00940

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 2347

July 24, 2015

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

Subject: Benedictine Health Center Innsbruck - IDR
Provider # 245310
Project # S5310025

Dear Ms. Ager:

This is in response to your letter of April 22, 2015, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies identified at tags F225 S/S -D 483.13(c)(1)(ii) and F226 S/S- D 483.13(c) issued pursuant to the survey event WU4911, completed on March 26, 2015.

The information presented with your letter, the CMS 2567 dated March 26, 2015 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F225 S/S-(D) 42 CFR § 483.13 (c)(1)(ii): Investigate/Report Allegations/Individuals-
The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

F226 S/S-(D) 42 CFR § 483.13(c) Develop/Implement Abuse/Neglect,etc Policies-
The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

Minnesota Department of Health • Health Regulation Division •
General Information: 651-201-5000 • Toll-free: 888-345-0823
http://www.health.state.mn.us
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Summary of the facility's reason for IDR of this tag:
The facility disputed the findings based on their assertions including: the identified events had been reported to the Office of Health Facility Complaints (OHFC) and were allegedly cleared; the date documented on an incident report was a clerical error; and examples identified on the 2567 were not reportable and/or were reported within the appropriate time frame to the State agency (SA).

Summary of findings:
According to facility progress note and incident report documentation, R200 had been discovered missing from his usual environment (described as an elopement in the facility's investigation report) on 9/7/14, at 2:20 p.m. The corresponding incident report indicated the incident had been reported to facility administration on that day however, the elopement was not reported to the SA until the following day. The date reflected on the "date incident submitted to MDH/OHFC and the Common Entry Point (CEP)" form: 9/8/14. Immediate reporting to the SA did not occur.

According to the care plan, R200's behavioral symptoms included: history of wandering, exit seeking behaviors, physical and verbal aggression, and refusal of cares which had been identified as of 9/5/14. Interventions had been added to R200's care plan by the licensed social worker on 9/5/14 including: (1) resident has wanderguard (2) is identified in the elopement risk book.

An incident report submission dated 1/28/15, indicated R102 had accused an unidentified nurse of kneeling on her feeding tube site during cares. According to an email from the physical therapy department to the facility's social worker on 1/28/15, the following was noted: R102 informed the therapist that someone punched her in the stomach and was being mean to her. The e-mail documented "Could you please investigate further?" According to the MDH/OHFC tracking report, the incident had been submitted to the SA on 1/30/15, two days after staff had become aware of the alleged concern. Immediate reporting to the SA did not occur.

The facility presented information which negated the third example. That example indicated R3 had reported to the charge nurse that nursing assistant (NA)-B had shaken R3's shoulders during cares on 2/17/15, the allegation had been reported to the SA on 2/18/15. The facility provided information which indicated a clerical error had been made and the date the allegation had occurred was actually 2/18/15 versus 2/17/15. An initial tracking form for the incident revealed the allegation of abuse was reported to the SA on 2/18/15. NA-B's time card was presented which confirmed NA-B had been sent home immediately following the allegation on 2/18/15. Documentation was reviewed from an interview with NA-B's co-worker who was interviewed during the investigation process which confirmed the incident had occurred on 2/18/15. Therefore, this example will be removed from the CMS 2567.

The facility failed to report allegations immediately (F225) and failed to implement their policy titled Abuse Prevention Plan dated 1/15, which required immediate reporting to the SA.

The removal of the example related to R3's allegation due to an erroneous date does not negate the findings in the remainder of the deficiencies at F225 and F226. Both F225 and F226 remain valid deficiencies at the correct scope and severity of a D.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Kathryn M. Serie, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-476-4233 Fax: 507-537-7194

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Jessica Sellner, St.Cloud B Unit Supervisor

MDH L&C 3201

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- Print your name and address on the reverse so that we can return the card to you.
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1. Article Addressed to:

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

COMPLETE THIS SECTION ON DELIVERY

A. Signature
X Jaye Rogers ☐ Agent ☐ Addressee

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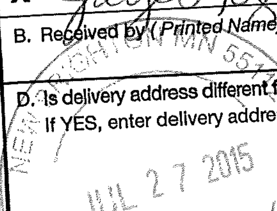

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7008 0150 0001 1713 2347 IDR ML/Please return within 5 days

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING ______ B. WING ______	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Revised 2567 as a result of an Informal Dispute Resolution	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225		5/5/15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/17/2015

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 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all allegations of abuse were immediately reported to the state agency (SA) for 2 of 8 allegations (R102, R200) reviewed. Findings include: R102's quarterly MDS dated 2/16/15, revealed R102 had a BIMS of 13 (cognitively intact), and indicated R102 had no history of hallucinations. A facility Incident Report Submission indicated on 1/28/15, R102 accused an unidentified nurse of kneeling on her feeding tube site during cares. The report was not submitted to the SA until 1/30/15, two days after the allegation was initially received by social worker (SW)-A from a physical therapy staff member via email.	F 225		

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F 225	Continued From page 2	F 225		

R200's quarterly MDS dated 12/5/14, revealed R200 had a BIMS score of 12 (moderate cognitive impairment) and no behavioral symptoms.

A Incident Tracking submitted to the SA indicated R200 had been found wandering toward the facility parking lot on 9/7/14, and R200 had stated he was going to check out the patio by the freeway. The incident tracking indicated the incident was not submitted to the SA until the next day on 9/8/14.

During interview on 3/26/15, at 11:29 a.m. the director of social services (DSS) stated incidents of abuse should be reported immediately, and facility staff needed to "Get sharper on that [reporting immediately]." The DSS stated the nursing staff generally reported allegations of abuse to the DON, who immediately notified the administrator. The DSS stated she might wait until next day to report an incident to the SA if the resident was safe and something happened during the night, and the administrator was notified immediately at time of the verbal report via text or email, and any alleged perpetrators were put on suspension pending investigation of the incident.

During interview on 3/26/15, at 1:36 p.m. the director of nursing (DON) stated if she received an allegation of abuse she would call the administrator immediately and then report the incident to the SA, however, she stated she had up to 24 hours to report allegations of abuse to the SA. The DON stated she was unaware of the incident involving R102 until a couple of days after it had happened, and had notified the administrator and SA when she was made aware

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PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 3 of the incident. During interview on 3/26/15, at 1:36 p.m. the facility administrator stated she was notified immediately of allegations of abuse, however, she thought the facility had up to 24 hours to report incidents to the SA unless substantiated abuse or neglect was suspected at the time of the initial report. The facility policy titled Abuse Prevention Plan dated 1/15, instructed all allegations of abuse should be immediately reported to the SA and the administrator.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse reporting procedure related to immediate reporting of allegations of abuse to the state agency (SA)for 2 of 8 allegations (R102, R200) reviewed. Findings include: R102's quarterly MDS dated 2/16/15, revealed R102 had a BIMS of 13 (cognitively intact), and indicated R102 had no history of hallucinations.	F 226		5/5/15

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F 226	Continued From page 4	F 226		

A facility Incident Report Submission indicated on 1/28/15, R102 accused an unidentified nurse of kneeling on her feeding tube site during cares. The report was not submitted to the SA until 1/30/15, two days after the allegation was initially received by social worker (SW)-A from a physical therapy staff member via email.

R200's quarterly MDS dated 1[illegible]5/14, revealed R200 had a BIMS score of 12 (moderate cognitive impairment) and no behavioral symptoms.

A Incident Tracking submitted to the SA indicated R200 had been found wandering toward the facility parking lot on 9/7/14, and R200 had stated he was going to check out the patio by the freeway. The incident tracking indicated the incident was not submitted to the SA until the next day on 9/8/14.

