, including restriction from participation in group activities. Contact Precautions are generally intended to be time limited and, when implemented, should include a plan for discontinuation or de-escalation." Facility provided infection precautions for Transmission Based Precaution (TBP) list printed 5/14/25, indicated R12, R26, and R136 were on contact precautions due to Methicillin-resistant Staphylococcus aureus (MRSA). The list did not indicate R11, R23, and R74 were on contact precautions.	F 880	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Contact precautions for residents R12, R26 and R136 were reviewed and removed based on their diagnoses and CDC guidelines. Residents determined to not require Transmission-Based Precautions (TBP) no longer share rooms with those who do require precautions. Staff members specifically identified as not following proper procedures for hand hygiene and use of PPE, including NA-F, NA-I and NA-J, received re-education on 5/14/25 according to Benedictine's Infection Prevention and Control Plan (IPCP). 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All other residents with contact based and/or transmission-based precaution (TBP) orders were reviewed to ensure compliance and appropriateness. Residents who were colonized with MRSA in their nares but showed no respiratory or cold symptoms were removed from contact precautions. Residents requiring transmission-based precautions, including those with MRSA, were either cohorted appropriately or placed in private rooms in accordance with CDC guidelines.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

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F 880	Continued From page 78 Facility provided infection precautions for Enhanced Barrier Precautions (EBP) list printed 5/14/25, indicated R23 was on EBP due to a urinary catheter. Resident census dated 5/12/25, indicated R26 and R23, R136 and R74, and R11 and R12 shared double occupancy rooms. During interview on 5/14/25 at 12:50 p.m., infection preventionist (IP) and director of nursing (DON) stated ideally residents not requiring TBP should not be sharing a room with residents who do require TBP. In the example where a resident on contact precautions for MRSA shared a room with a resident not on contact precautions, the whole room should be treated with contact precautions and staff would need to gown and glove prior to entrance into the room. During interview on 5/15/25 at 11:03 a.m., IP stated R23 was on EBP due to a urinary catheter and was considered high risk for contracting a facility acquired organism, R23 should not be sharing a room with R26 who was on contact precautions due to MRSA. Facility policy Contact Precautions dated 9/2023, indicated resident placement would be made on a case by case basis, and consideration would be given to risk of transmission to a roommate. Considerations included, "Cohort residents who are infected or colonized with the same pathogen." Additional considerations included, "Avoid placing residents on Contact Precautions in the same room with residents who have conditions that place them at risk of adverse outcomes, should they become infected - or that may facilitate transmission. This includes, but is	F 880	3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. All nursing and laundry staff were provided re-education on the facility's hand hygiene protocols, proper PPE use and donning/doffing procedures. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The facility's IP/designee will conduct an audit of 2 residents weekly on contact and/or transmission based precautions to ensure compliance for a period of 6 weeks. The use of proper hand hygiene, PPE usage and donning/doffing during care and support services will be conducted 2 time weekly for a period of 6 weeks. The audit results will be reviewed by the Quality Council to determine if further action is needed.	

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 _____	C 05/15/2025

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F 880	Continued From page 79 not limited to: ...Those with any form of tube - foley catheter, G/J tube for feeding." TBP R11 and R12 R11's admission Minimum Data Set (MDS) dated 4/23/25, indicated R11 was cognitively intact, was dependent on staff for many activities of daily living (ADLs), and had a fracture of the right shoulder. R11's care plan dated 4/17/25, lacked evidence of need for any transmission based precautions (TBP). R11's provider orders lacked evidence of need for any TBP. R12's quarterly MDS dated 4/15/25, indicated R12 was cognitively intact, required substantial/maximal assistance with most ADLs, occasionally incontinent of bowel and bladder, and had a recent hip replacement. R12's diagnoses included MRSA infection, infection and inflammatory reaction due to internal right hip prosthesis, and bacteremia. R12's care plan dated 5/14/25, indicated R12 was on isolation contact precautions due to MRSA of the urine. R12's care plan indicated R12 would be isolated to the room to prevent spread of the infection. The care plan further instructed staff to "wash hands, wear gown, mask, gloves and goggle as needed to prevent spread of infection." R12's provider order dated 1/10/25, indicated, "Contact Isolation ESBL [extended-spectrum	F 880		

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F 880	Continued From page 80 beta-lactamase-an enzyme produced by a bacteria that causes resistance to several antibiotics], MRSA [methicillin-resistant staphylococcus aureus-a staph bacteria resistant to many antibiotics]. Facility resident census indicated R11 and R12 shared a double occupancy room. During observation on 5/13/25 at 8:53 a.m., signage indicating "Contact Precautions" was posted outside R11/R12's room. An unidentified housekeeper was cleaning the room and was not wearing a gown. Director of spiritual care also in the room speaking to R11 and was not wearing any PPE. During observation on 5/13/25 at 8:54 a.m., nurse practitioner (NP) entered R11/R12's room and did not don any PPE. During observation on 5/13/25 at 9:21 a.m., activities personnel (A)-A entered R11/R12's room without donning PPE. A-A asked both invited both residents to attend morning exercise group upstairs. Both declined. During observation on 5/13/25 at 9:53 a.m., A-A entered R12's room and did not perform hand hygiene and did not don any PPE. A-A invited R12 to a different activity and R12 accepted. A-A pushed R12 out of the room to the elevator. During interview on 5/14/25 at 7:45 a.m., nursing assistant (NA)-D stated R12 was on contact precautions and R11 was not on precautions, therefore if she needs to just drop something off to R11, PPE was not necessary, but would use PPE if providing any cares for either R11 or R12.	F 880		

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F 880	Continued From page 81 NA-D was not sure if someone on contact precautions should be leaving the room and joining activities. During observation on 5/15/25 at 8:07 a.m., licensed practical nurse (LPN)-A entered R11's room to administer medications. LPN-A did not don any PPE. R73 and R76 During observation on 5/14/25 at 11:36 a.m., nurse practitioner (NP) entered R73 and R76's room without donning a gown or gloves. The room had signage indicating "Contact Precautions." NP stopped to talk R76 into seeing podiatry today. NP touched R76's bedside table to move it out of the way, pulled off R76's socks and touched and assessed his feet and toenails. NP was not wearing gloves or gown. NP went over to R73's side of the room and moved R73's bedside table out of the way touching it without gloves. During observation at 5/14/25 at 11:37 a.m., NA-B donned gown and gloves to enter and deliver R76's meal to his bedside table. During observation on 5/14/25 at 11:41 a.m., R76 wheeled self out of room to go to visit podiatry. During observation on 5/14/25 at 11:43 a.m., NA-C entered room to deliver R73's meal and did not don gown or gloves prior to entrance. During interview on 5/14/25 at 11:49 a.m., NP stated R73 had diagnoses history of right lower extremity wound and MRSA. NP stated R76 had a history of MRSA with location not classified. NP	F 880		

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F 880	Continued From page 82 stated neither R73 nor R76 had active infections and did not think they were on contact precautions; therefore he did not gown and glove prior to entrance. NP did not agree the two residents required contact precautions, but stated if signage directed staff to use contact precautions the sign should be followed, and precautions should be utilized. NP stated thinking the signage was in place due to facility policy and that they just follow policy when the state comes in. NP stated, "we are just spreading it." Laundry During observation on 5/15/25 at 10:15 a.m., laundry aide (LA)-A was sorting dirty clothes and linen in the soiled laundry room. LA-A had gloves on but did not have a gown on. Director of environmental services (DES) stated the expectation was for staff to be wearing gown and gloves whenever handling and sorting soiled linen. During interview 5/15/25 at 10:16 a.m., LA-A stated she usually wore a gown and gloves when sorting soiled linen and could not explain why she was not wearing a gown now. During interview on 5/15/25 at 10:57 a.m., infection preventionist (IP) stated expectation for staff to wear correct PPE to include gown and glove anytime they were handling soiled linen. Laundry workers should wear a gown and gloves when sorting soiled laundry. During interview on 5/15/25 at 11:29 a.m., Administrator stated expectation that staff follow the policy and wear gown and glove when handling and sorting soiled clothing and linen.	F 880		

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F 880	Continued From page 83 Facility policy Linen and Laundry, undated, indicated, "Soiled health care textiles must be assumed to be contaminated; personnel who handle soiled textiles must follow Standard Precautions including gloves and a gown." R62 R62's discharge MDS dated 3/28/25, indicated intact cognition and diagnoses of quadriplegia, traumatic rupture of cervical intervertebral disc (C5-6), spinal stenosis, and neurogenic bladder. It further indicated R62 required substantial assistance with toileting and was always incontinent of urine. During observation on 5/14/25 at 8:42 a.m., NA-F entered R62's room to answer his call light and asked him if someone had changed his brief yet. R62 responded no. NA-F washed her hands and put on gloves, handed R62 a wet washcloth to wash his face, and then removed his bilateral heel protectors. NA-F removed R62's gown and brief (which was visibly full of urine) and assisted him to turn on his right side, and wiped his bottom with wipes. Then NA-F removed the pad from underneath him (which was also visibly wet), put it in a plastic bag, assisted him to turn onto his back, and wiped his peri area. NA-F then fastened his brief, pulled up his pants, touched the back of his shoulder, put on his shoes, grabbed a pack of wipes and put them on his dresser, and touched the door handle. NA-F then removed her gown and gloves but did not perform hand hygiene. NA-F then grabbed the EZ stand lift from the hallway, got new gloves from R62's bathroom, touched the bed remote, applied the sling, and NA-E assisted her to transfer R62 to his wheelchair. Once he was in his chair NA-F	F 880		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 880	Continued From page 84 made the bed and then removed her gown and gloves, brought the EZ stand lift out into the hallway, brought a bag of dirty laundry to the soiled utility room, and did not perform hand hygiene. NA-F then applied new gloves and went into another resident's room and shut the door. During interview on 5/14/25 at 9:15 a.m. NA-F stated when entering a resident's room to perform cares, she washes her hands and puts on gloves and then when the cares have been completed, she will remove her gloves and wash her hands. NA-F verified she had not removed her gloves or performed hand hygiene after removing R62's wet brief and did not perform hand hygiene in between glove changes and should have. During interview on 5/14/25 at 9:30 a.m., registered nurse (RN)-D stated when going from a dirty area to clean area while performing personal cares for a resident, staff should change gloves and then perform hand hygiene. This was important in order to prevent spreading germs. During interview on 5/14/25 at 2:00 p.m., (NA)-G stated when you are performing cares and you go from a dirty area (changing a wet/soiled brief) to a clean area (assisting a resident to get dressed), staff should change gloves, wash their hands/use hand sanitizer, and apply new gloves. During interview on 5/15/24 at 10:56 a.m., the DON stated when staff are performing personal cares and going from a dirty area to a clean area, they should change gloves and perform hand hygiene. Staff should also be performing hand hygiene in between glove changes. This was important because there was the potential of spreading germs to other residents or the staff.	F 880		

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F 880	Continued From page 85	F 880		

R59 (hand hygine/TBP)
R59's admission Minimum Data Set (MDS) dated 4/25/25, indicated R59 was cognitively intact and had diagnoses of bilateral humerus (upper arm) fractures. Furthermore, R59 had occasional incontinence and required staff assistance with toileting. R59 did not require isolation due to active infectious disease.

R59's provider order dated 4/22/25, indicated R59 required contact precautions due to Methicillin-resistant Staphylococcus aureus (a resistant bacteria MRSA) of the nare.

R59's care plan dated 4/22/25, indicated R59 was on contact precautions due to MRSA of the nares and R59 would be isolated to their room to prevent the spread of infection. Interventions directed staff to wash hands, wear gown, mask, gloves and goggles as needed to prevent spread of infection. Staff were also required to perform hand hygiene upon entrance and exit of R59's room.

An observation on 5/12/25 at 1:42 p.m., R59's room had a sign that read contact isolation on their door. The sign further instructed staff to gown and glove when entering the room.
An observation on 5/12/25 at 5:18 p.m., NA-I was picking up dinner trays. NA-I had gloved hands on and pushed a cart near R59's room. Without gowning, hand hygiene or glove exchange, NA-I

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 880	Continued From page 86 entered R59's room came out with the dinner tray and placed it on the cart. With the same gloves, NA-I entered room 118 and exited with the dinner tray and placed it on the cart. With the same gloves, NA-I entered room 116-I and exited with the dinner tray and placed it on the cart. With same gloves, NA-I pushed the cart down to the kitchen area. When interviewed on 5/12/25 at 5:18 p.m., NA-I verified they had not donned a gown as instructed when entering R59's room and had worn the same gloves in all three resident rooms. NA-I stated hand hygiene should have been done and new gloves placed for each room. NA-I stated other staff were waiting for the dirty dishes and they were in a hurry. An observation on 5/13/25 at 9:37 a.m., after donning gown and gloves, NA-J entered R59's room to assist with morning cares. After helping R59 choose clothing, NA-J assisted R123 with putting on gripper socks, placed a transfer belt on and assisted walking R59 to the bathroom. R123 walked by the toilet and NA-J then assisted R59 with pulling down the brief. NA-J removed the soiled brief and placed in the garbage. R59 sat on the toilet. NA-J then removed gloves and without hand hygiene, placed donned new gloves. NA-J then assisted with washing face, arms, back and legs. R59's gown was removed and NA-J assisted R59 with putting on a shirt. NA-J then assisted putting a clean brief and pants around R59's ankles before assisting R59 to stand. Once standing, NA-J used wipes to provide peri cares for front and back. NA-J removed gloves and without hand hygiene donned new gloves. R59's clean brief and pants were pulled up and R59 was assisted out of the bathroom to their	F 880		

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F 880	Continued From page 87	F 880		

wheelchair. NA-J assisted R59 to be positioned in the wheelchair in the room and provided R59 the call light. NA-Jthen removed gown and gloves before exiting room and performed hand hygiene upon exit.

When interviewed on 5/13/25 at 10:12 a.m., NA-J verified they had not performed hand hygiene after glove removals and was supposed to. NA-J stated R59 was on contact precautions but was not sure why. NA-J stated they follow the signs on the doors.

When interviewed on 5/13/25 at 10:16 a.m., registered nurse (RN)-I stated R59 was on contact precautions for MRSA. RN-I further stated the MRSA was not active and many times contact precautions were placed as more of a precautionary basis.

R73

R73's quarterly Minimum Data Set (MDS) dated 3/17/25, indicated she had intact cognition and diagnoses of high blood pressure and diabetes. The MDS also reported she received application of ointment(s) to areas other than her feet during the lookback period.

R73's physician order report dated 4/1/25 - 4/30/25 included the following orders:

- "Unna Boots - every Friday. Remove, cleanse with warm water, re-wrap Unna and Coban cover" once daily every Friday, dated 9/27/24 (Unna Boots are a type of compression bandage and

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 880	Continued From page 88 Coban is a brand of self-adherent wrap). The physician order report further indicated R73's diagnoses included "non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity," and "methicillin-resistant Staphylococcus aureus (MRSA) infection as the cause of diseases classified elsewhere-RLE" (right lower extremity). R73's care plan dated 12/7/24, identified she was on contact precautions related to MRSA and directed all staff to wash hands; wear gown, mask, gloves and googles as needed to prevent spread of infection. An undated nursing assistant (NA) care sheet identified R73 was on contact precautions for MRSA. R76 R76's quarterly MDS date 4/1/25, indicated he had intact cognition with diagnoses of high blood pressure and high cholesterol. The MDS also reported he received application of ointment(s) and dressings to areas other than his feet. R76's Care Area Assessment (CAA) dated 10/5/24 for Activities of Daily Living (ADLs) triggered related to "needing assist with cares and mobility" due to his "cellulitis-MRSA/pseudomonas" in his lower extremities. The CAA indicated he required assist of 1 with cares and mobility and directed staff to the plan of care to support his care mobility needs. R76's CAA dated 10/5/24 for Pressure	F 880		

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F 880	Continued From page 89 Ulcer/Injury indicated he had "recurring open aeras on both legs" and the CAA triggered related to "cellulitis - MRSA/pseudomonas". R76's physician order reported dated 4/1/25 - 4/30/25 included the following orders: - "Bilateral leg dressing; Change twice weekly; cleanse, apply 2 grams ammonium lactate lotion to each leg, apply Vaseline gauze to open areas wrap Unna boots. Do not leave leg unwrapped for > [sic, greater than] 30 min. [sic, minutes]. Once Click or tap here to enter text. day and once a day as needed," dated 4/17/25. The order report also identified diagnoses including cellulitis of right lower limb (a bacterial skin infection), non-pressure chronic ulcer of unspecified lower leg with unspecified severity - bilateral (meaning both sides), MRSA infection, and pseudomonas (aeruginosa) (mallei) (psedomallei). R76's care plan last reviewed/revised 4/8/25, identified under "diagnosis" his MRSA and pseudomonas (aeruginosa) (mallei) (pseduomalleli), however, lacked documentation of measurable objectives and timeframes to meet his medical and nursing needs related to his MRSA and pseudmonas infection and lacked documentation of interventions related to transmission-based precautions (TBP). An undated NA care sheet identified R76 was on contact precautions. Per observation on 5/12/25 at 5:39 p.m., R73 and R76 were on contact precautions evidenced by the signage posted outside their shared room	F 880		

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F 880	Continued From page 90 next to the door frame at approximate standing eye-level. The sign read, "Contact Precautions: Everyone Must: clean hands when entering and leaving room. Doctors and Staff Must: gown and gloves at door." During observation on 5/13/25 at 8:52 a.m., nursing assistant (NA)-N pushed a four-wheeled meal cart down the unit hallway. NA-N stopped the cart outside of R73 and R76's room and walked past the contact precautions signage into the room without performing hand hygiene or donning personal protective equipment (PPE) of gown and gloves. NA-N walked back out of the room, did not perform hand hygiene, returned to the cart and poured liquid from a carafe into a cup and re-entered the room without performing hand hygiene and without donning PPE. NA-N exited the room again and returned to the cart, without performing hand hygiene, picked up utensils from the cart, and walked past contact precautions signage and into the room without performing hand hygiene or donning PPE. NA-N walked out of the room and back to the cart, did not perform hand hygiene, and picked up the carafe and poured liquid into a cup and picked up condiments from the cart and walked past the contact precautions signage and into the room without performing hand hygiene or donning PPE. NA-N exited the room, did not perform hand hygiene, and used bare hands to push the meal cart down the hallway to the next room. NA-N did not perform hand hygiene before entering the next room and told the unidentified resident, "I have your breakfast." NA-N exited the room, did not perform hand hygiene, and used bare hands to pick up a white plate with food on it and walked it into the unidentified resident's room. NA-N exited the room, did not perform hand hygiene	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 91 and stated, "lord tell me I didn't forget a fork," and used bare hands to grab the handle of a fork. NA-N re-entered the unidentified resident's room without performing hand hygiene. NA-N exited the room without performing hand hygiene, walked across the hallway to a covered linen cart, used bare hands to pick up towels. At 8:55 a.m., NA-N re-enters the resident's room and sets up the bedside table with the meal before exiting the room without performing hand hygiene. Per follow-up interview at 8:55 a.m. with NA-N, staff should wear PPE for contact precautions when doing the cares. NA-N and the surveyor walked to R73 and R76's shared room to review the contact precautions signage. When asked when to wear gown and gloves in their shared room, NA-N stated, "I can ask my manager," and then asked the surveyor if they could return to delivering the breakfast "so it doesn't get cold." Surveyor asked NA-N to review the contact precautions signage and asked when staff should wear PPE and NA-N stated, "when doing cares," before walking away. During observation and interview on 5/13/25 at 8:58 a.m., NA-M was at R73 and R76's shared door and performed hand hygiene before donning a gown and gloves. NA-M entered the shared room and delivered two mugs with lids. NA-M remarked how warm the room temperature was and offered to submit a work order for them. With the room door open, NA-M was observed doffing the gown and gloves at the doorway, then performing hand hygiene before exiting the room. At 9:01 a.m., NA-M stated staff should wear PPE whenever going in or out of the room "just in case you come in contact with them or something." When asked if NA-N should have donned gown and gloves as the signage indicated outside R73 and R76's shared room, NA-M confirmed, "the	F 880		

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	245310	A. BUILDING _____ B. WING _____	C 05/15/2025

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F 880	Continued From page 92 general rule is you should do what you read" but said "everybody kinda just does their own thing." Per interview on 5/13/25 at 9:03 a.m., licensed practical nurse (LPN)-B confirmed both R73 and R76 were on contact precautions and verified staff were expected to follow TBP signage instructions if they were posted on the resident's door. Per interview on 5/14/25 at 9:27 a.m., registered nurse (RN)-E would expect staff to follow [transmission-based] precaution signs posted on the resident's doorway. When asked if staff would be expected to don full PPE of gown and gloves for a resident room identified as having contact precautions to deliver meal trays, RN-E stated if staff were not expecting to come into contact with a resident for cares, they would not need to don full PPE. During the interview, RN-E and surveyor reviewed the Center for Disease Control (CDC)'s recommendations for Transmission-Based Precautions dated 4/3/24, which indicated, "Wear gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens." Additionally, RN-E and the surveyor reviewed the CDC's Contact Precautions signage, which indicated, "providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit." RN-E acknowledged there was confusion among staff with TBP and requested to speak with the facility's infection preventionist (IP) to clarify. RN-E stated the expectation was staff follow the CDC's recommendations for precautions.	F 880		

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F 880	Continued From page 93 Per interview on 5/15/25 at 12:38 p.m. with the director of nursing (DON), staff were expected to follow the signage on a resident's door as it related to TBP. The DON stated if staff were unsure what PPE to wear or had questions about in what situations they needed to wear PPE, they knew they could ask either the DON or the IP. Per facility policy titled Contact Precautions last revised 9/23, contact precautions were used to prevent nosocomial spread of organisms that could be transmitted by direct resident contact or indirect contact of environmental surfaces or contaminated resident care equipment. The policy directed staff to perform the following steps for appropriate contact precaution procedure: "1. Hand Hygiene is done prior to donning PPE. 2. PPE is donned prior to entering room. A gown and gloves are needed upon entering room. 3. Change gown and gloves between residents even if only one resident is on Contact Precautions. 4. Use of masks, eye protection and face shields is not routinely part of contact precautions, however, just as with Standard Precautions, these items are own during resident care activities that are likely to create splashes or sprays of blood, bodily fluid, secretions, and excretions. 5. Hand hygiene is performed between glove changes and when removing gloves." Furthermore, the policy directed associates to "practice hand hygiene and don gown and gloves before entering and remove gown and gloves prior to exiting room per CDC guidelines. Hand Hygiene must occur once PPE is removed."	F 880		

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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 5/12/25- 5/15/25, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H53109446C (MN00107254), H53104530C (MN00112940) with no licensing orders issued. The following complaints were reviewed: H53104289C (MN00109774) with licensing orders issued at 0840 and 1855, H53104290C (MN00106629) with licensing orders issued at 1810. 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 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic	2 000		

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2 000	Continued From page 2 State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure safe resident handling for 2 of 2 residents reviewed for accidents (R47, R60). Furthermore, the facility failed to reassess and, if needed, develop new	2 830	Corrected	6/30/25

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2 830	Continued From page 3 interventions to reduce the risk of injury during resident handling for 1 of 1 residents (R60) who sustained an injury during a transfer at the facility. In addition, the facility failed to ensure fall interventions were implemented for 1 of 1 resident (R9) reviewed for falls. Findings include: R47 R47's quarterly Minimum Data Set (MDS) dated 4/8/25, indicated he had intact cognition, required partial-to-moderate staff physical assistance for bed mobility and was dependent on staff for transfers. The MDS reported diagnoses of a cerebrovascular accident or CVA (a stroke, or an episode of insufficient blood supply to the brain caused by either a blood clot or abnormal bleeding), and hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis) and aphasia (a language disorder caused by injury to the brain). R47's Care Area Assessment (CAA) dated 1/13/25 for Activities of Daily Living (ADLs) was triggered related to needing assistance with "cares and mobility due to CVA" and left-sided hemiplegia, in addition to other co-morbidities. The CAA indicated he required extensive assist of 2 with "bed mobility, transfers (EZstand), and toileting" and directed staff to "proceed to the care plan for risk". A safe lifting and movement assessment dated 4/8/25, indicated R47 was able to bear weight as tolerated to is upper and lower extremities but was unable to stand safely for 8 seconds without any assistive devices. The assessment identified his hemiplegia and pain as physical limitations to	2 830		

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2 830	Continued From page 4 a safe transfer and recommended "two person transfer with Stand Assist Lift". The assessment indicated the lift manufacturer recommendations for correct harness size and his care plan was reviewed. R47's care plan last revised 2/26/25 identified his alteration in mobility related to his need for assistance with mobility due to CVA and left-sided hemiplegia, among his other co-morbidities. The care plan directed staff "assist 2 with transfers (EZs Stand). The care plan also identified he was susceptible for abuse related to residing in a skilled nursing facility (SNF) and directed staff to provide a safe environment for him and follow his plan of care to ensure for safety. An undated nursing assistant (NA) care sheet identified R47 required assist of 2 with an "EZ Lift". During a continuous observation on 5/13/25 between 11:19 a.m. and 11:41 a.m., R47 was in his wheelchair and was in a laid-back position. NA-B pulled R47's wheelchair from a table and NA-D locked the brakes on the wheelchair. NA-D used their foot to push the pedal on his wheelchair that said "TILT" and the wheelchair reclined backwards. NA-B and NA-I stood in front of R47 facing him and each of the NAs put one of their arms under one of his arms until they were under his shoulder joint on either side. The NAs counted to three and together they lifted him in an upwards and backwards motion so his buttocks was off of the wheelchair seat and he was boosted up in his wheelchair. NA-B asked, "are you alright?" and NA-D unlocked the brakes on the wheelchair, used their foot to press the "TILT" pedal and the wheelchair was moved forward in an upright position. NA-D pushed his wheelchair	2 830		

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2 830	Continued From page 5 back to the table. At 11:40 a.m., R47's was in his wheelchair in a semi-reclined/laid-back position. At 11:41 a.m., he was in his wheelchair outside of the elevator doors and waiting for the elevator. The NAs reclined his wheelchair using the "TILT" pedal and locked the brakes on the wheelchair. NA-B and NA-I stood facing him and each of the NAs put one of their arms under one of his arms until they were under his shoulder joint. Next, the NAs each put their other arm under one of his legs, each positioning their hand above his knee joint in the middle of his upper leg on his thigh. The NAs together lifted him in an upwards and backwards motion in the wheelchair and R47 groaned out as the NAs performed the maneuver. When the NAs finished, he was sitting upright in his wheelchair. During interview on 5/13/25 at 11:45 a.m., NA-D confirmed the observation stated he "always sides down in his chair" and indicated staff used the observed positioning maneuver "or sometimes we pull the waist of his pants" to pull him up. NA-D stated he had weakness on his left side and said staff "grab very gently and then we pull him". NA-D stated staff used the "TILT" pedal on his wheelchair to recline him because it allowed staff to pull him back easier in his chair as well as helped keep pressure off his backside. NA-D stated he required 2 staff assistance for his transfers and had to be repositioned "like, every 10-15 minutes" because he would slide down "that way" in his wheelchair. NA-D explained to position him, staff would lay the chair all way back, support his head with pillows if he was in his room, use their arms to support his weak side "because his weak side does not go up, so we have to support that side and we position him that way". NA-D stated it was important to be mindful	2 830		

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2 830	Continued From page 6 of his weak side during positioning because his weak side was painful and if staff were not cautious, "he will scream". NA-D demonstrated his weak side's restricted range of motion (ROM) and stated he would scream if staff were not careful. Per interview on 5/13/25 at 3:18 p.m. with the director of physical therapy (PT)-I, the recommended approach to reposition a resident in a wheelchair would be to use a gait belt and pull their hips back against the edge of the chair. PT-I stated if the resident had a "tilt and space" wheelchair, staff could tilt the wheelchair back and "let gravity take effect" to assist with the repositioning. When asked if it would be appropriate to reposition a resident as observed by pulling a resident upwards and backwards by their underarms, PT-I stated depending on the resident's body physical characteristics, like body shape, height and weight; if staff had good support from the legs, "you could boost someone like that, but it shouldn't be the primary method. I would recommend trying to get a gait belt under and behind the resident so they can get support from the trunk area instead of under the arms. PT-I indicated the observed method of positioning R47 should be reserved a last resort for boosting/positioning. PT-I stated there are "a lot of nerves" under a person's shoulder and indicated there could be potential for injury. Per interview on 5/14/25 at 7:25 a.m., registered nurse (RN)-E stated staff should not position or boost a resident by their arms as observed because of the risk of bodily harm to the resident or themselves. RN-E stated all staff underwent safe lifting education and if management observed such positioning or boosting, were expected to provided education on the spot and	2 830		

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2 830	Continued From page 7 provide re-education to the involved staff, which would "go in their file". RN-E expected staff to position a resident with their hips or the appropriate lift as identified on their care plan as opposed to under their arms. RN-E indicated NA-B and NA-D would be educated regarding appropriate positioning techniques. Per interview on 5/15/25 at 12:34 p.m., the director of nursing (DON) stated staff were trained on more appropriate ways to position a resident. R60 Findings include: R60's quarterly Minimum Data Set (MDS) dated 3/10/25, indicated she had intact cognition and required partial-to-moderate assistance for bed mobility but was dependent on staff for transfers. The MDS identified diagnoses of a cerebrovascular accident or CVA (a stroke, or an episode of insufficient blood supply to the brain caused by either a blood clot or abnormal bleeding), and hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis) and aphasia (a language disorder caused by injury to the brain). R60's Care Area Assessment (CAA) dated 6/16/24, for Activities of Daily Living (ADLs) triggered related to her needing assistance with cares and mobility related to her CVA with left-sided hemiparesis. The CAA indicated she required 2 staff assist with bed mobility and transfers and directed staff to "proceed to the plan of care". A safe lifting and movement assessment dated	2 830		