During interview on 3/26/15, at 11:29 a.m. the director of social services (DSS) stated incidents of abuse should be reported immediately, and facility staff needed to "Get sharper on that [reporting immediately]." The DSS stated the nursing staff generally reported allegations of abuse to the DON, who immediately notified the administrator. The DSS stated she might wait until next day to report an incident to the SA if the resident was safe and something happened during the night, and the administrator was notified immediately at time of the verbal report via text or email, and any alleged perpetrators were put on suspension pending investigation of the incident.

During interview on 3/26/15, at 1:36 p.m. the director of nursing (DON) stated if she received

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F 226	Continued From page 5 an allegation of abuse she would call the administrator immediately and then report the incident to the SA, however, she stated she had up to 24 hours to report allegations of abuse to the SA. The DON stated she was unaware of the incident involving R102 until a couple of days after it had happened, and had notified the administrator and SA when she was made aware of the incident. During interview on 3/26/15, at 1:3[illegible] p.m., the facility administrator stated she was notified immediately of allegations of abuse, however, she thought the facility had up to 24 hours to report incidents to the SA unless substantiated abuse or neglect was suspected at the time of the initial report. The facility policy titled Abuse Prevention Plan dated 1/15, instructed all allegations of abuse should be immediately reported to the SA and the administrator.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R95) reviewed for activities of daily living received assistance with shaving as directed by the care plan.	F 282		4/22/15

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F 282	Continued From page 6 Findings include: R95's quarterly minimum data set (MDS) dated 3/21/15, indicated R95 had moderate cognitive impairment, and required extensive assistance of one staff for all grooming activities. R95's care area assessment (CAA) dated 9/23/14, indicated R95 needed assistance in all activities of daily living including grooming due to muscle weakness. R95's care plan dated 3/25/15, indicated R95 had diagnoses including tremor, muscular atrophy, difficulty walking, and required staff assistance with shaving daily. During observation on 3/23/15, at 7:40 p.m. R95 had a significant amount of facial hair, especially under his chin and on the upper neck. During interview at this time, R95 stated he preferred to be clean shaven but needed staff to help him shave. During observation on 3/24/15, at 9:17 a.m. R95 was still unshaven. R95 stated it took them [staff] "Forever," to come to help him this morning and staff had still not helped him to shave but, "I sure wish they would." During observation on 3/25/15, at 8:45 a.m. R95 was observed with significant facial hair on the upper neck and chin area, approximately 3/4" long. Nursing Assistant (NA)-A assisted R95 with his morning cares and did not offer R95 shaving assistance before leaving the room to assist other residents.	F 282		

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F 282	Continued From page 7 During interview on 3/25/15, at 9:47 a.m. R95 stated he wished staff would shave him consistently, and he wanted his facial hair trimmed. During interview on 3/25/15, at [illegible] a.m. NA-A stated R95 should be offered assistance with shaving on a daily basis and his electric razor was broken so staff needed to use a straight razor to shave R95. During interview on 3/25/15, at [illegible] a.m., registered nurse (RN)-C, who was the assistant director of nursing, stated R95 should be offered shaving assistance daily and R95 had razors available for use. Facility policies related to shaving and grooming were requested, but not provided.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R95) reviewed for activities of daily living received assistance with shaving. Findings include:	F 312		4/22/15

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F 312	Continued From page 8	F 312		

R95's quarterly minimum data set (MDS) dated 3/21/15, indicated R95 had moderate cognitive impairment, and required extensive assistance of one staff for all grooming activities.

R95's care area assessment (CAA) dated 9/23/14, indicated R95 needed assistance in all activities of daily living including grooming due to muscle weakness.

R95's care plan dated 3/25/15, indicated R95 had diagnoses including tremor, muscular atrophy, difficulty walking, and required staff assistance with shaving daily.

During observation on 3/23/15, at 7:40 p.m. R95 had a significant amount of facial hair, especially under his chin and on the upper neck. During interview at this time, R95 stated he preferred to be clean shaven but needed staff to help him shave.

During observation on 3/24/15, at 9:17 a.m. R95 was still unshaven. R95 stated it took them [staff] "Forever," to come to help him this morning and staff had still not helped him to shave but, "I sure wish they would."

During observation on 3/25/15, at 8:45 a.m. R95 was observed with significant facial hair on the upper neck and chin area, approximately 3/4" long. Nursing Assistant (NA)-A assisted R95 with his morning cares and did not offer R95 shaving assistance before leaving the room to assist other residents.

During interview on 3/25/15, at 9:47 a.m. R95 stated he wished staff would shave him consistently, and he wanted his facial hair

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F 312	Continued From page 9 trimmed. During interview on 3/25/15, at 9:48 a.m. NA-A stated R95 should be offered assistance with shaving on a daily basis, and his electric razor was broken so staff needed to use a straight razor to shave R95. During interview on 3/25/15, at 9:54 a.m. registered nurse (RN)-C, who was the assistant director of nursing, stated R95 should be offered shaving assistance daily and R95 had razors available for use. Facility policies related to shaving and grooming were requested, but not provided.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bed side rails were in compliance with Food and Drug Administration (FDA) requirements to minimize the risk of entrapment, for 1 of 1 resident (R291) reviewed for side rail safety. Findings include:	F 323		4/3/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10	F 323		

R291 admission Minimum Data Set (MDS) dated 3/17/15, identified R291 had moderately impaired cognition and required extensive assistance for most activities of daily living (ADLs) including bed mobility and transfers.

R291's care plan dated 3/20/15, indicated the resident had bilateral (two, one on each side of the bed), one-half side rails which were used to assist R291 with bed mobility and positioning.

R291's Restraints/Adaptive Equipment assessment dated 3/10/15, indicated diagnoses including chronic obstruction pulmonary disease (COPD), generalized pain, a history of falls, and status post rehabilitation procedure. The assessment identified R291 required two, one-half side rails to his bed, related to weakness from COPD, and for increased independence with bed mobility and/or transfers. The assessment lacked any indication the side rails were evaluated to be safe for R291, to reduce the risk for entrapment.

During observtion on 3/23/15, at 1:05 p.m. bilateral, half, metal side rails were raised on R291's bed, with the far side of the bed flush against the wall. The outward-facing side rail was observed tilted down at an angle of approximately 30 degrees from the head of the bed to the foot of the bed. The rail also angled outward, lying away from the bed, at an angle of approximately 15 degrees from the top of the rail to the bottom of the rail. The spacing between the under-side of the rail to the mattress at the head of the bed (FDA zone six), was greater than seven and one

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F 323	Continued From page 11 half inches. Upon manipulation, the rail was loose and maneuverable, with movement both parallel and perpendicular to the mattress, allowing for even greater spacing at zone six. R291 was not in the room at the time of this observation. During interview on 3/23/15, at 1:07 [illegible]m. the director of nursing (DON) stated R291's siderails had been like this on the bed, "for years and years and years." The DON demonstrated by dialing a black knob at the center of the rail where it was affixed to the bed frame, that the rail could not be tightened and it was as secured to the bedframe as the hardware allowed. After attempting to tighten the rail, the DON confirmed the rail remained loose and maneuverable, with spacing in zone six of greater than seven and one half inches, which put R291 at risk for entrapment. On 3/24/15, at 9:35 a.m. R291 stated his siderail was very loose and he did not utilize the side rail and felt they were, "Useless." R291 stated, "Try to pull on that thing [siderail]." As writer maneuvered the side rail, both parallel and perpendicular to the bed, R291 stated, "Exactly, you think it's going to hold 200 pounds?" During interview on 3/24/15, at 10:07 a.m. the DON, facility administrator and the environmental services director (ESD) were interviewed and all stated the side rails on R291's bed were loose. The DON, facility administrator, and ESD stated they were familiar with FDA requirements for bed side rail safety spacing to minimize the risk for entrapment, and the administrator stated all of the facility beds and side rails had been tested and checked routinely by maintenance. . ESD turned the black knob to the right on the side rail,	F 323		