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2 830	Continued From page 8 3/5/25, indicated R60 was unable to bear weight in her upper and lower extremities and was not able to stand safely for 8 seconds without holding onto an assistive device. The assessment identified her hemiparesis as a physical limitation to safe transfers and recommended "two person transfer with full lift". The assessment also indicated lift manufacturer recommendation were reviewed to ensure for correct sling size and her care plan was reviewed. R60's care plan last revised 3/11/25, identified her alteration in mobility related to her needing assistance with mobility due to her CVA and left-sided hemiparesis, among her other co-morbidities. The care plan direct staff to transfer her using the "ceiling lift" and 2-person assistance. The care plan also identified she had a fracture to her left humerus (the long bone going from the shoulder to the elbow in the upper arm) "due to and not limited to pathological bone changes, which was identified by a provider on an x-ray," dated 5/12/25. A North Star mobile X-ray patient report dated 4/24/25, indicated the x-ray results or findings were "a proximal humeral fracture is identified just beneath the humeral head. Inferior medial displacement of the distal fracture fragment is noted." A "proximal humeral fracture" is a fracture or break in the upper arm bone near the shoulder joint. A progress note dated 4/22/25 indicated it was "recorded as Late Entry on 4/24/25 5:29 p.m." and reported "resident complain of pain writer assess resident note resident was lying on her side, writer reposition resident vitals are stable, administer two Tylenol 500mg as staff continue to monitor."	2 830		

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2 830	Continued From page 9 A progress note dated 4/23/25 at 10:59 a.m., indicated the writer was updated on R60's "painful shoulder" and during an assessment, the left shoulder was "swollen, warm and tender to touch" and had limited mobility due to pain. The progress note indicated she denied falling and utilized assistance of 2 with a mechanical lift for transfers. The progress note identified she received Tylenol for pain which was effective. The progress note reported her NP was updated. An additional progress note dated 4/23/25 at 1:45 p.m., indicated R60 complained of pain when staff were assisting her with dressing and "she was unable to move her left arm". The progress note indicated Tylenol was administered and an ice pack was applied to her left shoulder, her NP and family were updated. A progress note dated 4/26/25 indicated the interdisciplinary team (IDT) reviewed an incident "that occurred on 4/22/25 around [sic] while staff assisted with cares." The progress note indicated staff were interviewed on 4/22/25 and "while two staff members assisted the resident from her wheelchair into bed using a ceiling lift" R60 heard a "crack" sound she stated came from her left shoulder. The progress note indicated a nursing assistant (NA) notified the nurse "promptly" of her "complaint" and a nurse assessed her and "found that the resident experienced pain associated with the popping sound during the transfer". The progress note indicated the nurse "administered 1000 mg of Tylenol." The progress note continued, "on April 23, 2025, the resident continued to report pain in her left shoulder during morning care assistance provided by nursing assistants." R60's nurse practitioner (NP) was updated regarding her reports of pain and limited	2 830		

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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
2 830	Continued From page 10 range of motion (ROM) to her left upper extremity and ordered an x-ray and pain management plan including "acetaminophen 1000 mg three times daily, tramadol 25 mg as needed every four hours, and the application of ice packs." The progress note indicated she took "omeprazole, a proton pump inhibitor that increases the risk of bone fractures." The progress note stated staff would continue to monitor her condition and update the provider as needed but lacked documentation of further assessment of R60's safe lifting and movement to determine if new interventions were necessary to reduce the risk of future injury during transfers. R60's electronic health record (EHR) was reviewed on 5/15/25 and lacked documentation of post-incident safe lifting and movement assessment. During observation and interview on 5/12/25 at 4:54 p.m., R60 was lying in her bed without a sling on her left arm. She stated while she was getting into bed, "I heard a big crack, it hurt." R60 stated she was "okay" to have the sling off while in bed but needed to have staff assist her with putting it on when out of bed. She stated not a lot of staff knew how to put the sling on. She stated she broke her left shoulder, which was the side affected by her stroke. She stated she felt staff were doing a "pretty good job" at managing her pain, however, were not offering her ice packs anymore, which was something she would like to have for pain management. During observation on 5/13/25 at 9:24 a.m., R60 was up in her wheelchair and requested to lay down. She pushed her call light at 9:25 a.m. and at 9:29 a.m., registered nurse (RN)-E and nursing assistant (NA)-Q entered her room to answer her	2 830		

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2 830	Continued From page 11 call light. After performing hand hygiene, donning gloves and providing for privacy, NA-Q retrieved the lift sling from the back of the door and asked her to lean forward and began tucking the sling behind and down her back. NA-Q pulled the sling straps under her legs, first under her right hip and through the front of her right leg and then NA-Q repeated the steps on the left side. NA-Q walked across the room and pulled the ceiling mechanical lift from one side of the room over to above R60 and used the remote to lower the lift. RN-E asked her to hold onto her left hand and guided her to her affected left hand in the sling. NA-Q crisscrossed the sling straps in the front and hooked the sling straps up to the mechanical lift before using the remote to lift her up from the wheelchair. The bottom hem of the sling was above her sacral level; however, her head was above the top hem and there was no slipping observed during the transfer. Together, RN-E and NA-Q pushed her over top of her bed and NA-Q used the remote to lower her onto the bed. NA-Q asked her if she was okay and she answered, "yeah". RN-E and NA-Q assisted her to turn to the side to tuck the sling, and then to sit forward. Together, they removed the sling out from behind her. RN-E stated she had a stroke and only had "one working arm and hand" and had always transferred with a mechanical body lift. NA-Q provided the call light within her reach, lowered the bed and gave her a stuffed animal. During observation and interview on 5/14/25 at 11:49, R60 was wearing her sling and family member (FM)-J stated being told she had a fracture that wouldn't require surgery but could not recall if the facility had reported how the fracture occurred. FM-J stated, "I was not told how this happened, only that the injury occurred." FM-J stated preference for wanting to know what	2 830		

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2 830	Continued From page 12 happened to have caused to injury. FM-J stated, "the day it happened, I wasn't here when it happened, I was here beforehand, and after she told me about the pain." FM-J indicated the "nursing supervisors" was notified the following day and "decided R60 needed a doctor to look her over and he decided she need an x-ray and ice pack." FM-J denied concern with the facility's management of her pain. FM-J and R60 would not recall which nurse or NA were working when she sustained the injury. FM-J indicated he was not present for many transfers but stated "they tell me and I have witnessed on a few occasions them using the ceiling lift." During interview on 5/14/25 at 12:08 p.m., NP-H reviewed previous documentation and stated R60 was "transferring and she heard a pop." NP-H stated she had a proximal left humerus fracture recent follow-up imaging showed the fracture was "more prominent", which NP-H explained meant there was no evidence of healing on the x-ray. NP-H stated the x-ray results "probably means the matrix hasn't formed yet and it's still a fracture." NP-H further explained the matrix formed after a fracture began to heal and formed a callus, and the follow-up x-ray did not show such a callus. When asked if taking omeprazole could be a contributing factor to her fracture as identified in the IDT progress note dated 4/24/25, NP-H confirmed it could be, however stated it would be "kind of a weak argument, but maybe". NP-H expected staff involved in the incident to have been "interrogated". NP-H stated, "I would be curious about the body mechanics; how was she transferred; was it with the lift?" NP-H indicated her follow-up x-ray was sent to geriatric orthopedics and physical therapy (PT) and occupation therapy (OT) for further evaluation.	2 830		

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2 830	Continued From page 13 During interview on 5/14/25 at 12:28 p.m., NA-O stated staff could locate a resident's transfer status on the NA care sheet. NA-O stated staff should read their assignment sheet "first thing" to determine if a resident's care has changed. NA-O stated they also received shift report with pertinent resident care information and staff could ask questions during report if they were unsure. During initial interview on 5/14/25 at 2:06 p.m., NA-B indicated she was not working on the day of R60's incident and could not recall any details from the incident. NA-B stated R60 had been at the facility for a long time and at times, would refuse cares, like a shower or getting up in the morning. NA-B stated she did not have physical or verbal behaviors related to her refusal of cares and stated, "she will tell you what she wants." During interview on 5/14/25 at 2:26 p.m., RN-E recalled R60 complaining of shoulder pain when "I came in the morning". RN-E assessed and interviewed her to determine what happened and FM-J stated, 'they were transferring you and you said you heard something pop'. RN-E indicated reporting the incident "immediately" to the supervisor and initiating an investigation. RN-E stated the NA said when they heard the pop, the nurse was notified. When the nurse went to assess her, FM-J was there and R60 complained of pain and was given Tylenol. RN-E stated on-the-spot education was provided to the NAs involved regarding how to choose the appropriate sling size, how to know if staff were using the correct sling size and who to report to if staff felt a transfer was not safe. RN-E stated, "we went together, and I asked them to show me how to check the sling size," and indicated the NAs performed a teach-back of an appropriate transfer of R60. RN-E stated the NAs involved	2 830		

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2 830	Continued From page 14 were interviewed right away after the incident was reported and education was provided over the phone initially. RN-E stated staff were expected to follow the plan of care for transfers and safe resident handling and indicated staff received safe patient handling education yearly. During interview on 5/15/25 at 8:41 a.m., the director of physical therapy (PT)-I stated ceiling lift transfers should always be performed with two people. PT-I explained the proper ceiling lift transfer technique to assist a resident from a chair to the bed was to get the sling under them and ensure it was centered. Next, staff should get the two leg pieces under the resident's legs and cross them over each other (in a crisscross fashion). Next, PT-I stated the sling's loops should be hooked up to the lift according to the color associated with the resident's preferred position (for example, a particular color loop was associated with a more upright position while the other color was associated with a more reclined position). PT-I continued to explain once sling was centered, the leg straps were hooked up, the upper body loops should be hooked up and one person could operate the lift while the other person maneuvered the resident's body to ensure for their safety, being mindful of their limbs. PT-I stated contributing factors to a resident's risk for injury, like a shoulder fracture, during a ceiling lift transfer, could include if a resident had brittle bones or other diagnoses, the resident's position in the sling, and inappropriate sling size. PT-I stated, "I don't see a way that could happen if the proper procedure was followed." During follow-up interview on 5/15/25 at 8:41 a.m., NA-B confirmed working with R60 during the incident and stated when RN-E interviewed staff about the incident, "I told her the next day	2 830		

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2 830	Continued From page 15 when RN-E asked that it was two people in to do that." NA-B reported two staff transferred her with the ceiling lift per her care plan and denied hearing a "popping" or "cracking" sound as R60 reported hearing. NA-B stated, "when we transferred on the ceiling lift, we were there with 2 and we put her to bed, the wheelchair was close to the bed, but it was two people that did that." During interview on 5/15/25 at 9:38 a.m., licensed practical nurse (LPN)-C was unsure what day she assessed R60 after the injury but recalled she had swelling in her shoulder and "I gave her some Tylenol, I think I applied some ice." LPN-C asked her if she could lift her arm, and she stated she could not because it hurt. LPN-C stated the information was passed along to the next shift. During interview, NA-M was sitting nearby and indicated it was the following day because it was "my morning shift." During interview on 5/15/25 at 9:40 a.m., NA-M confirmed being R60's assigned NA on the day LPN-C was recounting during interview and indicated it was the day following the initial incident. NA-M stated, "I went to get LPN-C because when I touched her arm she said ouch, so I covered her back up and immediately went to get the nurse." NA-M stated "nobody on night shift" reported anything about her having pain. NA-M stated R60 did not have physical behaviors and stated she "says 'no' if she don't [sic] want something, but she doesn't get aggressive with cares." NA-M stated if a resident was care planned to use a mechanical lift for a transfer, "we should be doing that to keep the resident safe." During interview on 5/15/25 at 11:54 a.m., the director of nursing (DON) recounted, "We asked	2 830		

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2 830	Continued From page 16 the patient if the transfer was rough, she said 'no.' ... I checked the sling size to confirm it was the right size. It was medium, which she uses, and it was the right size of the sling." The DON continued and stated the NAs were brought in and shown "the right way to put the sling on," and were provided on-the-spot education about the incident, but it was not considered disciplinary action. The DON reported staff also received annual safe resident handling education. The DON indicated staff performed an investigation into R60's accident but was unable to identify or provide documentation of an identified root cause analysis of the incident. The DON stated staff assessed sling size appropriateness using the lift manufacturer's guidelines and stated the facility did not have their own assessment tool. The DON indicated R60's sling was "visually" inspected after the accident to determine it was the appropriate sling size. The DON stated RN-E had "handwritten" documentation of the sling assessments and safe lifting and movement assessment post-accident but was unable to provide such documentation when requested. A facility education form dated 4/23/25 was reviewed on 5/15/25 at 2:06 p.m. and indicated NA-B and NA-D received education regarding the ceiling lift and safe resident transfers after R60's accident. A request was made for the ceiling lift's manufacturer's instruction manual and/or sling guidelines but was not received. Per undated facility policy titled Safe Lifting and Movement of Residents copyright 2024, all communities used appropriate techniques and devices to lift and move residents in order to protect the safety and well-being of associates	2 830		

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2 830	Continued From page 17 and residents, and to promote quality care. The policy indicated safe lifting and movement of residents was part of an overall Safe Patient Handling program and indicated associates would be observed for competency in using mechanical lifts and observed periodically for adherence to polices and procedures regarding use of equipment and safe lifting techniques. R9's significant change Minimum Data Set (MDS) dated 4/11/25, indicated severe cognitive impairment, did not reject cares, used a wheelchair, and required substantial assist with toileting hygiene, and partial to moderate assist with dressing. Further, R9's vision was adequate with glasses. R9's care area assessment (CAA) dated 4/14/25, indicated R9 triggered for falls due to needing assist with cares, mobility, toileting due to multiple diagnoses and received Seroquel for psychotic disorder with delusions, and Zoloft for depression. R9's optional state assessment (OSA) dated 4/11/25, indicated R9 required assist with bed mobility, transfers, and toileting. R9's Facesheet undated, indicated the following diagnoses: rheumatoid arthritis, Myelodysplastic syndrome, weakness, history of falling, and Alzheimer's disease. R9's Active Orders form indicated the following orders: 3/20/24, Seroquel (an antipsychotic) 25 milligram (MG) tablet orally daily at 4:00 p.m. 1/2/25, hip protector on at all times every shift. 1/29/25, Zoloft (an antidepressant) 125 mg orally every a.m. 4/4/25, Admit to Allina Hospice with a primary	2 830		

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2 830	Continued From page 18 diagnosis of vascular dementia. R9's medication administration record (MAR) and treatment administration record (TAR) dated April 2025, indicated starting 2/5/25, and ending 4/22/25, R9 required night staff to check on the resident, prepare her, and bring her to the dining room for monitoring before the end of their shift to prevent falls. R9's care plan dated 4/14/25, indicated R9 had good vision and required assistance with her glasses as needed, additionally R9 had an intervention to assist with vision exams as needed. R9's care plan dated 4/14/25, indicated R9 had an alteration in activities of daily living (ADLs) due to needing assist with cares and required assist of one with bathing, dressing grooming. Additionally, R9 required her call light be within reach. R9's care plan dated 4/14/25, indicated R9 had an alteration in mobility and required one assist with transfers, her wheelchair, and ambulation. R9's care plan dated 4/14/25, indicated R9 was on the Falling Star program, and was at risk for falls due to needing assist with cares, mobility, toileting, and had a history of frequent falls due to multiple diagnoses. R9's goal was to remain free from falls with injury and had the following interventions: essential oils as needed, night staff check on the resident, prepare her, and bring her to the dining room for monitoring before the end of the shift, anti-roll backs on wheelchair, ensure R9 wore her glasses and that they were clean and in good repair, keep call light in reach at all times, keep the bed in the lowest position to allow	2 830		