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F 323	Continued From page 12 while she set the rail parallel to the bed so it was no longer tilted outward, and she was able to tighten the black knob, securing the rail firmly to the bed frame, limiting the maneuverability of the rail and setting the rail in a manner which resulted in acceptable spacing for zone six. Review of the facility's room maintenance and safety audits indicated the side rail on R29's bed was last inspected on 2/25/15, prior to R29's admission to the facility. The audit did not specify aspects of the side rail which were examined and just indicated, "Everything checked out." The facility's Adaptive Equipment policy dated 1/15, indicated, "The facility has assessed the space between all mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used) ... New models of beds and mattresses are assessed if they are purchased and installed ... Residents are checked annually, quarterly, with significant change and PRN [as needed] for safety relative to the adaptive equipment used." Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, detailed the FDA guidance on side rail safety. The guidelines recommended openings in the bed system were to be no more than four and three-quarter inches to reduce the risk of head entrapment. The guidelines also defined zone six as the space between the end of the rail and the side edge of the head or foot board.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		4/1/15

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F 356	Continued From page 13 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently include current census information on the daily nursing hours posting. This had the potential to affect all 100 residents who resided in the facility.	F 356		

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Findings include:

During initial tour of the facility on 3/23/15, at 12:59 p.m. the facility's Nursing Service Hours Form dated 3/23/15, was observed affixed to the bulletin boards at the entrances of both the Transitional Care Unit (TCU) and the Pioneer Village Unit. The sections of each form designated for notation of the census during each shift were left blank and the facility census was not listed anywhere on the form.

During interview on 3/24/15, at 3:11 p.m. health information coordinator (HIC) stated she was the main employee responsible for daily completion of the facility's Nursing Service Hours Form. HIC stated on weekdays when she arrived at 6:45 a.m., she looked up the census in the facility's electronic medical record system and checked with the overnight charge nurse to determine whether there were any updates to the scheduled hours for the day shift, and then completed the forms based on the information and posted them on the bulletin boards in each unit of the facility. HIC stated at the end of her shift she again determined whether there were updates to the census or the scheduled hours for the afternoon shift, and made the appropriate adjustments to the posting before she left the facility each day. HIC stated the charge nurse from the evening shift was responsible for identifying census or schedule changes and updating the forms at the end of their shift. On weekends, the charge nurses for each shift were responsible for updating the forms with current census and schedule information for the subsequent shift.

Review of Nursing Service Hours Forms from 1/1/15, through 3/23/15, indicated the following:

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F 356	Continued From page 15 The facility census was not identified on the posting for eight out of 80 days, or 10% of days. The facility census was not added to the posting until the end of the evening shift, for an additional eight out of 80 days, or 10% of days. The facility's Nursing Services Hours Forms were accurately posted for less than 80% of days. On 3/24/15, at 3:15 p.m. HIC stated most of the days where the report was inaccurate corresponded with weekends and/or days she was gone on vacation. HIC stated she was having some difficulty with ensuring the postings were updated when she was not available.	F 356		

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Revised 2567 as a result of an Informal Dispute Resolution	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225		5/5/15

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/17/2015

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 225	Continued From page 1 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all allegations of abuse were immediately reported to the state agency (SA) for 2 of 8 allegations (R102, R200) reviewed. Findings include: R102's quarterly MDS dated 2/16/15, revealed R102 had a BIMS of 13 (cognitively intact), and indicated R102 had no history of hallucinations. A facility Incident Report Submission indicated on 1/28/15, R102 accused an unidentified nurse of kneeling on her feeding tube site during cares. The report was not submitted to the SA until 1/30/15, two days after the allegation was initially received by social worker (SW)-A from a physical therapy staff member via email.	F 225		

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F 225	Continued From page 2 R200's quarterly MDS dated 12/5/14, revealed R200 had a BIMS score of 12 (moderate cognitive impairment) and no behavioral symptoms. A Incident Tracking submitted to the SA indicated R200 had been found wandering toward the facility parking lot on 9/7/14, and R200 had stated he was going to check out the patio by the freeway. The incident tracking indicated the incident was not submitted to the SA until the next day on 9/8/14. During interview on 3/26/15, at 11:29 a.m. the director of social services (DSS) stated incidents of abuse should be reported immediately, and facility staff needed to "Get sharper on that [reporting immediately]." The DSS stated the nursing staff generally reported allegations of abuse to the DON, who immediately notified the administrator. The DSS stated she might wait until next day to report an incident to the SA if the resident was safe and something happened during the night, and the administrator was notified immediately at time of the verbal report via text or email, and any alleged perpetrators were put on suspension pending investigation of the incident. During interview on 3/26/15, at 1:36 p.m. the director of nursing (DON) stated if she received an allegation of abuse she would call the administrator immediately and then report the incident to the SA, however, she stated she had up to 24 hours to report allegations of abuse to the SA. The DON stated she was unaware of the incident involving R102 until a couple of days after it had happened, and had notified the administrator and SA when she was made aware	F 225		

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F 225	Continued From page 3 of the incident. During interview on 3/26/15, at 1:36 p.m. the facility administrator stated she was notified immediately of allegations of abuse, however, she thought the facility had up to 24 hours to report incidents to the SA unless substantiated abuse or neglect was suspected at the time of the initial report. The facility policy titled Abuse Prevention Plan dated 1/15, instructed all allegations of abuse should be immediately reported to the SA and the administrator.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse reporting procedure related to immediate reporting of allegations of abuse to the state agency (SA)for 2 of 8 allegations (R102, R200) reviewed. Findings include: R102's quarterly MDS dated 2/16/15, revealed R102 had a BIMS of 13 (cognitively intact), and indicated R102 had no history of hallucinations.	F 226		5/5/15

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F 226	Continued From page 4 A facility Incident Report Submission indicated on 1/28/15, R102 accused an unidentified nurse of kneeling on her feeding tube site during cares. The report was not submitted to the SA until 1/30/15, two days after the allegation was initially received by social worker (SW)-A from a physical therapy staff member via email. R200's quarterly MDS dated 1[illegible]5/14, revealed R200 had a BIMS score of 12 (moderate cognitive impairment) and no behavioral symptoms. A Incident Tracking submitted to the SA indicated R200 had been found wandering toward the facility parking lot on 9/7/14, and R200 had stated he was going to check out the patio by the freeway. The incident tracking indicated the incident was not submitted to the SA until the next day on 9/8/14. During interview on 3/26/15, at 11:29 a.m. the director of social services (DSS) stated incidents of abuse should be reported immediately, and facility staff needed to "Get sharper on that [reporting immediately]." The DSS stated the nursing staff generally reported allegations of abuse to the DON, who immediately notified the administrator. The DSS stated she might wait until next day to report an incident to the SA if the resident was safe and something happened during the night, and the administrator was notified immediately at time of the verbal report via text or email, and any alleged perpetrators were put on suspension pending investigation of the incident. During interview on 3/26/15, at 1:36 p.m. the director of nursing (DON) stated if she received	F 226		

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F 226	Continued From page 5 an allegation of abuse she would call the administrator immediately and then report the incident to the SA, however, she stated she had up to 24 hours to report allegations of abuse to the SA. The DON stated she was unaware of the incident involving R102 until a couple of days after it had happened, and had notified the administrator and SA when she was made aware of the incident. During interview on 3/26/15, at 1:30 p.m., the facility administrator stated she was notified immediately of allegations of abuse, however, she thought the facility had up to 24 hours to report incidents to the SA unless substantiated abuse or neglect was suspected at the time of the initial report. The facility policy titled Abuse Prevention Plan dated 1/15, instructed all allegations of abuse should be immediately reported to the SA and the administrator.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R95) reviewed for activities of daily living received assistance with shaving as directed by the care plan.	F 282		4/22/15