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2 830	Continued From page 19 feet to be flat on the floor with the brakes locked, give verbal reminders not to ambulate or transfer without assist, wears hip protector at all times to minimize injury, provide proper, well maintained footwear, provide an environment free of clutter, keep personal items and frequently used items within reach, and toilet per plan of care. R9's care plan dated 4/14/25, indicated R9 required assist with toileting upon rising, before and after meals, at bedtime, on night rounds, and as needed. R9's care plan dated 5/12/25, indicated R9 was at high risk for falling due to dementia and overall decline and interventions included fall prevention reduction precautions per facility protocol, monitor side effects of medication: cardiac medication as ordered. Narcotic pain medication as ordered. Monitor for side effects such as dizziness, lethargy, increased confusion, decreased respirations and report to the provider, and toilet per the urinary bowel section of the care plan. R9's Villa Team Report sheet dated 4/22/25, and provided by registered nurse (RN)-F on 5/12/25 at 12:08 p.m., indicated R9 was a falling star, ensure resident is in bed in the early hours, hip protector at all times, and night staff to check on the resident, prepare her, and bring her to the dining room for monitoring before the end of their shift. R9's Team 1 Villa Assignments sheet, undated, indicated R9 was at high risk for falling, was a falling star, required assist of one for dressing, grooming, toileting, and staff were to offer to toilet every three hours and as needed and the night staff were to check and toilet patient before their shift ended and bring R9 to the dining room for	2 830		

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2 830	Continued From page 20 monitoring. Further, the form indicated R9 always needed her call light and personal items in reach with the bed in the low position, gripper socks on when in bed, hip protector at all times, and could not be left unattended on the toilet or in the room unless sleeping. Further, the form indicated R9 required anti-roll backs on the wheelchair, and staff needed to monitor the bruise on R9's right forehead. R9's Event Report dated 2/4/25 at 9:37 a.m., indicated R9 was in her room when she fell trying to go to the bathroom. Further, R9 took 9 or more medications including antidepressants, antihypertensives, and antipsychotics and had fallen previously on 1/1/25. Additionally, R9 was on the floor behind the door and was last seen at 7:10 a.m. R9's interdisciplinary team (IDT) reviewed the fall on 2/5/25, and determined the night staff would check on the resident, prepare her, and bring her to the dining room for monitoring before the end of their shift, as she was an early riser and preventative measures to avoid fall injuries would continue, such as utilizing hip protectors. R9's Event Report dated 2/18/25, indicated R9 fell in her room. R9 was in her wheelchair in the hallway prior to the fall and R9 stated the entrance of the door slipped her and she fell. Under a heading, "Possible Contributing Factors" indicated R9 had confusion. Under a heading, "Drug Review-Does resident use any of the following types of medications?" indicated check boxes for various medications including antidepressants, analgesics, and antipsychotics. Additionally, there was a check box for "None of above". The information was undocumented. Under a heading, "Notes", indicated R9 was in the hall and wheeling her wheelchair around her	2 830		

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2 830	Continued From page 21 room prior to the fall. R9 was on the floor and the wheelchair was far away from the resident. R9 was transferred to her wheelchair and brought to the dining room to prevent another fall and on 2/19/25 at 12:29 a.m., was escorted to the hospital. Further, the IDT reviewed R9's fall and determined to prevent injuries from frequent falls, R9 wore a hip protector additionally, plans were in place to install an anti-roll back device on R9's wheelchair. Further, the Event Report indicated IDT met on 3/4/25, and evaluated the effectiveness of interventions related to R9's fall on 2/18/25 and determined therapy was not appropriate and would implement hip protectors and install an anti-rollback device on R9's wheelchair. R9's Event Report dated 5/11/25, indicated R9 fell from her wheelchair in the dining room at 7:04 p.m., and sustained a bump on her right forehead. IDT reviewed R9's fall on 5/12/25, and indicated R9 was in the dining room using her wheelchair when another resident came up from behind and pushed R9's wheelchair causing R9 to fall and interventions implemented included providing the other resident with a stroller and a doll when showing a tendency to push other residents. R9's Post Fall report dated 3/10/24, indicated R9 fell going to the bathroom to brush her teeth and was re-educated on using her call button for help. R9's Post Fall report dated 1/2/25, indicated R9 fell backward in her room and under a heading, "EVALUATION" indicated, "Call light not use". Further, measures taken to prevent further falls included frequent checks and assist R9 with toileting per the care plan.	2 830		

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2 830	Continued From page 22 R9's Post Fall report dated 2/5/25, indicated R9 was in bed prior to falling, took antidepressants and antihypertensives, and last fell on "1/7/202". Further, R9 was at risk for falls due to dementia, and not getting resident up early when she is up, and staff would get resident up when she is up and toilet R9 to prevent falling. R9's Post Fall report dated 2/19/25,indicated R9 was sitting on the floor when staff members entered the room and was previously in her wheelchair, complained of chest pain and was sent to the ED for further evaluation. R9's Post Fall report dated 5/12/25, indicated R9 had a witnessed fall in the dining room from her wheelchair, did not take 9 or more medications, took antidepressants, and narcotics. Under a heading, "EVALUATION" was left undocumented and under a subheading, "Describe measures to be taken to prevent further falls" was left undocumented. During observation on 5/12/25 at 1:58 p.m., R9 was in bed and her call light was on the floor under the bed on the side closest to the door. R9's wheelchair was unlocked and approximately two to three feet from the foot of the bed next to the room divider curtain and parallel to the foot of the bed. R9 had a bruise on the right side of her face. During interview on 5/12/25 at 3:13 p.m., family member (FM)-K stated there was another resident on the floor and did not know if the resident was pushing R9 or went to push R9 and scared her, but R9 fell out of her wheelchair and hit her head on the table. FM-K stated the facility updated her and further, did not indicate if there were any new interventions to prevent falls.	2 830		

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	00940	A. BUILDING: _____ B. WING _____	C 05/15/2025

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2 830	Continued From page 23 FM-K stated when R9 lays down, staff provide a call light and clip it so R9 can see it, but didn't know if R9 understood what it was. Further, FM-K stated FM-K stated R9 lost her glasses three weeks ago and has been without glasses since. FM-K further stated she told SW-A on 5/9/25, he had to do something because R9's glasses still had not been found. During observation on 5/13/25 at 8:11 a.m., R9's door was closed. During observation on 5/13/25 at 8:12 a.m., R9 was in bed and her wheelchair was located by her closet and next to a garbage can and unlocked. R9's call light was on the floor under her bed and on the side closest to the door and there was a clip on the call light cord. R9's glasses were not located on the nightstand. During interview and observation on 5/13/25 at 8:35 a.m., nursing assistant (NA)-H entered R9's room and checked on both residents and was going to leave the room and stated she got the residents up when they were awake and further stated they were both not early persons. NA-H stated R9 sometimes woke up early and stated R9 used her call light. NA-H verified R9's call light was on the floor and picked the call light up and clipped it to R9's sheet. During interview and observation on 5/13/25 between 8:57 a.m., and 9:17 a.m., NA-H went into R9's room and asked if she was ready to get up and offered clothing. At 8:59 a.m., NA-H left the room and stated she would be right back. R9 did not have glasses on. At 9:01 a.m., NA-H asked R9 to go to the bathroom and donned R9's shoes, but did not tie the laces. At 9:01 a.m., NA-H applied a gait belt and at 9:02 a.m., NA-H	2 830		

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2 830	Continued From page 24 assisted to stand R9 and pivot transfer her to the wheelchair. R9's shoelaces were dragging on the floor. NA-H did not apply any glasses. At 9:03 a.m., NA-H assisted R9 to stand in the bathroom using the sink and registered nurse (RN)-F entered the room. R9 sat down on the toilet and her shoes were still untied. At 9:06 a.m., NA-H verified R9's shoes were untied and stated she would tie the shoes. At 9:08 a.m., NA-H donned R9's pants and hip protector and at 9:19 a.m., assisted resident to sit down again in her wheelchair. R9 did not have glasses on. During interview and observation on 5/13/25 at 9:24 a.m., R9 did not have anti tips or rollbacks on her wheelchair. NA-H stated R9 refused cares one time a couple of weeks ago because she did not want to get up. NA-H stated she looked to the care sheet to know what cares a resident required and pulled out a care sheet that indicated the night shift was to check and toilet patient before the shift ended and bring R9 to the dining room for monitoring and stated the night shift ended at 7:00 a.m. Further, NA-H stated if a resident refused, they documented and let the nurse know and verified R9's care sheet indicated nights were supposed to get R9 up. NA-H stated R9 was a falling star and staff had to keep an eye on the falling star person and added there was a time when R9 would wake up early and then they brought her to the dining room to keep an eye on her for safety and stated she guessed R9 was sleeping and that was why they didn't get R9 up. NA-H stated they don't close the door 100% for safety. NA-H stated she could not provide a copy of her care sheet. During interview on 5/13/25 at 9:35 a.m., RN-F stated the aides used care sheets and further, care plans were updated and then they printed	2 830		

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2 830	Continued From page 25 new care sheets. RN-F stated a blue star indicated a patient fell a few times and call it a falling star. During interview on 5/13/25 at 9:47 a.m., RN-F stated the care plan should be followed and if care deviated from the care plan they would have to document the deviation. RN-F stated R9's glasses have been missing and stated they looked in the laundry and couldn't find them and the social worker (SW)-A was aware. RN-F stated R9 should have her call light in bed and stated once in a while she used it and R9 probably shook the bed. RN-F verified R9's care plan indicated night staff were to check on R9, prepare her and bring her to the dining room for monitoring before the end of their shift and stated if R9 was awake then nights would get R9 up. RN-F verified R9 did not have antiroll backs on her wheelchair and verified R9's care plan indicated R9 required antiroll backs. Further, RN-F stated they normally kept doors ajar to check on residents. During interview on 5/13/25 at approximately 1:50 p.m., social worker (SW)-A stated he was aware R9 was missing her glasses and had been missing a couple of weeks and would check to see if R9 was signed up for HealthDrive and verified R9 had signed up for HealthDrive on 3/3/23. During observation on 5/13/25 at 2:02 p.m., R9 was in the dining room and did not have glasses on and did not have the antiroll backs on the wheelchair. During interview on 5/13/25 at 2:45 p.m., NA-P stated he worked on 5/11/25, and witnessed R9 was sitting in her wheelchair and used her feet to	2 830		

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2 830	Continued From page 26 move the chair and was trying to get past the threshold when another resident came from behind to push R9 forward in her chair and stated R9 fell out of her chair. NA-P stated they had strollers for the other resident so the other resident wouldn't push residents. During interview on 5:13/25 at 3:30 p.m., the director of nursing (DON) stated he expected staff follow the care plan and if interventions were no longer relevant expected interventions be discontinued. Further the DON stated interventions implemented should reflect on the care plan and nursing assistant assignment sheet and stated R9 had anti roll backs on her wheelchair in February because R9 tried to stand and the chair moved backward and stated the intervention for R9's chair was in place unless they washed the chair, or if hospice changed R9's chair. The DON stated the SW-A was working on the concern of R9's missing glasses. At 3:42 p.m., the DON checked R9's wheelchair and verified she did not have anti roll backs. A policy, Integrated Fall Management, undated, indicated fall risk assessment, identification and implementation of appropriate interventions as necessary to maintain resident safety, prevent falls, and reduce further injury from falls. Residents at risk for falls have an individualized resident centered care plan developed. Care plan interventions are based on the finding of the fall risk assessment. The IDT reviews the fall and care plan changes and may, if needed, implement additional interventions. Documentation of the above items is completed. SUGGESTED METHOD OF CORRECTION:	2 830		

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2 830	Continued From page 27 The director of nursing (DON) or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally	2 840		6/30/25

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2 840	Continued From page 28 appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain dignity for 1 of 1 resident (R62) reviewed for dignity. R62's discharge Minimum Data Set (MDS) dated 3/28/25, indicated intact cognition and diagnoses of quadriplegia, traumatic rupture of cervical intervertebral disc (C5-6), spinal stenosis, and neurogenic bladder. It further indicated R62 required substantial assistance with toileting, was always incontinent of urine, and received a diuretic on routine basis. R62's care plan dated 4/25/25, indicated the potential for alteration of bowel and bladder related to a diagnosis of a neurogenic bladder and included an intervention of R62 requiring 2	2 840	Corrected	

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2 840	Continued From page 29 person assistance to use the toilet upon rising in the morning, before and after each meal, bedtime, on night rounds, and as needed. R62 also required assistance with all toileting tasks and used brief/pads for incontinence protection indicating he was not able to reliably notify staff of his need to be toileted. During interview on 5/12/25 at 5:25 p.m. R62 stated he had to wait 20-45 minutes (on average)almost every time he needed to use the urinal. Since his spinal cord injury, he doesn't have much notice when having to urinate and often ends up urinating in his brief. When that happens he then had to wait long periods of time sitting in his urine or feces. R62 also stated he had reported this to RN-E and the DON but nothing ever happened to fix the problem stating "It's a culture here to not help each other out. I put my call light on and wait for staff to respond. When they don't respond, I go out into the hallway (in my wheelchair) to get help and I am often told by staff they're not my aide and then continue to play on their phone." During observation on 5/14/25 at 7:04 a.m., the following events occurred: -7:15 a.m. R62 put his call light on. -7:28 a.m. NA-E answered call light for another resident who's room was in close proximity to R62's room (exited the room at 7:34 a.m.) but failed to answer R62's call light when she was finished assisting the other resident. -7:35 a.m. NA-F was walking down the hall towards R62's room with the vital signs (VS) machine. NA-F entered the room and asked R62 what he needed because his call light was on. He stated he had to urinate but he already urinated in his brief because he couldn't hold it. NA-G stated that was okay, proceeded to take his blood	2 840		

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2 840	Continued From page 30 pressure, then left the room stating "I will come back later and get you up when she's (unknown) done." -7:45 a.m. NA-F assisted another resident with a shower. -8:01 a.m. registered nurse (RN)-D entered R62's room with medications, blood sugar monitor, and stethoscope. RN-D asked his name, date of birth, took his VS, tested his blood sugar, administered his medications, and gave him a nebulizer treatment. RN-D did not change R62's brief. -8:30 a.m. RN-D exited R62's room. -8:34 a.m. R62 stated RN-D did not change him while she was in his room and that he put his call light on at 7:15 a.m. when he first had to go to the bathroom. -8:40 a.m. R62 put on his call light again. -8:42 a.m. NA-F answered R62's call light and R62 stated he was still waiting for his brief to be changed. NA-F changed his brief (which was visibly full of urine) and removed the pad underneath him which was also visibly wet. During interview on 5/14/25 at 9:15 a.m. NA-F verified R62 told her he had urinated in his brief when she answered his call light at 7:35 a.m. NA-F stated was waiting for the nurse to go in and do what she needed to do but she should have changed him right away before the next call light went on. During interview on 5/14/25 at 9:30 a.m. RN-D stated anyone can answer call lights but it was usually the NA's who answer them. They try to answer call lights within 15 minutes and if a resident stated they need to be changed, staff should try to do that immediately or as soon as possible and changing a brief would take precedence over giving a resident a shower. RN-D further stated NA's are assigned to a group	2 840		

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2 840	Continued From page 31 of residents but the other NA's are expected to answer the call lights and help each other out. If the nurse needs to administer medications or perform cares, etc. they can wait if a resident needed to be changed. RN-D verified she did not change R62 when she was in his room because she was unaware he needed to be changed. There was no reason he needed to wait to be changed until after she was done working with him. During interview on 5/14/25 at 2:00 p.m. NA-D stated NA's are assigned to a certain group of residents and "we stick with our residents, unless someone is really busy, but everyone can help." NA-D further stated they try to answer call lights within 15 minutes and changing a residents brief should be done before giving a resident shower. An hour was too long for a resident to wait to have their brief changed and stated 10 minutes should be the longest they should have to wait unless they were really busy. During an follow up interview on 5/15/25 at 11:16 a.m., R62 stated if he hadn't fallen, he would still be able to do all all the things the staff do for him by himself and it took awhile for him to get used to staff having to help him and when he has to sit in his own urine or feces he feels "useless and worthless." When it takes 45 minutes to an hour for staff to come, It makes him think staff don't want to help him and it's embarrassing and degrading. During interview on 5/15/24 at 10:56 a.m., the director of nursing (DON) stated he did not think an hour was too long for a resident to have to sit in a wet brief and there wouldn't be any negative outcomes as a result (specifically skin breakdown). The DON further stated changing a	2 840		

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2 840	Continued From page 32 residents brief didn't necessarily take precedence over giving another resident a shower and would depend on the situation. He was unable to provide an approximate amount/range of time he would expect a residents call light to be answered or a residents brief to be changed (once they put their call light on.) A facility policy reagrding dignity was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, monitor, evaluate to assure residents who are incontinent of urine receive the necessary services and care following each episode of incontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 875	MN Rule 4658.0520 Subp. 2 I Adequate and Proper Nursing Care; Monitor TPR Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: I. Monitoring resident temperature, pulse, respiration, and blood pressure as often as indicated by the resident's condition but at least weekly. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate	2 875	Corrected	6/30/25

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2 875	Continued From page 33 monitoring was in place for 1 of 1 residents (R60) who sustained an injury during a transfer reviewed for safe resident handling. In addition, the facility failed to ensure tube feeding (TF) was administered and maintained per provider orders. Findings include: R60's quarterly Minimum Data Set (MDS) dated 3/10/25, indicated she had intact cognition and required partial-to-moderate assistance for bed mobility but was dependent on staff for transfers. The MDS identified diagnoses of a cerebrovascular accident or CVA (a stroke, or an episode of insufficient blood supply to the brain caused by either a blood clot or abnormal bleeding), and hemiplegia (one-sided weakness) or hemiparesis (one-sided paralysis) and aphasia (a language disorder caused by injury to the brain). R60's Care Area Assessment (CAA) dated 6/16/24, for Activities of Daily Living (ADLs) triggered related to her needing assistance with cares and mobility related to her CVA with left-sided hemiparesis. The CAA indicated she required 2 staff assist with bed mobility and transfers and directed staff to "proceed to the plan of care". R60's treatment administration record (TAR) dated 4/2025 reflected the following orders: - "NWB L arm every shift," dated 4/25/25 (where "NWB" denoted "non-weight bearing"). - "Ok for ice pack on L shoulder Q1 hr" as needed, dated 4/25/25 (where "L" denoted "left" and "Q1 hr" denoted "every 1 hour").	2 875		

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2 875	Continued From page 34 - "Sling L arm - on day off in bed x 2 weeks" for left humerus fracture, dated 4/25/25 - 5/9/25. Her TAR dated 4/25 was reviewed 5/14/25 and lacked documentation of neurovascular assessments of her left upper extremity. Neurovascular assessments would include an evaluation of the color, temperature, capillary refill or circulation, palpable pulse, edema or swelling, sensation, motor function or strength, and pain to her left upper extremity compared to both her baseline and her right upper extremity. R60's TAR dated 5/25 reflected the following orders: - "ensure L) arm in sling at all times every shift," dated 5/12/25. - "NWB L arm every shift," dated 4/25/25. - "Ok for ice pack on L shoulder Q1 hr" as needed, dated 4/25/25. - "Sling L arm - on day off in bed x 2 weeks" for left humerus fracture, dated 4/25/25 - 5/9/25. The TAR dated 5/25 was reviewed 5/15/25 and lacked documentation of neurovascular monitoring. A provider progress note dated 4/29/25 indicated she was seen for follow-up sustaining an injury from a "transfer via hoyer". The progress note referenced the x-ray dated 4/24/25, which showed the proximal humerus fracture, and indicated R60 was having "unrelieved pain" and "did not appear comfortable". The progress note identified under the "Assessment/Plan:" header the plan was to consult orthopedics, "OK to ice",	2 875		

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2 875	Continued From page 35 non-weight bearing status to left upper extremity, wear a sling "24/7" and have a follow-up x-ray in 4 weeks. R60's electronic health record (EHR) was reviewed 5/14/25 and lacked documentation of neurovascular monitoring of her left upper extremity. During observation and interview on 5/12/25 at 4:54 p.m., R60 was lying in her bed without a sling on her left arm. She stated while she was getting into bed, "I heard a big crack, it hurt." R60 stated she was "okay" to have the sling off while in bed but needed to have staff assist her with putting it on when out of bed. She stated not a lot of staff knew how to put the sling on. She stated she broke her left shoulder, which was the side affected by her stroke. She stated she felt staff were doing a "pretty good job" at managing her pain, however, were not offering her ice packs anymore, which was something she would like to have for pain management. During observation on 5/13/25 at 9:24 a.m., R60 was up in her wheelchair and requested to lay down. She pushed her call light at 9:25 a.m. and at 9:29 a.m., registered nurse (RN)-E and nursing assistant (NA)-Q entered her room to answer her call light. After performing hand hygiene, donning gloves and providing for privacy, NA-Q retrieved the lift sling from the back of the door and asked her to lean forward and began tucking the sling behind and down her back. NA-Q pulled the sling straps under her legs, first under her right hip and through the front of her right leg and then NA-Q repeated the steps on the left side. NA-Q walked across the room and pulled the ceiling mechanical lift from one side of the room over to above R60 and used the remote to lower the lift.	2 875		

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2 875	Continued From page 36 RN-E asked her to hold onto her left hand and guided her to her affected left hand in the sling. NA-Q crisscrossed the sling straps in the front and hooked the sling straps up to the mechanical lift before using the remote to lift her up from the wheelchair. The bottom hem of the sling was above her sacral level; however, her head was above the top hem and there was no slipping observed during the transfer. Together, RN-E and NA-Q pushed her over top of her bed and NA-Q used the remote to lower her onto the bed. R60 made an "ouch" noise during the transfer and NA-Q asked her if she was okay, and she answered, "yeah". RN-E and NA-Q assisted her to turn to the side to tuck the sling, and then to sit forward. Together, they removed the sling out from behind her. RN-E stated she had a stroke and only had "one working arm and hand" and had always transferred with a mechanical body lift. NA-Q provided the call light within her reach, lowered the bed and gave her a stuffed animal. There was no offer to elevate her left arm on a pillow and no assessment of her pain prior to staff exiting the room, however, R60 did not report her pain to staff. During observation and interview on 5/14/25 at 11:49, R60 was wearing her sling and stated she had not been offered ice for her shoulder. R60 stated she had numbness and tingling in her left hand and fingers that was not her baseline. The color in her left fingers was normal per her race and she indicated the strength in her moveable index finger felt "the same" as before the fracture. R60 stated staff had not asked her about the sensation or strength in her left hand or arm, and family member (FM)-J endorsed this. FM-J stated they visited R60 often and had not heard staff asking about sensation, movement, temperature or strength to her affected arm.	2 875		

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2 875	Continued From page 37 During interview on 5/14/25 at 12:08 p.m., nurse practitioner (NP)-H reviewed previous documentation and stated she had a proximal left humerus fracture and recent follow-up imaging showed the fracture was "more prominent", which NP-H explained meant there was no evidence of healing on the x-ray. NP-H stated the x-ray results "probably means the matrix hasn't formed yet and it's still a fracture." NP-H further explained the matrix formed after a fracture began to heal and formed a callus, and the follow-up x-ray did not show such a callus. NP-H indicated she was "non-compliant with her sling" and stated when she was wearing the sling, "she's moving it around a lot", referring to her left upper extremity. NP-H indicated her follow-up x-ray was sent to geriatric orthopedics and physical therapy (PT) and occupation therapy (OT) for further evaluation. NP-H hoped PT/OT could evaluate her for a better fitting wheelchair that would promote better positioning for her arm to "help elevate it" and maintained ice and elevation remained appropriate interventions for her fracture. During interview on 5/14/25 at 2:26 p.m., registered nurse (RN)-E expected staff to monitor for pain and swelling and stated initially, R60 was using ice for pain management but "now when we ask she says no, she does not want ice." RN-E expected staff to elevate her affected arm on a pillow and to perform a neurovascular assessment (circulation, movement, sensation or CMS) and indicated the assessment should be documented in progress notes. RN-E reviewed her progress notes and was unable to locate such documentation. RN-E reviewed her treatment orders and indicated there was an order to assess previously but stated, "it fell off, it looks	2 875		

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2 875	Continued From page 38 like. It was on there from before, so they were documenting that from before, but it fell of." RN-E confirmed there was no current documentation or order in place and stated there should be. During interview on 5/15/25 at 11:54 a.m., the director of nursing (DON) stated assessing for neurovascular changes (CMS changes) after a fracture was a standard of practice and expected staff to perform the assessment when applying R60's sling per orders. The DON reviewed her orders and identified the order to ensure her sling was on at all times or "24/7". When asked what part of the order directed staff to assess her neurovascular status or for CMS changes, the DON stated the order did not state specifically to monitor, however, identified progress notes in which staff documented swelling in her shoulder and discomfort. When asked about documentation of sensation, temperature, pulses, color, and strength, the DON indicated staff should be charting by exception. A request was made for documentation of staff's assessment of her neurovascular status or CMS after the fracture, however this information was not received. During interview on 5/15/25 at 12:45 p.m., licensed practical nurse (LPN)-B stated NAs put R60's sling on in the morning, "but I can put it on, too". LPN-B stated, "there's an order in there I mark off every day if its on or not." LPN-B stated for a resident who sustained a fracture, "I look for signs of swelling at the site of fracture, signs of infection, like redness and warmth, and I assess for pain." LPN-B stated they could compare it to the other side to see how it looked and would document that if noted. During interview on 5/15/25 at 12:50 p.m., NA-M	2 875		

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2 875	Continued From page 39 stated NAs normally applied her sling in the morning and confirmed applying that morning stating, "I heard they were having trouble with her sling this morning, so I helped with it." A policy pertaining to monitoring and/or assessing post-accident or fracture was requested but not available and not received. Feeding Tube R37's quarterly Minimum Data Set (MDS) dated 4/8/25, indicated R37 was cognitively intact, was dependent on staff for all activities of daily living (ADLs), and required a FT for nutrition. R37's diagnoses included dysphagia (difficulty swallowing) and nutritional deficiency, R37's care plan dated 5/13/24, indicated R37 had swallowing difficulty related to severe esophageal dysphagia and required nutrition provided using a feeding tube through a G-tube. R37's care plan instructed staff to check residual every four hours, flush G-tube with water before and after medications, maintain FT materials, not allow formula to hang longer than eight hours at room temperature, and change set up daily. R37's provider orders included the following: -Diet: NPO (nothing by mouth) except small sips of water-4/17/25 -Diet: tube feeding 45cc per hour for 22 hours Novasource renal-5/13/25 -Ensure formula bag for enteral feed has time and date on bag. Discard formula and replace every 24 hours-10/29/22 -Hold tube feeding between 5:00 a.m. and 7:00 a.m.-4/4/25 -Change bag, tubing, and syringe daily-1/12/23 -Flush G-tube with 30cc water before and after	2 875		

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2 875	Continued From page 40 each medication-2/3/22 During observation on 5/12/25 at 12:29 p.m., R37 in bed with TF running with a pump. There was one bag of formula and one bag of water flush. A graduated cylinder containing a syringe sat on the dresser with other supplies. The cylinder was dated 5/4 at 0430 (4:30 a.m.). During observation on 5/13/25 at 8:14 a.m., R37 was lying in bed. Cylinder with syringe on dresser dated 5/12/25. No TF or water bag hanging on pole and pump turned off. During observation on 5/13/25 at 9:46 a.m., R37 was sleeping in bed. Still no TF being administered. During observation and interview on 5/13/25 at 10:13 a.m., registered nurse (RN)-A into R37's room to administer medications. R37 stated, "It's time to hook me up to my food, isn't it?" meds. RN-A administered medications using the syringe and cylinder date 5/12/25 and then hung a new bag of tube feeding formula, tubing and water flush. RN-A labeled both bags with date and time. RN-A stated the date on the cylinder reflected when the cylinder and the syringe were last changed, in this case 5/12/25. RN-A could not state how often they needed to be changed and stated, "I will have to check on that" and left the room. R37 stated her TF had been turned off and disconnected at about 5:00 a.m. and should have been restarted by now. During interview on 5/13/25 at 10:36 a.m., RN-A stated the cylinder and syringe were supposed to be changed daily and proceeded to date a new cylinder and placed in R37's room.	2 875		

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2 875	Continued From page 41 During observation of 5/14/25 at 7:18 a.m., a full bag of TF hanging with water flush bag but pump not on and tubing not attached to R37. Neither TF bag nor water bag dated. Cylinder with syringe sitting on dresser dated 5/13. During observation on 5/15/25 at 8:10 a.m., cylinder with syringe labeled 5/13, water bag now labeled 5/14/25- 8:00 a.m. TF bag not dated. During observation and interview on 5/15/25 at 8:25 a.m., licensed practical nurse (LPN)- A stated the TF bag and tubing should be changed out every 24 hours and was on the treatment administration record (TAR) for the evening shift to complete. LPN-A stated evening shift will leave the bag up since there was still TF formula left in it, in which case nights or days would change it. LPN-A stated if the formal runs out and the bag had not reached 24 hours, they will just add more TF formula to the hanging bag. LPN-A stated she added the label to the water bag yesterday at 8:00 a.m., but could not confirm when the bags or tubing had been changed prior to that time since they were not dated. LPN-A stated the entire set up including the bags, tubing, cylinder and syringe should be changed every 24 hours and should be labeled with the date and time of change. LPN-A confirmed the cylinder with syringe was dated 5/13 and should have been changed yesterday (5/14/25). LPN-A stated she would change out the whole set up this morning and label everything appropriately. During interview on 5/15/25 at 10:09 a.m., RN-B stated staff should change TF materials including bag, tubing and syringe every 24 hours and all should be labeled to indicate the date and time of change. RN-B stated the TF materials change	2 875		