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F 282	Continued From page 6 Findings include: R95's quarterly minimum data set (MDS) dated 3/21/15, indicated R95 had moderate cognitive impairment, and required extensive assistance of one staff for all grooming activities. R95's care area assessment (CAA) dated 9/23/14, indicated R95 needed assistance in all activities of daily living including grooming due to muscle weakness. R95's care plan dated 3/25/15, indicated R95 had diagnoses including tremor, muscular atrophy, difficulty walking, and required staff assistance with shaving daily. During observation on 3/23/15, at 7:40 p.m. R95 had a significant amount of facial hair, especially under his chin and on the upper neck. During interview at this time, R95 stated he preferred to be clean shaven but needed staff to help him shave. During observation on 3/24/15, at 9:17 a.m. R95 was still unshaven. R95 stated it took them [staff] "Forever," to come to help him this morning and staff had still not helped him to shave but, "I sure wish they would." During observation on 3/25/15, at 8:45 a.m. R95 was observed with significant facial hair on the upper neck and chin area, approximately 3/4" long. Nursing Assistant (NA)-A assisted R95 with his morning cares and did not offer R95 shaving assistance before leaving the room to assist other residents.	F 282		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 During interview on 3/25/15, at 9:47 a.m. R95 stated he wished staff would shave him consistently, and he wanted his facial hair trimmed. During interview on 3/25/15, at 9:4[illegible] a.m. NA-A stated R95 should be offered assistance with shaving on a daily basis and his electric razor was broken so staff needed to use a straight razor to shave R95. During interview on 3/25/15, at 9:[illegible]4 a.m., registered nurse (RN)-C, who was the assistant director of nursing, stated R95 should be offered shaving assistance daily and R95 had razors available for use. Facility policies related to shaving and grooming were requested, but not provided.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R95) reviewed for activities of daily living received assistance with shaving. Findings include:	F 312		4/22/15

REVISED

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 ______	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 8	F 312		

R95's quarterly minimum data set (MDS) dated 3/21/15, indicated R95 had moderate cognitive impairment, and required extensive assistance of one staff for all grooming activities.

R95's care area assessment (CAA) dated 9/23/14, indicated R95 needed assistance in all activities of daily living including grooming due to muscle weakness.

R95's care plan dated 3/25/15, indicated R95 had diagnoses including tremor, muscular atrophy, difficulty walking, and required staff assistance with shaving daily.

During observation on 3/23/15, at 7:40 p.m. R95 had a significant amount of facial hair, especially under his chin and on the upper neck. During interview at this time, R95 stated he preferred to be clean shaven but needed staff to help him shave.

During observation on 3/24/15, at 9:17 a.m. R95 was still unshaven. R95 stated it took them [staff] "Forever," to come to help him this morning and staff had still not helped him to shave but, "I sure wish they would."

During observation on 3/25/15, at 8:45 a.m. R95 was observed with significant facial hair on the upper neck and chin area, approximately 3/4" long. Nursing Assistant (NA)-A assisted R95 with his morning cares and did not offer R95 shaving assistance before leaving the room to assist other residents.

During interview on 3/25/15, at 9:47 a.m. R95 stated he wished staff would shave him consistently, and he wanted his facial hair

REVISED

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 ______	03/26/2015

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 312	Continued From page 9 trimmed. During interview on 3/25/15, at 9:48 a.m. NA-A stated R95 should be offered assistance with shaving on a daily basis, and his electric razor was broken so staff needed to use a straight razor to shave R95. During interview on 3/25/15, at 9:54 a.m. [illegible] registered nurse (RN)-C, who was the assistant director of nursing, stated R95 should be offered shaving assistance daily and R95 had razors available for use. Facility policies related to shaving and grooming were requested, but not provided.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bed side rails were in compliance with Food and Drug Administration (FDA) requirements to minimize the risk of entrapment, for 1 of 1 resident (R291) reviewed for side rail safety. Findings include:	F 323		4/3/15

REVISED

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 ______	03/26/2015

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 323	Continued From page 10	F 323		

REVISED

R291 admission Minimum Data Set (MDS) dated 3/17/15, identified R291 had moderately impaired cognition and required extensive assistance for most activities of daily living (ADLs) including bed mobility and transfers.

R291's care plan dated 3/20/15 indicated the resident had bilateral (two, one on each side of the bed), one-half side rails which were used to assist R291 with bed mobility and positioning.

R291's Restraints/Adaptive Equipment assessment dated 3/10/15, indicated diagnoses including chronic obstruction pulmonary disease (COPD), generalized pain, a history of falls, and status post rehabilitation procedure. The assessment identified R291 required two, one-half side rails to his bed, related to weakness from COPD, and for increased independence with bed mobility and/or transfers. The assessment lacked any indication the side rails were evaluated to be safe for R291, to reduce the risk for entrapment.

During observtion on 3/23/15, at 1:05 p.m. bilateral, half, metal side rails were raised on R291's bed, with the far side of the bed flush against the wall. The outward-facing side rail was observed tilted down at an angle of approximately 30 degrees from the head of the bed to the foot of the bed. The rail also angled outward, lying away from the bed, at an angle of approximately 15 degrees from the top of the rail to the bottom of the rail. The spacing between the under-side of the rail to the mattress at the head of the bed (FDA zone six), was greater than seven and one

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	245310	A. BUILDING ____ B. WING ____	03/26/2015

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

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F 323	Continued From page 11	F 323		

half inches. Upon manipulation, the rail was loose and maneuverable, with movement both parallel and perpendicular to the mattress, allowing for even greater spacing at zone six. R291 was not in the room at the time of this observation.

During interview on 3/23/15, at 1:07 [illegible].m. the director of nursing (DON) stated R291's siderails had been like this on the bed, "for years and years and years." The DON demonstrated by dialing a black knob at the center of the rail where it was affixed to the bed frame, that the rail could not be tightened and it was as secured to the bedframe as the hardware allowed. After attempting to tighten the rail, the DON confirmed the rail remained loose and maneuverable, with spacing in zone six of greater than seven and one half inches, which put R291 at risk for entrapment.

On 3/24/15, at 9:35 a.m. R291 stated his siderail was very loose and he did not utilize the side rail and felt they were, "Useless." R291 stated, "Try to pull on that thing [siderail]." As writer maneuvered the side rail, both parallel and perpendicular to the bed, R291 stated, "Exactly, you think it's going to hold 200 pounds?"

During interview on 3/24/15, at 10:07 a.m. the DON, facility administrator and the environmental services director (ESD) were interviewed and all stated the side rails on R291's bed were loose. The DON, facility administrator, and ESD stated they were familiar with FDA requirements for bed side rail safety spacing to minimize the risk for entrapment, and the administrator stated all of the facility beds and side rails had been tested and checked routinely by maintenance. . ESD turned the black knob to the right on the side rail,

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	245310	A. BUILDING ______ B. WING ______	03/26/2015

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 323	Continued From page 12 while she set the rail parallel to the bed so it was no longer tilted outward, and she was able to tighten the black knob, securing the rail firmly to the bed frame, limiting the maneuverability of the rail and setting the rail in a manner which resulted in acceptable spacing for zone six. Review of the facility's room maintenance and safety audits indicated the side rail on R[illegible]'s bed was last inspected on 2/25/15, prior to R29's admission to the facility. The audit did not specify aspects of the side rail which were examined and just indicated, "Everything checked out." The facility's Adaptive Equipment policy dated 1/15, indicated, "The facility has assessed the space between all mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used) ... New models of beds and mattresses are assessed if they are purchased and installed ... Residents are checked annually, quarterly, with significant change and PRN [as needed] for safety relative to the adaptive equipment used." Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, detailed the FDA guidance on side rail safety. The guidelines recommended openings in the bed system were to be no more than four and three-quarter inches to reduce the risk of head entrapment. The guidelines also defined zone six as the space between the end of the rail and the side edge of the head or foot board.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		4/1/15

REVISED

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

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F 356	Continued From page 13 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently include current census information on the daily nursing hours posting. This had the potential to affect all 100 residents who resided in the facility.	F 356		

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

PRINTED: 07/23/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING ______ B. WING ______	03/26/2015

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 356	Continued From page 14	F 356		

Findings include:

During initial tour of the facility on 3/23/15, at 12:59 p.m. the facility's Nursing Service Hours Form dated 3/23/15, was observed affixed to the bulletin boards at the entrances of both the Transitional Care Unit (TCU) and the Pioneer Village Unit. The sections of each form designated for notation of the census during each shift were left blank and the facility census was not listed anywhere on the form.