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2 875	Continued From page 42 was scheduled for evening shift, but not always done on that shift, which made it very important to indicate the date and time of change. RN-B stated TF materials should not be used for longer than 24 hours due to the increased risk of bacterial growth and possible infection. During interview on 5/15/25 at 10:40 a.m., director of nursing (DON) stated expectation for staff to administer and maintain TF per provider orders. DON referred to facility policy and stated TF materials should be changed out every 24 hours and labeled with date and time when changed. DON stated TF materials used greater than recommended time could lead to bacterial growth and could cause infection. Facility policy Gastrostomy "G" Tube Use, undated, indicated syringe and administration set should be changed every 24 hours. The policy further indicated, "On the formula label document initials, date and time the formula was hung/administered." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures related to fractures and post-fracture assessments and monitoring and could provide staff education related to these policies and procedures. The director of nursing or designee could develop an audit tool to ensure appropriate monitoring is provided. The DON or designee could conduct audits of resident monitoring orders and assessment documentation and report the results of these audits to the Quality Assurance committee.	2 875		

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2 875	Continued From page 43 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 875		
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 the daily cleaning schedule was followed in the kitchen. During observation on 5/12/25 at 12:05 p.m., the kitchen floor was visibly soiled with dirt, there were multiple footprints, food spills, it was sticky, and there were copious amounts of food particles pushed down into the grout of the floor. During observation and interview on 5/14/25 at 10:37 a.m., the kitchen floor was visibly soiled with dirt, there were multiple footprints, food spills, it was sticky, and there were copious amounts of food particles pushed down into the grout of the floor. The director of dining services (DDS) verified the floor was dirty and stated kitchen staff were responsible for mopping the floor daily. During interview on 5/14/25 at 11:04 a.m., dietary aide (DA)-A stated the dishwasher was responsible for mopping the kitchen floor every day and verified the floor was dirty stating "It had been a while" since it had been cleaned.	21015	Corrected	6/30/25

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21015	Continued From page 44 During interview on 5/15/25 at 10:47 a.m., the administrator stated the kitchen staff were contracted employees, it was their responsibility to clean the kitchen, and she expected them to be following their cleaning schedule and their policies. The cleaning schedule for the kitchen titled "Back of the House Cleaning Log" for the month of May 2025, indicated the kitchen floor should be swept and mopped daily. It further indicated the last time the floor had been swept and/or mopped was on 5/10/25. A facility policy regarding the cleaning schedule for the kitchen was requested and received, however did not address cleaning of the floor or frequency. SUGGESTED METHOD OF CORRECTION: The director of nursing, director of dietary services and/or designee could assure policies and procedures are current, implemented, and monitored to assure kitchen staff maintain clean and sanitary food prepartation and storage areas. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection	21385		6/30/25

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21385	Continued From page 45 control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper hand hygiene practices for 2 of 2 residents (R62, R59) observed during personal cares. In addition, the facility failed to ensure appropriate room assignment for 6 of 10 residents (R26,R23,R136,R74,R12,R11) reviewed for transmission based precautions (TBP). Also, the facility failed to ensure consistent and appropriate personal protective equipment (PPE) use for 5 of 10 residents (R11,R12,R73,R76, R59) reviewed for TBP and staff handling soiled laundry. Findings include: Room Assignment From CDC website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes	LTCFs	CDC "Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. The resident is given dedicated equipment (e.g., stethoscope and blood pressure cuff) and is placed in a private room. When private rooms are not available, some residents (e.g., residents with the same pathogen) may be roomed together. Residents on Contact Precautions are recommended to be restricted to	21385	Corrected	

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21385	Continued From page 46 their rooms except for medically necessary care, including restriction from participation in group activities. Contact Precautions are generally intended to be time limited and, when implemented, should include a plan for discontinuation or de-escalation." Facility provided infection precautions for Transmission Based Precaution (TBP) list printed 5/14/25, indicated R12, R26, and R136 were on contact precautions due to Methicillin-resistant Staphylococcus aureus (MRSA). The list did not indicate R11, R23, and R74 were on contact precautions. Facility provided infection precautions for Enhanced Barrier Precautions (EBP) list printed 5/14/25, indicated R23 was on EBP due to a urinary catheter. Resident census dated 5/12/25, indicated R26 and R23, R136 and R74, and R11 and R12 shared double occupancy rooms. During interview on 5/14/25 at 12:50 p.m., infection preventionist (IP) and director of nursing (DON) stated ideally residents not requiring TBP should not be sharing a room with residents who do require TBP. In the example where a resident on contact precautions for MRSA shared a room with a resident not on contact precautions, the whole room should be treated with contact precautions and staff would need to gown and glove prior to entrance into the room. During interview on 5/15/25 at 11:03 a.m., IP stated R23 was on EBP due to a urinary catheter and was considered high risk for contracting a facility acquired organism, R23 should not be sharing a room with R26 who was on contact	21385		

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	00940	A. BUILDING: _____ B. WING _____	C 05/15/2025

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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
21385	Continued From page 47 precautions due to MRSA. Facility policy Contact Precautions dated 9/2023, indicated resident placement would be made on a case by case basis, and consideration would be given to risk of transmission to a roommate. Considerations included, "Cohort residents who are infected or colonized with the same pathogen." Additional considerations included, "Avoid placing residents on Contact Precautions in the same room with residents who have conditions that place them at risk of adverse outcomes, should they become infected - or that may facilitate transmission. This includes, but is not limited to: ...Those with any form of tube - foley catheter, G/J tube for feeding." TBP R11 and R12 R11's admission Minimum Data Set (MDS) dated 4/23/25, indicated R11 was cognitively intact, was dependent on staff for many activities of daily living (ADLs), and had a fracture of the right shoulder. R11's care plan dated 4/17/25, lacked evidence of need for any transmission based precautions (TBP). R11's provider orders lacked evidence of need for any TBP. R12's quarterly MDS dated 4/15/25, indicated R12 was cognitively intact, required substantial/maximal assistance with most ADLs, occasionally incontinent of bowel and bladder, and had a recent hip replacement. R12's diagnoses included MRSA infection, infection and	21385		

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21385	Continued From page 48 inflammatory reaction due to internal right hip prosthesis, and bacteremia. R12's care plan dated 5/14/25, indicated R12 was on isolation contact precautions due to MRSA of the urine. R12's care plan indicated R12 would be isolated to the room to prevent spread of the infection. The care plan further instructed staff to "wash hands, wear gown, mask, gloves and goggle as needed to prevent spread of infection." R12's provider order dated 1/10/25, indicated, "Contact Isolation ESBL [extended-spectrum beta-lactamase-an enzyme produced by a bacteria that causes resistance to several antibiotics], MRSA [methicillin-resistant staphylococcus aureus-a staph bacteria resistant to many antibiotics]. Facility resident census indicated R11 and R12 shared a double occupancy room. During observation on 5/13/25 at 8:53 a.m., signage indicating "Contact Precautions" was posted outside R11/R12's room. An unidentified housekeeper was cleaning the room and was not wearing a gown. Director of spiritual care also in the room speaking to R11 and was not wearing any PPE. During observation on 5/13/25 at 8:54 a.m., nurse practitioner (NP) entered R11/R12's room and did not don any PPE. During observation on 5/13/25 at 9:21 a.m., activities personnel (A)-A entered R11/R12's room without donning PPE. A-A asked both invited both residents to attend morning exercise group upstairs. Both declined.	21385		

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21385	Continued From page 49 During observation on 5/13/25 at 9:53 a.m., A-A entered R12's room and did not perform hand hygiene and did not don any PPE. A-A invited R12 to a different activity and R12 accepted. A-A pushed R12 out of the room to the elevator. During interview on 5/14/25 at 7:45 a.m., nursing assistant (NA)-D stated R12 was on contact precautions and R11 was not on precautions, therefore if she needs to just drop something off to R11, PPE was not necessary, but would use PPE if providing any cares for either R11 or R12. NA-D was not sure if someone on contact precautions should be leaving the room and joining activities. During observation on 5/15/25 at 8:07 a.m., licensed practical nurse (LPN)-A entered R11's room to administer medications. LPN-A did not don any PPE. R73 and R76 During observation on 5/14/25 at 11:36 a.m., nurse practitioner (NP) entered R73 and R76's room without donning a gown or gloves. The room had signage indicating "Contact Precautions." NP stopped to talk R76 into seeing podiatry today. NP touched R76's bedside table to move it out of the way, pulled off R76's socks and touched and assessed his feet and toenails. NP was not wearing gloves or gown. NP went over to R73's side of the room and moved R73's bedside table out of the way touching it without gloves. During observation at 5/14/25 at 11:37 a.m., NA-B donned gown and gloves to enter and deliver R76's meal to his bedside table.	21385		

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21385	Continued From page 50 During observation on 5/14/25 at 11:41 a.m., R76 wheeled self out of room to go to visit podiatry. During observation on 5/14/25 at 11:43 a.m., NA-C entered room to deliver R73's meal and did not don gown or gloves prior to entrance. During interview on 5/14/25 at 11:49 a.m., NP stated R73 had diagnoses history of right lower extremity wound and MRSA. NP stated R76 had a history of MRSA with location not classified. NP stated neither R73 nor R76 had active infections and did not think they were on contact precautions; therefore he did not gown and glove prior to entrance. NP did not agree the two residents required contact precautions, but stated if signage directed staff to use contact precautions the sign should be followed, and precautions should be utilized. NP stated thinking the signage was in place due to facility policy and that they just follow policy when the state comes in. NP stated, "we are just spreading it." Laundry During observation on 5/15/25 at 10:15 a.m., laundry aide (LA)-A was sorting dirty clothes and linen in the soiled laundry room. LA-A had gloves on but did not have a gown on. Director of environmental services (DES) stated the expectation was for staff to be wearing gown and gloves whenever handling and sorting soiled linen. During interview 5/15/25 at 10:16 a.m., LA-A stated she usually wore a gown and gloves when sorting soiled linen and could not explain why she was not wearing a gown now. During interview on 5/15/25 at 10:57 a.m.,	21385		

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21385	Continued From page 51 infection preventionist (IP) stated expectation for staff to wear correct PPE to include gown and glove anytime they were handling soiled linen. Laundry workers should wear a gown and gloves when sorting soiled laundry. During interview on 5/15/25 at 11:29 a.m., Administrator stated expectation that staff follow the policy and wear gown and glove when handling and sorting soiled clothing and linen. Facility policy Linen and Laundry, undated, indicated, "Soiled health care textiles must be assumed to be contaminated; personnel who handle soiled textiles must follow Standard Precautions including gloves and a gown." R62 R62's discharge MDS dated 3/28/25, indicated intact cognition and diagnoses of quadriplegia, traumatic rupture of cervical intervertebral disc (C5-6), spinal stenosis, and neurogenic bladder. It further indicated R62 required substantial assistance with toileting and was always incontinent of urine. During observation on 5/14/25 at 8:42 a.m., NA-F entered R62's room to answer his call light and asked him if someone had changed his brief yet. R62 responded no. NA-F washed her hands and put on gloves, handed R62 a wet washcloth to wash his face, and then removed his bilateral heel protectors. NA-F removed R62's gown and brief (which was visibly full of urine) and assisted him to turn on his right side, and wiped his bottom with wipes. Then NA-F removed the pad from underneath him (which was also visibly wet), put it in a plastic bag, assisted him to turn onto his back, and wiped his peri area. NA-F then	21385		

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21385	Continued From page 52 fastened his brief, pulled up his pants, touched the back of his shoulder, put on his shoes, grabbed a pack of wipes and put them on his dresser, and touched the door handle. NA-F then removed her gown and gloves but did not perform hand hygiene. NA-F then grabbed the EZ stand lift from the hallway, got new gloves from R62's bathroom, touched the bed remote, applied the sling, and NA-E assisted her to transfer R62 to his wheelchair. Once he was in his chair NA-F made the bed and then removed her gown and gloves, brought the EZ stand lift out into the hallway, brought a bag of dirty laundry to the soiled utility room, and did not perform hand hygiene. NA-F then applied new gloves and went into another resident's room and shut the door. During interview on 5/14/25 at 9:15 a.m. NA-F stated when entering a resident's room to perform cares, she washes her hands and puts on gloves and then when the cares have been completed, she will remove her gloves and wash her hands. NA-F verified she had not removed her gloves or performed hand hygiene after removing R62's wet brief and did not perform hand hygiene in between glove changes and should have. During interview on 5/14/25 at 9:30 a.m., registered nurse (RN)-D stated when going from a dirty area to clean area while performing personal cares for a resident, staff should change gloves and then perform hand hygiene. This was important in order to prevent spreading germs. During interview on 5/14/25 at 2:00 p.m., (NA)-G stated when you are performing cares and you go from a dirty area (changing a wet/soiled brief) to a clean area (assisting a resident to get dressed), staff should change gloves, wash their hands/use hand sanitizer, and apply new gloves.	21385		

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21385	Continued From page 53 During interview on 5/15/24 at 10:56 a.m., the DON stated when staff are performing personal cares and going from a dirty area to a clean area, they should change gloves and perform hand hygiene. Staff should also be performing hand hygiene in between glove changes. This was important because there was the potential of spreading germs to other residents or the staff. R59 (hand hygine/TBP) R59's admission Minimum Data Set (MDS) dated 4/25/25, indicated R59 was cognitively intact and had diagnoses of bilateral humerus (upper arm) fractures. Furthermore, R59 had occasional incontinence and required staff assistance with toileting. R59 did not require isolation due to active infectious disease. R59's provider order dated 4/22/25, indicated R59 required contact precautions due to Methicillin-resistant Staphylococcus aureus (a resistant bacteria MRSA) of the nare. R59's care plan dated 4/22/25, indicated R59 was on contact precautions due to MRSA of the nares and R59 would be isolated to their room to prevent the spread of infection. Interventions directed staff to wash hands, wear gown, mask, gloves and goggles as needed to prevent spread of infection. Staff were also required to perform hand hygiene upon entrance and exit of R59's room. An observation on 5/12/25 at 1:42 p.m., R59's room had a sign that read contact isolation on their door. The sign further instructed staff to gown and glove when entering the room. An observation on 5/12/25 at 5:18 p.m., NA-I was picking up dinner trays. NA-I had gloved hands	21385		

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21385	Continued From page 54 on and pushed a cart near R59's room. Without gowning, hand hygiene or glove exchange, NA-I entered R59's room came out with the dinner tray and placed it on the cart. With the same gloves, NA-I entered room 118 and exited with the dinner tray and placed it on the cart. With the same gloves, NA-I entered room 116-I and exited with the dinner tray and placed it on the cart. With same gloves, NA-I pushed the cart down to the kitchen area. When interviewed on 5/12/25 at 5:18 p.m., NA-I verified they had not donned a gown as instructed when entering R59's room and had worn the same gloves in all three resident rooms. NA-I stated hand hygiene should have been done and new gloves placed for each room. NA-I stated other staff were waiting for the dirty dishes and they were in a hurry. An observation on 5/13/25 at 9:37 a.m., after donning gown and gloves, NA-J entered R59's room to assist with morning cares. After helping R59 choose clothing, NA-J assisted R123 with putting on gripper socks, placed a transfer belt on and assisted walking R59 to the bathroom. R123 walked by the toilet and NA-J then assisted R59 with pulling down the brief. NA-J removed the soiled brief and placed in the garbage. R59 sat on the toilet. NA-J then removed gloves and without hand hygiene, placed donned new gloves. NA-J then assisted with washing face, arms, back and legs. R59's gown was removed and NA-J assisted R59 with putting on a shirt. NA-J then assisted putting a clean brief and pants around R59's ankles before assisting R59 to stand. Once standing, NA-J used wipes to provide peri cares for front and back. NA-J removed gloves and without hand hygiene donned new gloves. R59's clean brief and pants were pulled up and	21385		

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21385	Continued From page 55 R59 was assisted out of the bathroom to their wheelchair. NA-J assisted R59 to be positioned in the wheelchair in the room and provided R59 the call light. NA-Jthen removed gown and gloves before exiting room and performed hand hygiene upon exit. When interviewed on 5/13/25 at 10:12 a.m., NA-J verified they had not performed hand hygiene after glove removals and was supposed to. NA-J stated R59 was on contact precautions but was not sure why. NA-J stated they follow the signs on the doors. When interviewed on 5/13/25 at 10:16 a.m., registered nurse (RN)-I stated R59 was on contact precautions for MRSA. RN-I further stated the MRSA was not active and many times contact precautions were placed as more of a precautionary basis. R73 R73's quarterly Minimum Data Set (MDS) dated 3/17/25, indicated she had intact cognition and diagnoses of high blood pressure and diabetes. The MDS also reported she received application of ointment(s) to areas other than her feet during the lookback period. R73's physician order report dated 4/1/25 - 4/30/25 included the following orders: - "Unna Boots - every Friday. Remove, cleanse with warm water, re-wrap Unna and Coban cover" once daily every Friday, dated 9/27/24 (Unna Boots are a type of compression bandage and Coban is a brand of self-adherent wrap). The physician order report further indicated R73's	21385		

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21385	Continued From page 56 diagnoses included "non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity," and "methicillin-resistant Staphylococcus aureus (MRSA) infection as the cause of diseases classified elsewhere-RLE" (right lower extremity). R73's care plan dated 12/7/24, identified she was on contact precautions related to MRSA and directed all staff to wash hands; wear gown, mask, gloves and googles as needed to prevent spread of infection. An undated nursing assistant (NA) care sheet identified R73 was on contact precautions for MRSA. R76 R76's quarterly MDS date 4/1/25, indicated he had intact cognition with diagnoses of high blood pressure and high cholesterol. The MDS also reported he received application of ointment(s) and dressings to areas other than his feet. R76's Care Area Assessment (CAA) dated 10/5/24 for Activities of Daily Living (ADLs) triggered related to "needing assist with cares and mobility" due to his "cellulitis-MRSA/pseudomonas" in his lower extremities. The CAA indicated he required assist of 1 with cares and mobility and directed staff to the plan of care to support his care mobility needs. R76's CAA dated 10/5/24 for Pressure Ulcer/Injury indicated he had "recurring open aeras on both legs" and the CAA triggered related to "cellulitis - MRSA/pseudomonas".	21385		

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21385	Continued From page 57 R76's physician order reported dated 4/1/25 - 4/30/25 included the following orders: - "Bilateral leg dressing; Change twice weekly; cleanse, apply 2 grams ammonium lactate lotion to each leg, apply Vaseline gauze to open areas wrap Unna boots. Do not leave leg unwrapped for > [sic, greater than] 30 min. [sic, minutes]. Once Click or tap here to enter text. day and once a day as needed," dated 4/17/25. The order report also identified diagnoses including cellulitis of right lower limb (a bacterial skin infection), non-pressure chronic ulcer of unspecified lower leg with unspecified severity - bilateral (meaning both sides), MRSA infection, and pseudomonas (aeruginosa) (mallei) (psedomallei). R76's care plan last reviewed/revised 4/8/25, identified under "diagnosis" his MRSA and pseudomonas (aeruginosa) (mallei) (pseduomalleli), however, lacked documentation of measurable objectives and timeframes to meet his medical and nursing needs related to his MRSA and pseudmonas infection and lacked documentation of interventions related to transmission-based precautions (TBP). An undated NA care sheet identified R76 was on contact precautions. Per observation on 5/12/25 at 5:39 p.m., R73 and R76 were on contact precautions evidenced by the signage posted outside their shared room next to the door frame at approximate standing eye-level. The sign read, "Contact Precautions: Everyone Must: clean hands when entering and leaving room. Doctors and Staff Must: gown and gloves at door."	21385		

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21385	Continued From page 58 During observation on 5/13/25 at 8:52 a.m., nursing assistant (NA)-N pushed a four-wheeled meal cart down the unit hallway. NA-N stopped the cart outside of R73 and R76's room and walked past the contact precautions signage into the room without performing hand hygiene or donning personal protective equipment (PPE) of gown and gloves. NA-N walked back out of the room, did not perform hand hygiene, returned to the cart and poured liquid from a carafe into a cup and re-entered the room without performing hand hygiene and without donning PPE. NA-N exited the room again and returned to the cart, without performing hand hygiene, picked up utensils from the cart, and walked past contact precautions signage and into the room without performing hand hygiene or donning PPE. NA-N walked out of the room and back to the cart, did not perform hand hygiene, and picked up the carafe and poured liquid into a cup and picked up condiments from the cart and walked past the contact precautions signage and into the room without performing hand hygiene or donning PPE. NA-N exited the room, did not perform hand hygiene, and used bare hands to push the meal cart down the hallway to the next room. NA-N did not perform hand hygiene before entering the next room and told the unidentified resident, "I have your breakfast." NA-N exited the room, did not perform hand hygiene, and used bare hands to pick up a white plate with food on it and walked it into the unidentified resident's room. NA-N exited the room, did not perform hand hygiene and stated, "lord tell me I didn't forget a fork," and used bare hands to grab the handle of a fork. NA-N re-entered the unidentified resident's room without performing hand hygiene. NA-N exited the room without performing hand hygiene, walked across the hallway to a covered linen cart, used	21385		

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21385	Continued From page 59 bare hands to pick up towels. At 8:55 a.m., NA-N re-enters the resident's room and sets up the bedside table with the meal before exiting the room without performing hand hygiene. Per follow-up interview at 8:55 a.m. with NA-N, staff should wear PPE for contact precautions when doing the cares. NA-N and the surveyor walked to R73 and R76's shared room to review the contact precautions signage. When asked when to wear gown and gloves in their shared room, NA-N stated, "I can ask my manager," and then asked the surveyor if they could return to delivering the breakfast "so it doesn't get cold." Surveyor asked NA-N to review the contact precautions signage and asked when staff should wear PPE and NA-N stated, "when doing cares," before walking away. During observation and interview on 5/13/25 at 8:58 a.m., NA-M was at R73 and R76's shared door and performed hand hygiene before donning a gown and gloves. NA-M entered the shared room and delivered two mugs with lids. NA-M remarked how warm the room temperature was and offered to submit a work order for them. With the room door open, NA-M was observed doffing the gown and gloves at the doorway, then performing hand hygiene before exiting the room. At 9:01 a.m., NA-M stated staff should wear PPE whenever going in or out of the room "just in case you come in contact with them or something." When asked if NA-N should have donned gown and gloves as the signage indicated outside R73 and R76's shared room, NA-M confirmed, "the general rule is you should do what you read" but said "everybody kinda just does their own thing." Per interview on 5/13/25 at 9:03 a.m., licensed practical nurse (LPN)-B confirmed both R73 and R76 were on contact precautions and verified staff were expected to follow TBP signage	21385		

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	00940	A. BUILDING: _____ B. WING _____	C 05/15/2025

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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21385	Continued From page 60 instructions if they were posted on the resident's door. Per interview on 5/14/25 at 9:27 a.m., registered nurse (RN)-E would expect staff to follow [transmission-based] precaution signs posted on the resident's doorway. When asked if staff would be expected to don full PPE of gown and gloves for a resident room identified as having contact precautions to deliver meal trays, RN-E stated if staff were not expecting to come into contact with a resident for cares, they would not need to don full PPE. During the interview, RN-E and surveyor reviewed the Center for Disease Control (CDC)'s recommendations for Transmission-Based Precautions dated 4/3/24, which indicated, "Wear gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens." Additionally, RN-E and the surveyor reviewed the CDC's Contact Precautions signage, which indicated, "providers and staff must also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit." RN-E acknowledged there was confusion among staff with TBP and requested to speak with the facility's infection preventionist (IP) to clarify. RN-E stated the expectation was staff follow the CDC's recommendations for precautions. Per interview on 5/15/25 at 12:38 p.m. with the director of nursing (DON), staff were expected to follow the signage on a resident's door as it related to TBP. The DON stated if staff were unsure what PPE to wear or had questions about in what situations they needed to wear PPE, they knew they could ask either the DON or the IP.	21385		

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21385	Continued From page 61 Per facility policy titled Contact Precautions last revised 9/23, contact precautions were used to prevent nosocomial spread of organisms that could be transmitted by direct resident contact or indirect contact of environmental surfaces or contaminated resident care equipment. The policy directed staff to perform the following steps for appropriate contact precaution procedure: "1. Hand Hygiene is done prior to donning PPE. 2. PPE is donned prior to entering room. A gown and gloves are needed upon entering room. 3. Change gown and gloves between residents even if only one resident is on Contact Precautions. 4. Use of masks, eye protection and face shields is not routinely part of contact precautions, however, just as with Standard Precautions, these items are own during resident care activities that are likely to create splashes or sprays of blood, bodily fluid, secretions, and excretions. 5. Hand hygiene is performed between glove changes and when removing gloves." Furthermore, the policy directed associates to "practice hand hygiene and don gown and gloves before entering and remove gown and gloves prior to exiting room per CDC guidelines. Hand Hygiene must occur once PPE is removed." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. Additionally, the DON or designee could review/revise policies pertaining to transmission-based precautions. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the	21385		

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21385	Continued From page 62 policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21385		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow up on reported grievances in a timely manner for 1 of 2 residents (R9) reviewed for grievances. Findings include: See also F689 related to falls. R9's significant change Minimum Data Set (MDS) dated 4/11/25, indicated severe cognitive impairment, did not reject cares, used a wheelchair, and required substantial assist with toileting hygiene, and partial to moderate assist with dressing. Further, R9's vision was adequate with glasses.	21495	Corrected	6/30/25

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21495	Continued From page 63 R9's optional state assessment (OSA) dated 4/11/25, indicated R9 required assist with bed mobility, transfers, and toileting. R9's Facesheet undated, indicated the following diagnoses: rheumatoid arthritis, Myelodysplastic syndrome, weakness, history of falling, and Alzheimer's disease. R9's care plan dated 4/14/25, indicated R9 had an alteration in ADLs and required assist of one with dressing, and grooming. R9's care plan dated 4/14/25, indicated R9 had an alteration in mobility and required assist of one with transfers and ambulating. R9's care plan dated 4/14/25, indicated R9 had vision, and interventions indicated to assist with glasses as needed, and provide vision exams as needed. R9's care plan dated 4/14/25, indicated R9 was on the facility Falling Star program and was at risk for falling due to multiple diagnoses. R9's goal was to be free from falls with injury and interventions included ensuring R9 wore her glasses and that they were clean and in good repair. R9's care sheet undated, lacked information R9 wore glasses. R9's HealthDrive Eye Care Group note dated 2/28/25, indicated R9's daughter reported R9 had a bad fall the week prior and was in the hospital. Further, R9 required full time use of glasses for distance and reading. R9's progress notes were reviewed from 3/10/25,	21495		

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21495	Continued From page 64 to 5/15/25, and lacked documentation on any efforts the facility made to locate R9's glasses or that R9 was missing her glasses. A form, Customer Concerns Database, dated 2/13/25, through 5/13/25, was provided by the facility that included a list of residents in various units with various concern types including missing items. The form was reviewed and lacked information R9 was missing any items. A form, Lost Items Log dated 2025, was provided by the facility on 5/13/25 at 10:54 a.m., that indicated a list of residents with missing clothing items and the dates reported along with various notes whether items were found or if staff searched for the missing items. The form was reviewed and lacked information R9 was missing any items. A form, Combined Federal and State Bill of Rights, dated 6/18/19, indicated the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, and other concerns regarding their LTC (long-term care) facility stay. The resident has the right to, and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. The facility must make information on how to file a grievance or complaint available to the resident. The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights. The grievance policy must include, notifying resident individually or through	21495		

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21495	Continued From page 65 postings in prominent locations throughout the facility of the right to file grievances orally or in writing, the contact information of the grievance official with whom a grievance can be filed, a reasonable expected time frame for completing the review of the grievance, the right to obtain a written decision regarding his or her grievance, and the contact information of independent entities with whom grievances may be filed including the state agency, quality improvement organization, State survey agency, and the State Long Term Care Ombudsman program. Further, the policy must identify the grievance official, as necessary take immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated, ensure all written grievance decisions including the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued, and maintain evidence demonstrating the results of all grievances for a period of no less than 3 years from the issuance of the grievance decision. A form, Grievance Notice, dated 11/2022, indicated residents had a right to file grievances orally or in writing, and the right to file grievances anonymously. Further, the form indicated social worker (SW)-A was the community's grievance officer responsible for receiving grievances. Additionally, the form indicated the grievance officer generally acknowledges receipt of grievances within one business day and generally completes review of the grievance within five	21495		

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21495	Continued From page 66 business days. The form provided a list of independent agencies with whom grievances may be filed including the Minnesota Department of Health (MDH), Livanta LLC (Medicare Beneficiary and Family Centered Care Quality Improvement Organization), and the Minnesota office of Ombudsman for Long-Term Care. An undocumented Customer Concern form provided by SW-A on 5/13/25 at approximately 1:50 p.m., indicated a facility feedback investigation form that included an area for documenting the resident's name, the person voicing the concern and their phone number, a description of the concern with a request to include all details, including dates, times and description, the date and time of the event, the expected outcome, and the staff person who received the concern. During interview on 5/12/25 at 3:13 p.m., family member (FM)-K stated R9 used to go into other resident's rooms and lie down and would take off her glasses. FM-K stated R9 lost her glasses three weeks ago and has been without glasses since. FM-K further stated she told SW-A on 5/9/25, he had to do something because R9's glasses still had not been found. During observation on 5/13/25 at 8:12 a.m., R9 was in bed snoring softly and did not have glasses on her nightstand. During interview and observation on 5/13/25 between 8:57 a.m., and 9:19 a.m., nursing assistant (NA)-H entered R9's room and asked if she was ready to get up. R9 did not have her glasses on. At 9:01 a.m., NA-H donned R9's shoes, but did not tie the laces and at 9:02 a.m., NA-H assisted to stand R9 to pivot transfer into	21495		

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21495	Continued From page 67 her wheelchair. R9's shoelaces were dragging on the floor during the transfer. NA-H did not apply any glasses. At 9:19 a.m., NA-H completed assisting R9 in the bathroom and R9 did not have her glasses on. During interview on 5/13/25 at 9:35 a.m., registered nurse (RN)-F stated they updated care plans and printed care sheets for the aides to know what cares a resident required and stated R9 required assist with all cares and further stated R9 had a blue star that indicated she fell a few times and was called a falling star. During interview on 5/13/25 at 9:47 a.m., RN-F stated staff were supposed to report missing items to SW-A and they look for the items by checking rooms and looking in the laundry and document the missing item. RN-F stated R9 was missing her glasses, and they could not locate them and stated R9's daughter was aware R9's glasses were missing and further stated SW-A was also aware of the missing glasses. RN-F viewed R9's care plan and stated it would be important for R9 to have her glasses because she was a falling star and was important to prevent falls. During interview on 5/13/25, at approximately 1:50 p.m., SW-A stated if nursing or the front desk was aware of a missing item, they provide a missing item form to the resident or family, and SW-A will put the forms in a customer concerns data base and stated he did not have any concerns in the data base at this time. SW-A viewed the data base and verified nothing was documented in the database and mentioned another two residents with glasses missing and a resident with missing hearing aides and stated the residents he mentioned already had plans in	21495		