During interview on 3/24/15, at 3:11 p.m. health information coordinator (HIC) stated she was the main employee responsible for daily completion of the facility's Nursing Service Hours Forms. HIC stated on weekdays when she arrived at 6:45 a.m., she looked up the census in the facility's electronic medical record system and checked with the overnight charge nurse to determine whether there were any updates to the scheduled hours for the day shift, and then completed the forms based on the information and posted them on the bulletin boards in each unit of the facility. HIC stated at the end of her shift she again determined whether there were updates to the census or the scheduled hours for the afternoon shift, and made the appropriate adjustments to the posting before she left the facility each day. HIC stated the charge nurse from the evening shift was responsible for identifying census or schedule changes and updating the forms at the end of their shift. On weekends, the charge nurses for each shift were responsible for updating the forms with current census and schedule information for the subsequent shift.

Review of Nursing Service Hours Forms from 1/1/15, through 3/23/15, indicated the following:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING ______ B. WING ______	03/26/2015

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 356	Continued From page 15 The facility census was not identified on the posting for eight out of 80 days, or 10% of days. The facility census was not added to the posting until the end of the evening shift, for an additional eight out of 80 days, or 10% of days. The facility's Nursing Service Hours Forms were accurately posted for less than 80% of days. On 3/24/15, at 3:15 p.m. HIC stated most of the days where the report was inaccurate corresponded with weekends and/or days she was gone on vacation. HIC stated she was having some difficulty with ensuring the postings were updated when she was not available.	F 356		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WU49
Facility ID: 00940

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/13/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, Unit Supervisor 05/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 07/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 07/15/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245310
May 21, 2015

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

Dear Ms. Ager:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 5, 2015 the above facility is certified for or recommended for:

105 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

May 21, 2015

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

RE: Project Number S5310025

Dear Ms. Ager:

On April 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 26, 2015 . This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 5, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 26, 2015, effective May 5, 2015 and therefore remedies outlined in our letter to you dated April 8, 2015, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992   Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245310	A. Building B. Wing	5/13/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	**05/05/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**05/05/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**05/05/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	**05/05/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**05/05/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	**05/05/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	JS/KJ	05/21/2015	29249	5/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/26/2015				

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245310	A. Building B. Wing 01 - MAIN BUILDING 01	4/24/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0011	03/30/2015	ID Prefix Reg. # NFPA 101 LSC K0029	03/31/2015	ID Prefix Reg. # NFPA 101 LSC K0050	03/30/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 5/21/2015	Signature of Surveyor: 12424	Date: 4/24/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/26/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245310	02 - NEW BLDG	4/24/2015

Name of Facility	Street Address, City, State, Zip Code
BENEDICTINE HEALTH CENTER INNSBRUCK	1101 BLACK OAK DRIVE NEW BRIGHTON, MN 55112

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 03/30/2015	ID Prefix Reg. # NFPA 101 LSC K0018	Correction Completed 03/30/2015	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/30/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KJ	5/21/2015	12424	4/24/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/26/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WU49
Facility ID: 00940

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/26/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

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

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

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

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 04/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/20/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

Posted 05/22/2015 co.

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0470 0000 5262 1482
April 8, 2015

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

RE: Project Number S5310025

Dear Ms. Ager:

On March 26, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;**
>
> **<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6**

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 5, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 5, 2015 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 26, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 26, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

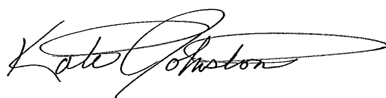
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Scanned 4/27/15

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

PRINTED: 04/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING ______ B. WING ______	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	RECEIVED APR 21 2015 MN Dept of Health St.Cloud	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	approved 4/27/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Agen	Administrator / CEO	4/17/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING ____ B. WING ____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all allegations of abuse were immediately reported to the state agency (SA) and administrator for 3 of 8 allegations (R3, R102, R200) reviewed. Findings include: R3's quarterly minimum data set (MDS) dated 2/23/15, revealed a brief interview for mental status (BIMS) score of 10 (moderate cognitive impairment), and indicated R3 required extensive assistance of one to two staff for all activities of daily living. A Facility Incident Tracking Report dated 2/24/15, indicated on 2/17/14, R3 had reported to a charge nurse that nursing assistant (NA)-B had shaken her by her shoulders during care. An initial tracking form for the incident revealed the allegation of abuse was reported to the SA the next day, 2/18/15.	F 225	**F225 D Facility failed to ensure their abuse prohibition policy was implemented for 3 of 8 allegations of abuse reviewed.** **How will we correct for issue cited?** No resident was harmed related to this citation. There was no suspected abuse/neglect in the 3 cases. All incidents were reported, investigated and cleared by OHFC. **What measures or systemic changes will be made to ensure that the deficient practice will not recur?** Employees were reminded through daily unit meetings and posters to report suspected abuse/neglect issues immediately. **How will we monitor its performance to make sure that solutions are sustained?** We review all incidents at daily IDT meetings to ensure we are compliant. **Date when corrective action will be completed.** May 5, 2015. Director of Social Services is responsible.	

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 ______	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 R102's quarterly MDS dated 2/16/15, revealed R102 had a BIMS of 13 (cognitively intact), and indicated R102 had no history of hallucinations. A facility Incident Report Submission indicated on 1/28/15, R102 accused an unidentified nurse of kneeling on her feeding tube site during cares. The report was not submitted to the SA until 1/30/15, two days after the allegation was initially received by social worker (SW)-A from a physical therapy staff member via email. R200's quarterly MDS dated 12/5/14, revealed R200 had a BIMS score of 12 (moderate cognitive impairment) and no behavioral symptoms. A Incident Tracking submitted to the SA indicated R200 had been found wandering toward the facility parking lot on 9/7/14, and R200 had stated he was going to check out the patio by the freeway. The incident tracking indicated the incident was not submitted to the SA until the next day on 9/8/14. During interview on 3/26/15, at 11:29 a.m. the director of social services (DSS) stated incidents of abuse should be reported immediately, and facility staff needed to "Get sharper on that [reporting immediately]." The DSS stated the nursing staff generally reported allegations of abuse to the DON, who immediately notified the administrator. The DSS stated she might wait until next day to report an incident to the SA if the resident was safe and something happened during the night, and the administrator was notified immediately at time of the verbal report via text or email, and any alleged perpetrators were put on suspension pending investigation of	F 225		

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 ____	03/26/2015

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 225	Continued From page 3 the incident. During interview on 3/26/15, at 1:36 p.m. the director of nursing (DON) stated if she received an allegation of abuse she would call the administrator immediately and then report the incident to the SA, however, she stated she had up to 24 hours to report allegations of abuse to the SA. The DON stated she was unaware of the incident involving R102 until a couple of days after it had happened, and had notified the administrator and SA when she was made aware of the incident. During interview on 3/26/15, at 1:36 p.m. the facility administrator stated she was notified immediately of allegations of abuse, however, she thought the facility had up to 24 hours to report incidents to the SA unless substantiated abuse or neglect was suspected at the time of the initial report. The facility policy titled Abuse Prevention Plan dated 1/15, instructed all allegations of abuse should be immediately reported to the SA and the administrator.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by:	F 226		

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F 226	Continued From page 4 Based on interview and document review, the facility failed to implement their abuse reporting procedure related to immediate reporting of allegations of abuse to the state agency (SA) and administrator for 3 of 8 allegations (R3, R102, R200) reviewed. Findings include: R3's quarterly minimum data set (MDS) dated 2/23/15, revealed a brief interview for mental status (BIMS) score of 10 (moderate cognitive impairment), and indicated R3 required extensive assistance of one to two staff for all activities of daily living. A Facility Incident Tracking Report dated 2/24/15, indicated on 2/17/14, R3 had reported to a charge nurse that nursing assistant (NA)-B had shaken her by her shoulders during care. An initial tracking form for the incident revealed the allegation of abuse was reported to the SA the next day, 2/18/15. R102's quarterly MDS dated 2/16/15, revealed R102 had a BIMS of 13 (cognitively intact), and indicated R102 had no history of hallucinations. A facility Incident Report Submission indicated on 1/28/15, R102 accused an unidentified nurse of kneeling on her feeding tube site during cares. The report was not submitted to the SA until 1/30/15, two days after the allegation was initially received by social worker (SW)-A from a physical therapy staff member via email. R200's quarterly MDS dated 12/5/14, revealed R200 had a BIMS score of 12 (moderate cognitive impairment) and no behavioral	F 226	**F226 D Facility failed to ensure allegations of abuse were reported immediately to the state agency for 3 of 8 allegations reviewed.** **How will we correct for issue cited?** No resident was harmed related to this citation. There was no suspected abuse/neglect. All incidents were reported, investigated and cleared by OHFC. **What measures or systemic changes will be made to ensure that the deficient practice will not recur?** We will create and use a form that captures the timeline of all reportable incidents and use that form to monitor report times to ensure that all reportable incidents are reported immediately and within the time frame identified by law. **How will we monitor its performance to make sure that solutions are sustained?** We review all incidents at daily IDT meetings and weekend/evening supervisors review to ensure we are compliant. **Date when corrective action will be completed.** May 5, 2015. Director of Social Services is responsible.	

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F 226	Continued From page 5 symptoms. A Incident Tracking submitted to the SA indicated R200 had been found wandering toward the facility parking lot on 9/7/14, and R200 had stated he was going to check out the patio by the freeway. The incident tracking indicated the incident was not submitted to the SA until the next day on 9/8/14. During interview on 3/26/15, at 11:29 a.m. the director of social services (DSS) stated incidents of abuse should be reported immediately, and facility staff needed to "Get sharper on that [reporting immediately]." The DSS stated the nursing staff generally reported allegations of abuse to the DON, who immediately notified the administrator. The DSS stated she might wait until next day to report an incident to the SA if the resident was safe and something happened during the night, and the administrator was notified immediately at time of the verbal report via text or email, and any alleged perpetrators were put on suspension pending investigation of the incident. During interview on 3/26/15, at 1:36 p.m. the director of nursing (DON) stated if she received an allegation of abuse she would call the administrator immediately and then report the incident to the SA, however, she stated she had up to 24 hours to report allegations of abuse to the SA. The DON stated she was unaware of the incident involving R102 until a couple of days after it had happened, and had notified the administrator and SA when she was made aware of the incident. During interview on 3/26/15, at 1:36 p.m. the	F 226		

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F 226	Continued From page 6 facility administrator stated she was notified immediately of allegations of abuse, however, she thought the facility had up to 24 hours to report incidents to the SA unless substantiated abuse or neglect was suspected at the time of the initial report. The facility policy titled Abuse Prevention Plan dated 1/15, instructed all allegations of abuse should be immediately reported to the SA and the administrator.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R95) reviewed for activities of daily living received assistance with shaving as directed by the care plan. Findings include: R95's quarterly minimum data set (MDS) dated 3/21/15, indicated R95 had moderate cognitive impairment, and required extensive assistance of one staff for all grooming activities. R95's care area assessment (CAA) dated 9/23/14, indicated R95 needed assistance in all activities of daily living including grooming due to	F 282	**F 282 D Facility failed to ensure 1 of 2 residents reviewed for activities of daily living received assistance with grooming as directed by the care plan.** The resident in question requires assistance with all activities of daily living, but often declines assistance from staff and sometimes gets agitated when staff attempt to redirect resident. **How will we correct for issue cited?** The resident has a new shaver (previous shaver was broken because he takes it apart). Staff have been able to help him shave almost daily. If he refuses, this is documented in EHR via eMAR.	

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F 282	Continued From page 7 muscle weakness. R95's care plan dated 3/25/15, indicated R95 had diagnoses including tremor, muscular atrophy, difficulty walking, and required staff assistance with shaving daily. During observation on 3/23/15, at 7:40 p.m. R95 had a significant amount of facial hair, especially under his chin and on the upper neck. During interview at this time, R95 stated he preferred to be clean shaven but needed staff to help him shave. During observation on 3/24/15, at 9:17 a.m. R95 was still unshaven. R95 stated it took them [staff] "Forever," to come to help him this morning and staff had still not helped him to shave but, "I sure wish they would." During observation on 3/25/15, at 8:45 a.m. R95 was observed with significant facial hair on the upper neck and chin area, approximately 3/4" long. Nursing Assistant (NA)-A assisted R95 with his morning cares and did not offer R95 shaving assistance before leaving the room to assist other residents. During interview on 3/25/15, at 9:47 a.m. R95 stated he wished staff would shave him consistently, and he wanted his facial hair trimmed. During interview on 3/25/15, at 9:48 a.m. NA-A stated R95 should be offered assistance with shaving on a daily basis, and his electric razor was broken so staff needed to use a straight razor to shave R95.	F 282	**What measures or systemic changes will be made to ensure that the deficient practice will not recur?** All residents are asked on admission and quarterly how often they want to be shaved and this recorded on the skin integrity form and care plan. All patient and resident ADLs are assessed upon admission to the facility, quarterly, annually and with significant change. ADLs provided by staff are documented in the facility electronic medical record system. **How will we monitor its performance to make sure that solutions are sustained?** The information is reviewed quarterly, annually and with significant changes. Daily rounds identify any resident needs and follow-up is completed as needed. **Date when corrective action will be completed.** April 22, 2015. The Director of Nursing or designee is responsible.	

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F 282	Continued From page 8 During interview on 3/25/15, at 9:54 a.m., registered nurse (RN)-C, who was the assistant director of nursing, stated R95 should be offered shaving assistance daily and R95 had razors available for use. Facility policies related to shaving and grooming were requested, but not provided.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 1 resident (R95) reviewed for activities of daily living received assistance with shaving. Findings include: R95's quarterly minimum data set (MDS) dated 3/21/15, indicated R95 had moderate cognitive impairment, and required extensive assistance of one staff for all grooming activities. R95's care area assessment (CAA) dated 9/23/14, indicated R95 needed assistance in all activities of daily living including grooming due to muscle weakness. R95's care plan dated 3/25/15, indicated R95 had	F 312	**F312 D Facility failed to ensure 1 of 2 residents reviewed for activities of daily living received assistance with shaving.** The resident in question requires assistance with all activities of daily living, but often declined assistance from staff and sometimes gets agitated when staff attempt to redirect resident. Staff will continue to offer to shave resident daily as he allows and document in the facility electronic medical record. **How will we correct for issue cited?** Staff will offer to shave resident every day and as needed. This information has been place on the resident plan of care to reflect resident daily care needs.	