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21495	Continued From page 68 place and stated staff notify him of missing items and will go through the resident's room, the med cart and common spaces and then would get entered in the data base once identified as missing and they conducted a walk through a few days later. SW-A stated he was aware R9 was missing her glasses and stated he could add it in the data base and was working with the family to try to locate her glasses. SW-A further stated it had been a while and would confirm R9 was on the list for HealthDrive and stated HealthDrive sends the facility a list of residents to see and stated he would check to see if R9 was signed up for the actual service. SW-A viewed R9's chart and verified R9 signed up for the HealthDrive service as of 3/3/23, but not because her glasses were missing, and further stated R9's glasses had been missing for a couple of weeks and stated it was his fault for not putting the information in there. SW-A stated R9 needed her glasses and verified the Concern log, was their grievance log and the purpose for completing the form was to ensure concerns were followed up on and to let residents know they are addressing concerns and added it was like a physical reminder. SW-A stated Concern forms were located by the elevators and the front desk and provided a concern form and verified he had not completed a form for R9. During interview on 5/13/25 at 3:42 p.m., the director of nursing (DON) stated grievances should be documented immediately and expected staff follow up immediately. During interview on 5/15/25 at 12:34 p.m., the administrator, (A)-C stated she had been at the facility about four weeks and stated if something could not be resolved in the moment, it was considered a grievance and further stated lost	21495		

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21495	Continued From page 69 glasses didn't consist of a concern, but stated she expected a reasonable timeframe would be within a week to let someone know the status of a missing item and further stated SW-A was working on R9's missing glasses. During interview on 5/15/25 at 2:10 p.m., A-C stated she revisited with SW-A and confirmed the family was aware of the missing eye glasses for a while and when asked about the expectation for following up with the family on the status A-C stated SW-A chatted with family on 5/14/25, and let them know they were going to have the optometrist come in and provide R9 an eye exam. A policy, Concerns, Grievances, dated 6/29/22, indicated the purpose was to create an environment where resident and customer concerns were solicited and readily resolved. Further, a resident/customer/resident representative has the right to voice grievances and concerns without discrimination or reprisal and without fear of discrimination or reprisal. The term "voice concerns" is not limited to a formal, written grievance process, but may include a resident's verbalized concerns to staff. The community view customer concerns as a primary method to learn of and meet customer expectations. In keeping with this belief, staff is trained to obtain and respond to resident/resident representative customer concerns. The community assures that after receiving a concern, there is a prompt response by the associates to acknowledge the receipt of the concern, investigate, seek a resolution, and keep the resident appropriately apprised of progress toward resolution. When a resident, resident representative, visitor or family member voices a concern to a staff member, the staff member completes a concern form and forwards the form	21495		

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21495	Continued From page 70 to the social services department/Grievance Officer/designee. Completed forms are processed in a timely manner. The SW checks the confidential container daily, removes the completed forms, logs the concern, and routes the copy to the staff responsible to acknowledge, investigate, and resolve the concern. The SW assigns the concern to an associate accountable for the work area and the staff person responsible acknowledges receipt of the concern with the resident/resident representative/customer within 24 hours or the next working day, in the event of a holiday or weekend and documents acknowledgement. The staff person responsible investigates, resolves the issue, and responds back to the customer within five business days and documents action. If more time is needed for a resolution, the customer is updated on the status until resolution. Documentation in the medical record, when applicable, reflects the concern, plan for addressing, and follow-up of the resolution. All written grievance decisions will include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concern(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued. SUGGESTED METHOD OF CORRECTION: The social work designee and director of nursing (DON) or designee, could develop and implement policies and procedures related to social service assessment and implementation. The DON or designee, could provide training for all nursing staff related to follow up with social service	21495		

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21495	Continued From page 71 needs. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation and interview the facility failed to maintain dignity for 1 of 1 resident (R62) reviewed for dignity. R62's discharge Minimum Data Set (MDS) dated 3/28/25, indicated intact cognition and diagnoses of quadriplegia, traumatic rupture of cervical intervertebral disc (C5-6), spinal stenosis, and neurogenic bladder. It further indicated R62 required substantial assistance with toileting, was always incontinent of urine, and received a diuretic on routine basis. R62's care plan dated 4/25/25, indicated the potential for alteration of bowel and bladder related to a diagnosis of a neurogenic bladder	21810	Corrected	6/30/25

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21810	Continued From page 72 and included an intervention of R62 requiring 2 person assistance to use the toilet upon rising in the morning, before and after each meal, bedtime, on night rounds, and as needed. R62 also required assistance with all toileting tasks and used brief/pads for incontinence protection indicating he was not able to reliably notify staff of his need to be toileted. During interview on 5/12/25 at 5:25 p.m. R62 stated he had to wait 20-45 minutes (on average)almost every time he needed to use the urinal. Since his spinal cord injury, he doesn't have much notice when having to urinate and often ends up urinating in his brief. When that happens he then had to wait long periods of time sitting in his urine or feces. R62 also stated he had reported this to RN-E and the DON but nothing ever happened to fix the problem stating "It's a culture here to not help each other out. I put my call light on and wait for staff to respond. When they don't respond, I go out into the hallway (in my wheelchair) to get help and I am often told by staff they're not my aide and then continue to play on their phone." During observation on 5/14/25 at 7:04 a.m., the following events occurred: -7:15 a.m. R62 put his call light on. -7:28 a.m. NA-E answered call light for another resident who's room was in close proximity to R62's room (exited the room at 7:34 a.m.) but failed to answer R62's call light when she was finished assisting the other resident. -7:35 a.m. NA-F was walking down the hall towards R62's room with the vital signs (VS) machine. NA-F entered the room and asked R62 what he needed because his call light was on. He stated he had to urinate but he already urinated in his brief because he couldn't hold it. NA-G stated	21810		

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 _____	C 05/15/2025

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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21810	Continued From page 73 that was okay, proceeded to take his blood pressure, then left the room stating "I will come back later and get you up when she's (unknown) done." -7:45 a.m. NA-F assisted another resident with a shower. -8:01 a.m. registered nurse (RN)-D entered R62's room with medications, blood sugar monitor, and stethoscope. RN-D asked his name, date of birth, took his VS, tested his blood sugar, administered his medications, and gave him a nebulizer treatment. RN-D did not change R62's brief. -8:30 a.m. RN-D exited R62's room. -8:34 a.m. R62 stated RN-D did not change him while she was in his room and that he put his call light on at 7:15 a.m. when he first had to go to the bathroom. -8:40 a.m. R62 put on his call light again. -8:42 a.m. NA-F answered R62's call light and R62 stated he was still waiting for his brief to be changed. NA-F changed his brief (which was visibly full of urine) and removed the pad underneath him which was also visibly wet. During interview on 5/14/25 at 9:15 a.m. NA-F verified R62 told her he had urinated in his brief when she answered his call light at 7:35 a.m. NA-F stated was waiting for the nurse to go in and do what she needed to do but she should have changed him right away before the next call light went on. During interview on 5/14/25 at 9:30 a.m. RN-D stated anyone can answer call lights but it was usually the NA's who answer them. They try to answer call lights within 15 minutes and if a resident stated they need to be changed, staff should try to do that immediately or as soon as possible and changing a brief would take precedence over giving a resident a shower.	21810		

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21810	Continued From page 74 RN-D further stated NA's are assigned to a group of residents but the other NA's are expected to answer the call lights and help each other out. If the nurse needs to administer medications or perform cares, etc. they can wait if a resident needed to be changed. RN-D verified she did not change R62 when she was in his room because she was unaware he needed to be changed. There was no reason he needed to wait to be changed until after she was done working with him. During interview on 5/14/25 at 2:00 p.m. NA-D stated NA's are assigned to a certain group of residents and "we stick with our residents, unless someone is really busy, but everyone can help." NA-D further stated they try to answer call lights within 15 minutes and changing a residents brief should be done before giving a resident shower. An hour was too long for a resident to wait to have their brief changed and stated 10 minutes should be the longest they should have to wait unless they were really busy. During an follow up interview on 5/15/25 at 11:16 a.m., R62 stated if he hadn't fallen, he would still be able to do all all the things the staff do for him by himself and it took awhile for him to get used to staff having to help him and when he has to sit in his own urine or feces he feels "useless and worthless." When it takes 45 minutes to an hour for staff to come, It makes him think staff don't want to help him and it's embarrassing and degrading. During interview on 5/15/24 at 10:56 a.m., the director of nursing (DON) stated he did not think an hour was too long for a resident to have to sit in a wet brief and there wouldn't be any negative outcomes as a result (specifically skin	21810		

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21810	Continued From page 75 breakdown). The DON further stated changing a residents brief didn't necessarily take precedence over giving another resident a shower and would depend on the situation. He was unable to provide an approximate amount/range of time he would expect a residents call light to be answered or a residents brief to be changed (once they put their call light on.) A facility policy reagrding dignity was requested but not received. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop and implement a plan of care by the interdisciplinary team to accurately reflect the individual need of each resident discussed above. It could also address other residents that may be at risk for the same concern. The facility could update policies and procedures, educate staff on these changes, and audit periodically to ensure the needs of resident(s) are maintained. Random audits for an amount of time determined by the quality assessment and performance improvement (QAPI) committee could ensure compliance. The administrator, DON, or designee could then take that information back to QAPI to assess need for further improvement. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and	21855		6/30/25

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21855	Continued From page 76 personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure personal privacy during activities of daily living (ADLs) was provided for 1 of 2 residents (R9) reviewed for privacy. Findings include: R9's significant change Minimum Data Set (MDS) dated 4/11/25, indicated severe cognitive impairment, did not reject cares, used a wheelchair, and required substantial assist with toileting hygiene, and partial to moderate assist with dressing. R9's optional state assessment (OSA) dated 4/11/25, indicated R9 required assist with bed mobility, transfers, and toileting. R9's Facesheet undated, indicated the following diagnoses: rheumatoid arthritis, Myelodysplastic syndrome, weakness, history of falling, and Alzheimer's disease. R9's care plan dated 4/14/25, indicated R9 had an alteration in ADLs and required assist of one with dressing, and grooming. R9's care plan dated 4/14/25, indicated R9 had an alteration in mobility and required assist of one	21855	Corrected	

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21855	Continued From page 77 with transfers and ambulating. R9's care plan dated 4/14/25, indicated R9 had an alteration in toileting and interventions included to assist with toileting upon rising before and after meals, at bedtime, on night rounds and as needed. R9'S care sheet undated, indicated R9 required assist of one with toileting. During observation on 5/13/25 at 8:57 a.m., nursing assistant (NA)-H entered R9's room and asked if she was ready to get up. At 9:01 a.m., NA-H asked resident if she wanted to go into the bathroom and stated they bring R9 to the bathroom and complete cares in the bathroom. At 9:03 a.m., NA-H assisted R9 to the bathroom and R9 stood up in the bathroom using the sink and sat on the toilet. At 9:03 a.m., registered nurse (RN)-F entered R9's room. At 9:08 a.m., NA-H donned R9's hip protector and pants. R9's wheelchair was outside the bathroom door and R9's room mate was in bed sleeping across from the opened bathroom door. There was no privacy curtain located on the track on the ceiling to provide privacy between the bathroom and R9's roommate. At 9:17 a.m., R9 was assisted by NA-H to stand up and R9's pants were down, the bathroom door was opened, and R9's roommate was in bed. NA-H wiped R9's bottom with the door open and pulled up R9's incontinent brief, hip protector and pants as R9 held on to the sink. During interview on 5/13/25 at 9:24 a.m., NA-H verified there was no privacy curtain and stated there used to be a curtain because there were hooks on the track and further stated it would be important to have for privacy and stated the	21855		

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21855	Continued From page 78 bathroom was crowded and R9 liked to sit on the toilet in the a.m. During interview on 5/13/25 at 10:02 a.m., RN-F verified there was no privacy curtain between the bathroom in R9's room and R9's roommate and stated she thought it was taken off to be washed and stated there could be a reason for why the curtain wasn't on the track and further stated it was important for privacy and added even though a resident had dementia, you still provide them with privacy. During interview on 5/13/25 at 3:42 p.m., the director of nursing (DON) viewed R9's room and stated one of the staff members informed the DON the curtains went down to the laundry and stated he expected staff provide privacy if a resident was in the bathroom with the door wide open with another resident in the room. A form, Combined Federal and State Bill of Rights, dated 6/18/19, indicated the resident has a right to personal privacy. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review/revise policies on dignity and personal privacy and educate all staff on those policies. The DON and/or designee could conduct audits of resident cares to ensure residents are offered and assisted to appropriately cover their exposed skin and to ensure personal privacy is maintained. TIME PERIOD FOR CORRECTION: Twenty one	21855		

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21855	Continued From page 79 (21) days.	21855		

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	245310	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/15/2025**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 05/15/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Benedictine Health Center of Innsbruck was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections	K 000		

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

Electronically Signed | 06/12/2025

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Benedictine Health Center at Innsbruck is a 2-story building with no basement. The building was built at three 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 II(222) construction. In 2005 the Transitional Care Unit (TCU) was added to the north that was determined to be of Type V(111) construction.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 105 beds and had a census of 88 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/15/2025 at 10:05 AM, it was revealed by observation that there was a penetration in the smoke barrier in smoke compartment D caused	K 372	This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truths or facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed in accordance with federal and state law requirements.	5/15/25

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K 372	Continued From page 3 by wires. An interview with the Director of Environmental Services and the Plant Operations Manager verified this deficient finding at the time of discovery.	K 372	1.A detailed description of the corrective action taken or planned to correct the deficiency. Repaired the penetration in the smoke barrier in smoke compartment D using properly rated fire caulking. 2.Address the measures that will be put in place to ensure the deficiency doesnt reoccur. Penetration of smoke barrier was related to ongoing construction being performed during a major renovation project. Contractor notified of need to monitor and ensure repairs are made immediately to any further penetrations of the smoke barrier caused by the construction process. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained. Weekly audits of all areas at risk of being affected by the construction process will be conducted. Audits will continue through the completion of the renovation project or 12/31/25, whichever comes sooner. 4.Identify who is responsible for the corrective actions and monitoring of compliance. Director of Environmental Services or Designee	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 4, 2025

Administrator
Benedictine Health Center Innsbruck

RE: CCN: 245310
Cycle Start Date: May 15, 2025

Dear Administrator:

On July 21, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 4, 2025

Administrator
BENEDICTINE HEALTH CENTER INNSBRUCK

1101 BLACK OAK DRIVE
NEW BRIGHTON, MN 55112

Re: Reinspection Results
Event ID: LT2H12

Dear Administrator:

On July 21, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 15, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us employer.