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F 312	Continued From page 9 diagnoses including tremor, muscular atrophy, difficulty walking, and required staff assistance with shaving daily. During observation on 3/23/15, at 7:40 p.m. R95 had a significant amount of facial hair, especially under his chin and on the upper neck. During interview at this time, R95 stated he preferred to be clean shaven but needed staff to help him shave. During observation on 3/24/15, at 9:17 a.m. R95 was still unshaven. R95 stated it took them [staff] "Forever," to come to help him this morning and staff had still not helped him to shave but, "I sure wish they would." During observation on 3/25/15, at 8:45 a.m. R95 was observed with significant facial hair on the upper neck and chin area, approximately 3/4" long. Nursing Assistant (NA)-A assisted R95 with his morning cares and did not offer R95 shaving assistance before leaving the room to assist other residents. During interview on 3/25/15, at 9:47 a.m. R95 stated he wished staff would shave him consistently, and he wanted his facial hair trimmed. During interview on 3/25/15, at 9:48 a.m. NA-A stated R95 should be offered assistance with shaving on a daily basis, and his electric razor was broken so staff needed to use a straight razor to shave R95. During interview on 3/25/15, at 9:54 a.m., registered nurse (RN)-C, who was the assistant director of nursing, stated R95 should be offered	F 312	**What measures or systemic changes will be made to ensure that the deficient practice will not recur?** All patients and residents will be asked about their shaving preferences on admission by the admitting nurse and this information will be documented on the admission skin integrity form. This information will then be incorporated into the patient plan of care. Daily rounds identify any resident needs and follow-up is completed as needed. **How will we monitor its performance to make sure that solutions are sustained?** The information will be reviewed quarterly, annually and with significant change. **Date when corrective action will be completed.** April 22, 2015. The Director of Nursing/designee is responsible.	

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F 312	Continued From page 10 shaving assistance daily and R95 had razors available for use. Facility policies related to shaving and grooming were requested, but not provided.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure bed side rails were in compliance with Food and Drug Administration (FDA) requirements to minimize the risk of entrapment, for 1 of 1 resident (R291) reviewed for side rail safety. Findings include: R291 admission Minimum Data Set (MDS) dated 3/17/15, identified R291 had moderately impaired cognition and required extensive assistance for most activities of daily living (ADLs), including bed mobility and transfers. R291's care plan dated 3/20/15, indicated the resident had bilateral (two, one on each side of the bed), one-half side rails which were used to	F 323	**F323 D Facility failed to ensure bed side rails were in compliance with FDA requirements to minimize the risk of entrapment, for 1 of 1 resident reviewed for side rail safety.** **How will we correct for issue cited?** The bed in question was exchanged immediately on March 24. A new bed was purchased and is in use. **What measures or systemic changes will be made to ensure that the deficient practice will not recur?** We identified 3 beds with the same design and replaced all three. Although these beds were assessed for safety and passed, it is remotely possible for the knob to come loose so we got rid of them. All beds are already on a preventative maintenance monthly check and we will continue to do this. All residents, including the individual in this bed, are assessed to use side rails safely.	

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F 323	Continued From page 11 assist R291 with bed mobility and positioning. R291's Restraints/Adaptive Equipment assessment dated 3/10/15, indicated diagnoses including chronic obstruction pulmonary disease (COPD), generalized pain, a history of falls, and status post rehabilitation procedure. The assessment identified R291 required two, one-half side rails to his bed, related to weakness from COPD, and for increased independence with bed mobility and/or transfers. The assessment lacked any indication the side rails were evaluated to be safe for R291, to reduce the risk for entrapment. During observtion on 3/23/15, at 1:05 p.m. bilateral, half, metal side rails were raised on R291's bed, with the far side of the bed flush against the wall. The outward-facing side rail was observed tilted down at an angle of approximately 30 degrees from the head of the bed to the foot of the bed. The rail also angled outward, lying away from the bed, at an angle of approximately 15 degrees from the top of the rail to the bottom of the rail. The spacing between the under-side of the rail to the mattress at the head of the bed (FDA zone six), was greater than seven and one half inches. Upon manipulation, the rail was loose and maneuverable, with movement both parallel and perpendicular to the mattress, allowing for even greater spacing at zone six. R291 was not in the room at the time of this observation. During interview on 3/23/15, at 1:07 p.m. the director of nursing (DON) stated R291's siderails had been like this on the bed, "For years and years and years." The DON demonstrated by dialing a black knob at the center of the rail where	F 323	**How will we monitor its performance to make sure that solutions are sustained?** We will continue to follow our current procedures of preventative maintenance and individual resident side rail assessments. **Date when corrective action will be completed.** April 3, 2015. Director of Environmental Services is responsible.	

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F 323	Continued From page 12	F 323		

it was affixed to the bed frame, that the rail could not be tightened and it was as secured to the bedframe as the hardware allowed. After attempting to tighten the rail, the DON confirmed the rail remained loose and maneuverable, with spacing in zone six of greater than seven and one half inches, which put R291 at risk for entrapment.

On 3/24/15, at 9:35 a.m. R291 stated his siderail was very loose and he did not utilize the side rail and felt they were, "Useless." R291 stated, "Try to pull on that thing [siderail]." As writer maneuvered the side rail, both parallel and perpendicular to the bed, R291 stated, "Exactly, you think it's going to hold 200 pounds?"

During interview on 3/24/15, at 10:07 a.m. the DON, facility administrator and the environmental services director (ESD) were interviewed and all stated the side rails on R291's bed were loose. The DON, facility administrator, and ESD stated they were familiar with FDA requirements for bed side rail safety spacing to minimize the risk for entrapment, and the administrator stated all of the facility beds and side rails had been tested and checked routinely by maintenance. . ESD turned the black knob to the right on the side rail, while she set the rail parallel to the bed so it was no longer tilted outward, and she was able to tighten the black knob, securing the rail firmly to the bed frame, limiting the maneuverability of the rail and setting the rail in a manner which resulted in acceptable spacing for zone six.

Review of the facility's room maintenance and safety audits indicated the side rail on R291's bed was last inspected on 2/25/15, prior to R291's admission to the facility. The audit did not specify

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F 323	Continued From page 13 aspects of the side rail which were examined and just indicated, "Everything checked out." The facility's Adaptive Equipment policy dated 1/15, indicated, "The facility has assessed the space between all mattress and side rails to reduce the risk for entrapment (the amount of safe space may vary, depending on the type of bed and mattress being used) ... New models of beds and mattresses are assessed if they are purchased and installed ... Residents are checked annually, quarterly, with significant change and PRN [as needed] for safety relative to the adaptive equipment used." Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 3/10/06, detailed the FDA guidance on side rail safety. The guidelines recommended openings in the bed system were to be no more than four and three-quarter inches to reduce the risk of head entrapment. The guidelines also defined zone six as the space between the end of the rail and the side edge of the head or foot board.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		

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F 356	Continued From page 14 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently include current census information on the daily nursing hours posting. This had the potential to affect all 100 residents who resided in the facility. Findings include: During initial tour of the facility on 3/23/15, at 12:59 p.m. the facility's Nursing Service Hours Form dated 3/23/15, was observed affixed to the bulletin boards at the entrances of both the Transitional Care Unit (TCU) and the Pioneer Village Unit. The sections of each form designated for notation of the census during each shift were left blank and the facility census was not listed anywhere on the form.	F 356	**F356 C Facility failed to consistently include the current census information on the nursing hours posting.** **How will we correct for issue cited?** We posted the correct form that had been delayed in posting on 2 of the 4 bulletin board postings. **What measures or systemic changes will be made to ensure that the deficient practice will not recur?** We will post on the Garden Terrace bulletin board near the lobby area. We will post a reference on each of the other 3 bulletin boards to direct visitors to correct posting location. We will ensure that the census is listed on the posting. **How will we monitor its performance to make sure that solutions are sustained?** The staffing coordinator will check status daily. On the weekends and holidays, the nursing supervisor will add census. Sheets will be audited once per week by the staffing coordinator. **Date when corrective action will be completed.** April 1, 2015. Director of Nursing is responsible.	

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

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F 356	Continued From page 15 During interview on 3/24/15, at 3:11 p.m. health information coordinator (HIC) stated she was the main employee responsible for daily completion of the facility's Nursing Service Hours Form. HIC stated on weekdays when she arrived at 6:45 a.m., she looked up the census in the facility's electronic medical record system and checked with the overnight charge nurse to determine whether there were any updates to the scheduled hours for the day shift, and then completed the forms based on the information and posted them on the bulletin boards in each unit of the facility. HIC stated at the end of her shift she again determined whether there were updates to the census or the scheduled hours for the afternoon shift, and made the appropriate adjustments to the posting before she left the facility each day. HIC stated the charge nurse from the evening shift was responsible for identifying census or schedule changes and updating the forms at the end of their shift. On weekends, the charge nurses for each shift were responsible for updating the forms with current census and schedule information for the subsequent shift. Review of Nursing Service Hours Forms from 1/1/15, through 3/23/15, indicated the following: The facility census was not identified on the posting for eight out of 80 days, or 10% of days. The facility census was not added to the posting until the end of the evening shift, for an additional eight out of 80 days, or 10% of days. The facility's Nursing Service Hours Forms were accurately posted for less than 80% of days. On 3/24/15, at 3:15 p.m. HIC stated most of the days where the report was inaccurate, corresponded with weekends and/or days she	F 356		

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 ____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	Continued From page 16 was gone on vacation. HIC stated she was having some difficulty with ensuring the postings were updated when she was not available.	F 356		

F5310024

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

PRINTED: 04/08/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING : MAIN BUILDING 01 B. WING	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Health Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	PoC ok B 4-17-15 RECEIVED APR 16 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 3-26-15   Dc: 5-5-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Ager
TITLE: Administrator /CEO
(X6) DATE: 4/15/15

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING MAIN BUILDING 01 B. WING	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Angela.Kappenman@state.mn.usand Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Benedictine Health Center at Innsbruck is a 2-story building with no basement. The building was built at 3 different times. The original building was constructed in 1965 and was determined to be of Type II (222) construction. In 1991 an addition was constructed to the north and was determined to be of Type I(222) construction. In 2005 the Transitional Care Unit (TCU) was added to the north that was determined to be of Type V(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building one was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19 and the TCU building was surveyed in accordance with LSC Chapter 18. Both buildings have a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING 02 - NEW BLDG B. WING ____	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 each resident room that is monitored for fire department notification. the facility has a capacity of 105 census at the time of this survey was 99. A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1965 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the 2-hour fire separation at the required location. This deficient practice could affect the safety of all residents, staff and visitors in the event of a fire, as fire and smoke could pass from one building to the other. Findings include: On facility tour between 9:30 AM and 2:30 PM on 03-26-2015, it was observed that the 2-hour fire separation doors did not operate as required in the following location:	K 011	**K-011 F Fire separation doors between building 1 and building 2 did not properly latch when tested.** **A description of what has been done.** Closers were improperly timed and not fast enough to pull door shut. Doors were adjusted. **The actual or proposed due date.** 3/30/15. **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** Director of Environmental Services	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 each resident room that is monitored for fire department notification. the facility has a capacity of 105 census at the time of this survey was 99.. A K-067 has been written in past surveys. upon further detailed investigation it has been found that The supply and return for the 1965 building meets the CMS S&C- 06-18, letter from May 26, 2006. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the 2-hour fire separation at the required location. This deficient practice could affect the safety of all residents, staff and visitors in the event of a fire, as fire and smoke could pass from one building to the other. Findings include: On facility tour between 9:30 AM and 2:30 PM on 03-26-2015, it was observed that the 2-hour fire separation doors did not operate as required in	K 011	**K-011 F Fire separation doors between building 1 and building 2 did not properly latch when tested.** **A description of what has been done.** Closers were improperly timed and not fast enough to pull door shut. Doors were adjusted. **The actual or proposed due date.** 3/30/15. **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** Director of Environmental Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 3 the following location: 1) The fire barrier door between the new and existing nursing home did not self close and latch when tested. This deficiency was verified by the facility Administrator (SA) at the time of discovery.	K 011		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This deficient practice could affect all residents, guests and staff within the smoke compartments Findings include: On facility tour between 09:30 AM and 02:30 PM on 03/26/2015, it was observed that the corridor to the 2nd floor Soiled Linen Room 213 did not automatically close and latch when tested.	K 029	**K-029 D Soiled Linen Room 213 door to corridor did not automatically close and latch when tested.** **A description of what has been done.** Hinges adjusted so door latches on 3/26/15. Maintenance went on tour throughout the building and checked all doors for latching in the facility that are on closers. Put door latching on preventive maintenance list for monthly checks. **The actual or proposed due date.** 3/31/15 **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** Director of Environmental Services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**03/26/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 This deficiency was verified by the facility Administrator (SA) at the time of discovery.	K 029		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:30 AM and 02:30 PM on 03/26/2015, based on review of available documentation it was reveled that Fire drills were not varied throughout the shift on the Evening Shift during the last 12 months. 6 drills were conducted and all were done between 3:30 PM and 6:00 PM This deficiency was verified by the facility Administrator (SA) at the time of discovery.	K 050	**K-050 C Evening shift fire drills were not varied throughout the shift in the last 12 months.** **A description of what has been done.** All fire drills scheduled on Outlook through 2015 so that times are spaced according to regulation. We will continue to do this annually. **The actual or proposed due date.** 3/30/15 **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** Director of Environmental Services	

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

F5310024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245310	(X2) MULTIPLE CONSTRUCTION A. BUILDING NEW BLDG B. WING ___	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER: BENEDICTINE HEALTH CENTER INNSBRUCK		STREET ADDRESS, CITY, STATE, ZIP CODE: 1101 BLACK OAK DRIVE, NEW BRIGHTON, MN 55112	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Benedictine Health Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	POC ok TB 4-17-15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 4/15/15

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING - NEW BLDG B. WING	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Angela.Kappenman@state.mn.usand Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Benedictine Health Center at Innsbruck is a 2-story building with no basement. The building was built at 3 different times. The original building was constructed in 1965 and was determined to be of Type II (222) construction. In 1991 an addition was constructed to the north and was determined to be of Type I(222) construction. In 2005 the Transitional Care Unit (TCU) was added to the north that was determined to be of Type V(111) construction. This facility was surveyed as two separate buildings because of different dates of construction. Building one was constructed prior to March 1, 2003. Therefore, it was surveyed in accordance with LSC Chapter 19 and the TCU building was surveyed in accordance with LSC Chapter 18. Both buildings have a complete automatic fire sprinkler system. The facility has a fire alarm system that consists of smoke detection in the corridors and areas open to the corridors and in	K 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING 02 - NEW BLDG B. WING ______	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 011	Continued From page 3 1) The fire barrier door between the new and existing nursing home did not self close and latch when tested. This deficiency was verified by the facility Administrator (SA) at the time of discovery.	K 011		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not have corridor doors that meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 09:30 AM and 02:30 PM on 03/26/2015, it was observed that the corridor doors do not properly latch to protect the room from the corridor in the following locations: 1) Linen Storage Room 118A. 2) Wheelcaair Storage Room 120A. This deficiency was verified by the facility Administrator (SA) at the time of discovery.	K 018	**K-018 D Linen Room 118A and Wheelchair Room 120A did not properly latch when tested.** **A description of what has been done.** We repaired and realigned both doors for latching. **The actual or proposed due date.** 3/30/15 **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** Director of Environmental Services	
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245310	A. BUILDING **02 - NEW BLDG** B. WING ______	03/26/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050 SS=C	Continued From page 4 Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:30 AM and 02:30 PM on 03/26/2015, based on review of available documentation it was reveled that Fire drills were not varied throughout the shift on the Evening Shift during the last 12 months. 6 drills were conducted and all were done between 3:30 PM and 6:00 PM This deficiency was verified by the facility Administrator (SA) at the time of discovery.	K 050	**K-050 C Evening shift fire drills were not varied throughout the shift in the last 12 months.** **A description of what has been done.** All fire drills scheduled on Outlook through 2015 so that times are spaced according to regulation. We will continue to do this annually. **The actual or proposed due date.** 3/30/15 **The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.** Director of Environmental Services	